The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 6th October 2022

Agenda and Papers

Excellence in Neuroscience

PUBLIC TRUST BOARD MEETING
Thursday 6th October 2022

Boardroom

09:30 - 13.15

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies (v)	Chair	N/A
2	09.30	Declaration of Interests (v)	Chair	N/A
3	09.35	Minutes and actions of meeting held on 1st September 2022 (d)	Chair	Decision
4	09.40	Patient Story (v)	Chief Nurse	Information
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update (v/d)	Chief Executive Officer	Information
6	10.15	Trust Strategy Update (p)	Medical Director	Approve
7	10.30	University Hospital Status Update (d)	Chief Executive Officer	Information
8	10.40	Board Assurance Framework Quarter 1 2022-23 (d)	Corporate Secretary	Assurance
INTEGRATED PERFORMANCE REPORT				
9	10.55	Integrated Performance Report (d)	Chief Executive Officer	Assurance
10	11.00	Business Performance Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
11	11.10	Quality Committee: Chair's Assurance Report (d)	Committee Chair	Assurance
12	11.20	Health Inequalities Update (p)	Chief People Officer	Assurance
11.30 BREAK				
QUALITY & SAFETY				
13	11.40	CQC Inpatient Survey (d)	Chief Nurse	Assurance
RESEARCH & DEVELOPMENT/ INNOVATION				
14	11.50	Research and Development Annual Report (d)	Chief People Officer	Assurance
WORKFORCE				
15	12.00	Staff Survey Update and TEA Feedback (d)	Chief People Officer	Assurance
16	12.10	Responding to In Work Poverty (d)	Chief People Officer	Assurance
GOVERNANCE				
17	12.20	Cheshire & Merseyside Provider Collaborative (CMAST) Collaborative Agreement and Committee in Common (d)	Chief Executive Officer	Information
CHAIR'S ASSURANCE REPORTS FROM BOARD COMMITTEES				

Item	Time	Item	Owner	Purpose
18	12.30	RIME Committee 7th September 2022: • Chairs Assurance Report (d) • Terms of Reference (d)	Committee Chair	Assurance
19	12.40	Remuneration Committee 1st September 2022: • Chairs Assurance Report (d) • Terms of Reference (d)	Committee Chair	Assurance
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Health Education England Self-Assessment (d) • EPRR Core Standards Self-Assessment (d) • NHS Prevention Pledge Progress Update (d)				
CONCLUDING BUSINESS				
20	12.50	Any Other Business (v)	Chair	Information
21	12.55	Review of Meeting (v)	Chair	Information

Date and Time of Next Meeting: 9.30am, 3rd November 2022, Boardroom, The Walton Centre

UNCONFIRMED

Minutes of the Public Trust Board Meeting

Meeting held via Microsoft Teams

1st September 2022

Present:

Max Steinberg	Chair
Karen Bentley	Non-Executive Director (NED-KB)
Paul May	Non-Executive Director (NED-PM)
Su Rai	Senior Independent Director (SID)
David Topliffe	Non-Executive Director (NED-DT)
Ray Walker	Non-Executive Director (NED-RW)
Mike Burns	Chief Financial Officer (CFO)
Mike Gibney	Chief People Officer (CPO)
Andy Nicolson	Medical Director (MD)
Jan Ross	Chief Executive (CEO)
Lisa Salter	Chief Nurse (CN)

In attendance:

John Baxter	Corporate Governance Officer (CGO) (minutes)
Katharine Dowson	Corporate Secretary (CS)
Sam Fleet	Senior External Communications Officer (SECO) (item 4)
Lisa Judge	Head of Patient & Family Experience (HPFE) (item 4)
John O'Sullivan	Director, Investors in People (DIIP) (item 12)
Rebekah Phillips	Associate Director of Operations (ADO) (deputising for COO)
Rachel Saunderson	Innovation Co-ordinator (IC) (items 8 and 12)
Elaine Vaile	Communications and Marketing Manager (CMM)

Observers:

Jonathan Desmond	Public Governor – Merseyside
Nanette Mellor	Partnership Governor – The Brain Charity

Apologies:

Lindsey Vlasman	Chief Operating Officer (COO)

1 Welcome and apologies

1.1 Apologies were received as above. The Chair welcomed everyone to the meeting.

2 Declarations of interest

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

3 Minutes of the meeting held on 7th July 2022

3.1 NED-DT requested the that the first sentence under paragraph 5.3 was amended to read *"It was recognised that backlog maintenance continued to be a major issue across the Integrated Care System (ICS) and a half day session to review this would be held on 21st July, the Chair would report back following this session".*

3.2 CFO requested that paragraph 16.6 was amended to read "*The updated financial plans had now been submitted to the ICS and it was recognised that there remained risks with the financial plan and non-recurrent mitigations had been built into the plan to assist however this was likely to be similar for all providers. ERF allocations were to be paid on a quarterly basis and calculated by the national team with performance data only produced mid-month following the quarter end."*

3.3 Following completion of these amendments the minutes of the meeting held on 7th July 2022 were approved as an accurate record of the meeting.

Action tracker

3.4 Action ref. 17 Medical Education Annual Report was updated and closed for removal from the tracker.

4 Patient Story

4.1 CMM and SECO joined the meeting and introduced the patient.

4.2 The patient informed that they had been a patient at the Trust under both Neurosurgery and Neurology. In 2013 following a craniotomy at The Walton Centre multiple meningiomas were identified and the patient underwent a neuropsychological assessment and radiology scans.

4.3 The patient described how they had not thought their symptoms were related to migraines as they had previously suffered from headaches related to brain tumours. They were therefore initially resistant to being referred to Dr Krishnan for review and exploration of migraines but ultimately this was the diagnosis.

4.4 The patient reported that they had felt safe throughout their journey and where anything had not gone according to plan this was followed up with an apology and action was taken to rectify the situation. The patient advised that they now had a much better sense of control and the bad days were better.

4.5 The patient highlighted that education for GPs regarding migraines and the different medications and treatments available would improve the patient journey. Waiting was the most difficult part of the patient journey and providing patients with an expected timeline, information about the patient's diagnosis for employers to improve understanding and signposting to patient support services would be helpful. The patient also provided an overview of things that the patient had undertaken themselves to assist with their journey and to improve the control of their symptoms.

4.6 MD stated that it was good to hear about how migraines had been explained and advised that work was ongoing to help support GPs and clinical staff, however there remained work to be completed in this area.

4.7 NED-PM recognised that the effect of patient anxiety regarding scans and waiting times was underestimated and it would be beneficial to utilise external research to assist with improving patient journeys.

4.8 NED-RW highlighted the importance of the Trust setting its standards out and

communicating these to patients as well as providing information for employers as this would assist in brokering conversations between patients and employers.

The Board recorded thanks to the patient for sharing their story.

5 Chair & Chief Executive's Report

5.1 The Chair updated that the vacant Non-Executive Director position had not been recruited to following the recent recruitment process. This position would be advertised again and an update provided to the December Board meeting.

5.2 The Annual Members Meeting was scheduled to take place on 8th September following the Council of Governors meeting. There were seven new Governors due to start in post on 7th September however there remained some vacancies within the Council of Governors.

5.3 The Chief Executive presented their report detailing updates from a national, regional and Trust perspective. the current wave of Covid infections had peaked during July and staff sickness rates were reducing however this had impacted on operational issues during July as presented in the Integrated Performance Report (IPR) (item 9)

5.4 NED-RW queried if there were any concerns regarding impact on patients in the Trust Winter Plan due to the focus on 78 week waits. CEO clarified that the Trust continued to deal with patients on a chronological basis and there should be no internal impact however external factors such as Covid and mutual aid may have an impact on how quickly patients were treated.

The Board noted the CEO Report.

6 Trust Strategy 2022-25 and Launch

6.1 MD presented the Trust Strategy and noted that some further comment on minor points and typos had been received since the meeting pack was published and these had been addressed.

6.2 MD informed that a public relations plan had been formulated around the launch of the strategy and this was scheduled to begin on 14th September with a walkabout of the Trust undertaken by the Chair and CEO followed by a walkabout by MD and the Deputy Director of Strategy on 15th September. *[Post-Board note: This date was delayed until the 29 September following the death of Queen Elizabeth II and a period of national mourning].*

6.3 Discussions with staff groups around the content of the strategy had been held at each of the recent Talk, Engage, Action (TEA) sessions with staff. A schedule of feedback to Board would be compiled to report progress of delivery against the strategic aims and this would be presented when available.

6.4 NED-RW highlighted the requirement for a clear plan for the reporting of substrategies and it was confirmed that this would form part of the cycle of business for Board.

The Board agreed that the Trust Strategy 2022-25 should be launched with stakeholders and staff.

7 Communications and Marketing Strategy Update

7.1 CMM informed the Board that work on the Communications and Marketing Substrategy was underway and would build on the last 18 months work undertaken by the communications team. The development of the Substrategy would require collaboration with other stakeholders, departments and divisions.

7.2 There had been a change in approach to external communications to raise the profile of the Trust and this had been received positively by key staff including Consultants. A number of opportunities for internal communications had been identified and it was reported that a new email platform had been implemented which had provided further insight; plans were also in place for a new intranet site.

7.3 The new Trust website was live and data relating to page visits was reported to be positive, changes had been made to content shared on Trust social media channels with some good stories being shared recently.

7.4 The communications team had worked closely with the Head of Fundraising and would be working collaboratively on the Charity and Fundraising Substrategy.

7.5 The Chair highlighted that Dan Carden MP was scheduled to visit the Trust on 9th September and noted the importance of having the new Trust Strategy available at this time. *[Post-Board note: This date was cancelled following the death of Queen Elizabeth II and a period of national mourning and the date is currently being rescheduled].*

7.6 NED-SR queried if the communications team had sufficient resources in place to deliver the Substrategy and CMM responded that there was a team of excellent staff in place however there would be an increased focus on marketing as work progressed through the Trust strategy. A clearer picture on resource requirements would be known within the next six to twelve months.

7.7 NED-PM recognised that the atmosphere felt different from a clinical point of view and CMM stated that the team had been working collaboratively with clinical teams to identify the best way to deliver the outcomes requested by clinicians when promoting services.

The Board noted the communications and marketing update.

8 Social Value Projects

8.1 IC joined the meeting to provide an update on programmes being undertaken across the Trust on a local and regional level that had social value at their core. CPO noted the role of the Trust in improving people's health and reducing health inequalities beyond the services it provided. The 'All Together Fairer' report published by Sir Michael Marmot in May 2022 set out the health inequality challenges for Cheshire and Merseyside and detailed eight principles along with some key recommendations and the Trust was focusing on principles seven and eight. The report highlighted Liverpool had the fourth highest proportion of its population living in income deprived households. It was recognised that 83% of Trust employees lived in the Liverpool City Region, with 40% of the workforce living in the three areas with the highest indices of deprivation, and therefore would face the same inequalities which would directly affect the health and wellbeing of staff and ultimately patient outcomes.

8.2 The Trust had signed up to the Social Value Charter and work towards Social Value Quality Mark accreditation was underway, Once level one accreditation was complete the Trust would then work towards level two accreditation.

8.3 IC provided an overview of key initiatives in regard to health inequalities and informed that the Trust was an active partner in developing the health zone of 'Everton in the Community' and 'Everton Minds' programmes which would have a focus on dementia. Discussions regarding potential Trust activity delivered at Goodison Park were underway, alongside the technological aspects of this work.

8.4 The Trust had signed up to the NHS Prevention Pledge and an action plan had been developed to deliver against the ten priority commitments. This work was being progressed through the Deputies Forum in collaboration with the Cheshire and Mersey Healthcare Partnership Equalities Group. The Trust was also working towards NHS Veterans accreditation and had lodged an application to the Liverpool City Region Fair Employer Charter.

8.5 IC also informed that work was ongoing to link with the communications team to publicise the Trusts involvement with these programmes. IC would also link in with Staff Partnership Committee to share progress with staff side colleagues and informed that staff side were fully supportive of these programmes.

8.6 NED-RW queried where this work would sit within the Trust for governance and CPO recognised that governance was pivotal and work was underway to identify key performance indicators and how these would be monitored. IC added that a working group had been developed which reported into the People Group which in turn reported into Business Performance Committee (BPC).

The Board noted progress against social value programmes and supported the continuation of delivery of the initiatives.

9 Integrated Performance Report

9.1 The CEO informed that check and challenge of the Integrated Performance Report (IPR) had not been undertaken at Board Committees in the normal way as there had been no committee meetings during August. Therefore, the Chairs of the relevant Committee would present the review of the June data as part of their assurance reports, but it should be noted that the July data hds not been subject to committee review.

9.2 NED-RW queried the increase in medical vacancies for the month of July and assurance was provided that while there were some gaps between appointments into vacancies there were no concerns, however the data would be reviewed for clarity.

9.3 NED-DT, as Chair of BPC, highlighted that the operational focus was on the activity recovery plan and this had progressed well during June with the exception of elective activity. A deep dive had been undertaken which provided assurance that there was a lot of work ongoing to address this. It was recognised that a stretch target was in place so there would be difficulties in achieving this, particularly due to the workforce and environmental challenges in July, as described by the CEO in their report.

9.4 There had been amendments to the finance indicators and this format was a work in progress with feedback welcomed. Additional commentary would be included moving forwards and training would be provided following the next Board meeting. Year to date finance variation against plan was slightly ahead of schedule however capital spend was behind schedule and capital prioritisation planning was ongoing. Compliance with the Better Payment Practice Code (BPPC) was also improving.

9.5 NED-RW noted that there was a steady declining trend in mandatory training compliance over the last two years and CPO clarified that compliance was currently just below target. The Trust had decided not to suspend mandatory training through Covid which had been part of the 'Reducing the Burden' guidance, but training levels had fallen due to the challenges of the pandemic. Recently physical face to face training had fallen behind due to increased competition for rooms and space to deliver training and a review of training room usage was underway.

9.6 NED-PM questioned what the sanction to the Trust was for not meeting mandatory training targets and it was confirmed that the Trust set their own mandatory training targets and there were no associated sanctions however the consequence was that staff would not be fully qualified and competent to complete their tasks. The Trust did however benchmark well in this area.

9.7 NED-RW queried why sickness absence data showed this percentage had stayed the same however the days lost had changed and it was clarified that this was due to the difference in the number of working days in month. Sickness absence data was reviewed twice a week.

9.8 NED-RW updated on discussions held at Quality Committee and reported that there had been an impact on some metrics relating to sickness due to Covid during July, there had also been impacts on activity from the heatwave, public transport strikes and the holiday period. Some 104 week waiters had fallen outside of the plan due to these impacts however all had now been treated with the Trust now moving its primary focus to 78 week waits. There had been changes in reporting guidance for waiting times and referral to treatment and the IPR had been amended to reflect these changes.

The Board noted the Integrated Performance Report

10 Business Performance Committee Chair's Assurance Report

10.1 NED-DT updated that a number of deep dives had been completed for the Committee. Work to identify Cost Improvement Plans (CIP) was ongoing with schemes totalling £3.5m identified. A number of these schemes were non-recurrent however there were recurrent schemes such as the bed repurposing programme and Health Procurement Liverpool collaboration. It was recognised that CIP remained a challenge but that the Trust was making progress towards achieving its annual target.

10.2 The main focus of the transformation programme was the bed repurposing programme and this programme would be fully implemented in the Autumn, following completion of this work the focus would move to Theatres.

10.3 Quality Committee had advised BPC that the Well Led rating for the Trust had reduced in the most recent CQC Insight report, which included trends in metrics in regard to workforce.

The workforce metrics from this report would be monitored and reviewed at the People Group in the future.

10.4 The equality and diversity annual report had been presented and it was confirmed that this was a prescribed format for both the self-assessment and the annual report. The Trust was delivering more than was reflected in the report due to the restrictions of the report format. All nine protected characteristics were covered by the report. This report was on the consent agenda for the Board.

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

11 Quality Committee Chair's Assurance Report

11.1 NED-RW reported that there was a national shortage of Consultant Neuro-Ophthalmologists and the Trust currently used the service provided by LUHFT however both of the Consultants would be retiring/ leaving the service later this year. Recruitment was underway for both positions and LUHFT were engaging with both Neurology and Neurosurgery divisions around the requirements of the recruitment process.

11.2 Cairns Ward had achieved gold standard following completion of their recent Communicate, Assess, Respect, Experience and Safety (CARES) assessment and it was also reported that Caton Ward had achieved bronze standard. An action plan had been developed to support Caton Ward to progress further at the next assessment.

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

12 Investors in People Health and Wellbeing Award

12.1 CPO introduced DIIP and IC to the meeting and reminded the Board that work towards Investors in People (IiP) accreditation began when the Human Resources services were brought back in-house at the Trust.

12.2 DIIP informed that the Trust had retained gold standard accreditation for Investors in People Health and Wellbeing, noting that there were very few organisations who reached the level of gold standard. An overview of the methodology utilised during the review was provided which includes a focus on outcomes.

12.3 The core themes of the review were presented, along with highlights identified during the review. DIIP reported that an effective strategic approach to health and wellbeing was identified and noted that the Trust had a progressive approach that focused on processes and systems. The culture within the Trust was evident and there was effective use of data which had improved since the previous review.

12.4 The Health and Wellbeing strategy was highlighted along with wide ranging employee offers, providing both preventative and responsive measures underpinned by a learning and development strategy.

12.5 Improvement actions identified since the previous assessment were presented and it was noted that a number of these had already been addressed including health MOTs to provide staff with lifestyle checks, implementation of an agile working policy which recognised the potential for isolation and contained measures to counter this and training of a number of mental health first aiders and wellbeing advocates across the Trust.

12.6 The future focus recommendations for the Trust were mostly already underway with the Trust working to upskill and develop additional wellbeing advocates and mental health first aiders. Talk, Engage, Action (TEA) events with staff would continue to be rolled out and deep dives would be undertaken to explore why ratings on some Pulse survey questions had deteriorated in the last two quarters.

12.7 Staff feedback received as part of the assessment was reported to be reflective of the last full assessment with a strong focus on equality, diversity and inclusion and staff surveys followed up with positive action.

12.8 The Trust was exceeding the national NHS average on a number of Pulse and national survey wellbeing questions and had also created an open atmosphere with regards to mental health and work-related stress. DIIP informed that a further annual assessment would be undertaken in June 2023 followed by the next full assessment in June 2024.

12.9 NED-PM queried what percentage of NHS providers engaged with the IiP accreditation process and DIIP informed that this was not known as this data was not currently published however there was a current move towards a more centralised approach to IiP assessment so this data may be available in the future and would be shared.

12.10 NED-RW questioned the impact on staff achieving goals against staff sickness rates and it was stated that sickness data was split between short-term sickness absence and long-term sickness absence and this was then reviewed over a three year period. There was a need for the Trust to demonstrate that these data sets were moving in the right direction in order to achieve gold and platinum accreditation.

12.11 SID queried how this information could be used to improve recruitment and promote achievements internally and externally. DIIP informed that a series of events were scheduled in Autumn to showcase organisations who have achieved accreditation and invites for these events would be shared. CPO recognised that the Trust had not always been good at celebrating successes however the value of this was now recognised across the Trust. Information about the accreditation was currently included in recruitment packs however these would be refreshed to include details around the re-accreditation. This would also be showcased to the Care Quality Commission (CQC).

The Board noted the Investors in People 'We Invest In Wellbeing' standard annual review outcome.

13 Workforce Race Equality Standard

13.1 CPO presented the Workforce Race Equality Standard (WRES) for 2021-2022 and provided an overview of Trust results against the nine indicators which highlighted that the number of Black and Minority Ethnic (BAME) staff had increased and there was a healthy staff turnover rate across the Trust. It was noted that indictor six, which related to the percentage of staff experiencing harassment, bullying or abuse from staff in the previous twelve months had deteriorated and the Trust had commissioned an independent external review of this indictor. The draft report was scheduled to be received in early November with recommendations to be received in mid-November, this would then be reviewed and presented to Board along with an action plan to address any recommendations.

13.2 NED-PM highlighted that both Equality, Diversity and Inclusion (ED&I) Leads recently left the Trust at the same time and requested assurance that there were no issues that had led to this. CPO assured that both left the Trust for unrelated reasons.

13.3 NED-RW requested three years of data the next time the report was presented and CPO informed that the report was in a prescribed format which only included two years data however additional data could be added for the Board if required.

13.4 SID recognised that it could be some time before an ED&I Lead was in post and requested that action plans presented to their associated committees were linked to WRES indictors.

13.5 NED-KB queried if a graphical overlay showing year on year differences and trends could be produced and CPO agreed that this could be explored.

The Board noted the Workforce Race Equality Standard report and endorsed the action plan.

14 Workforce Disability Equality Standard

14.1 CPO presented the Workforce Disability Equality Standard (WDES) for 2021-2022 and provided an overview of Trust results against the ten indicators, highlighting that staff self-declared if they had a disability and that a key issue was ensuring staff identify themselves as having a disability. The report highlighted concerns regarding reasonable adjustments, however it did not identify if reasonable adjustments had been requested.

14.2 NED-KB queried to what extent did the Trust make it clear to service users that abuse of staff would not be tolerated and CN provided assurance that this was clearly discussed with service users and followed up with a letter. Patients could also be excluded if required however this was dependent on whether the patient had capacity.

The Board noted the Workforce Disability Equality Standard report and endorsed the action plan.

15 Trust Constitution

15.1 CS informed that a full review of the Trust constitution was on hold until the national review of the NHS England Code of Governance had been completed however there was a current pressure relating to the quoracy of the Council of Governors. It was proposed to amend the quorum to one third of the number of Governors rather than a flat figure of 11. This would reduce the pressure on Governors when there was a high level of vacancies. Currently the requirement was over 50% of existing Governors to be present which was causing challenges in running meetings effectively.

The Board approved the amendment to the Trust Constitution.

16 Well Led Review

16.1 CS presented the outline plan for the Trust to prepare for external assessment against the Well Led Framework and highlighted that self-assessment against the Key Lines of Enquiry had been completed and these had been discussed at a Board Development meeting held in June 2022. Executive Directors were currently reviewing the action plan associated with recommendations made and this would be reported back to the Board Development session to be held in November 2022.

The Board approved the plan to review the Trust against the Well Led Framework and progress to appoint an external reviewer in quarter four 2022/23.

17 Board Cycle of Business

17.1 CS presented the Board cycle of business and informed that this was a live document. There was a need to review the cycle of business and operational plan to ensure alignment with the Trust Strategy and it was recognised that this would require an element of fluidity as Substrategies were developed.

The Board approved the Board cycle of business.

18 Audit Committee Chairs Assurance Report

18.1 SID provided an update from the Audit Committee meeting held on 19th July 2022 and highlighted that a number of audit reports were underway and details of which stage they were currently at was provided. The outstanding internal audit recommendations report had been reviewed and this evidenced a further decrease in the number of outstanding recommendations with work ongoing to close all remaining open recommendations.

18.2 The Clinical Audit plan had been presented and the impact of audits would be monitored at Quality Committee.

18.3 Work to improve compliance with the Better Payments Practice Code (BPPC) was presented and assurance was provided that robust processes were being implemented to improve compliance. The Committee also approved proposed changes to the tender waiver process for all Trusts involved in the Health Procurement Liverpool collaboration to ensure a consistent approach for all parties.

The Board noted the Audit Committee chairs assurance report.

19 Charity Committee Chairs Assurance Report

19.1 SID provided an update from the Charity Committee meeting held on 27th July 2022 and informed that the investment managers had presented the annual report on performance of the portfolio and this had been well received by the Committee. It was recognised that it had been a very challenging year and there had been some discussion regarding the volatility of the markets. The Committee agreed to continue to follow the Ethical Investment Policy

19.2 The Committee received a benchmark report of fundraising costs and charitable expenditure of ten NHS charities in the North West covering a three year period and this benchmarking exercise would be conducted on an annual basis.

19.3 The Committee had approved the recruitment of a Digital Fundraising Manager and the recruitment process was currently underway.

19.4 The Committee Effectiveness Review was presented and it was agreed to review the terms of reference regarding voting members, quoracy of meetings and the tenure of attendees. This would be presented to the Charity Committee for recommendation of Board approval in October.

The Board noted the Charity Committee chairs assurance report.

20 Research, Innovation and Medical Education (RIME) Committee Chairs Assurance Report

20.1 NED-PM presented an update from the RIME Committee meeting held on 6th July 2022 and stated that the Committee was undergoing a significant process of reform and the structure of the Committee would be changed to ensure a more dynamic approach with three operational subgroups formed. The membership and assurance processes for each subgroup were currently being defined.

20.2 The Committee were informed that a leadership review of the Clinical Research Network (CRN) had been undertaken and this had noted the key strengths of the CRN and following the review the network would be reconfigured to include Greater Manchester.

20.3 The research and development finance report was presented which had reported an overall deficit of £48k at the end of month two. The current forecast for the financial year was reported as £324k which was £50k lower than expected due to a shortfall in commercial trial activity. Current vacancies within the department had been recruited to and there was confidence that this figure would improve going forward.

The Board noted the RIME Committee chairs assurance report.

21 Consent Agenda

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

- **Guardian of Safe Working Report** – The Board noted the Guardian of Safe Working report.
- **Equality, Diversity & Inclusion Annual Report** – The Board approved the Equality, Diversity and Inclusion annual report.
- **Sustainability Plan** – The Board noted the sustainability plan.

22 Any Other Business

22.1 There was no other business to be discussed.

23 Review of Meeting

23.1 Those present agreed the agenda covered a lot of ground, that the meeting was open, strategic and well chaired with a good level of debate. The relevant issues for Board had been discussed and there had been a good balance between the Executive Directors and Non-Executive Directors.

There being no further business the meeting closed at 12.50

Date and time of next meeting - Thursday 6th October 2022 at 09:30 Boardroom

Trust Board Attendance 2022-23										
Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Mr M Steinberg	✓	✓	✓	✓	✓					
Ms K Bentley	✓	✓	✓	✓	✓					
Mr P May	✓	✓	A	✓	✓					
Ms S Rai	✓	✓	✓	✓	✓					
Mr D Topliffe	✓	✓	✓	✓	✓					
Mr R Walker	✓	✓	✓	✓	✓					
Mr M Burns	A	✓	✓	✓	✓					
Mr M Gibney	✓	✓	✓	✓	✓					
Dr A Nicolson	✓	✓	A	✓	✓					
Ms J Ross	✓	✓	✓	✓	✓					
Ms L Salter	✓	✓	✓	A	✓					
Ms L Vlasman	✓	✓	✓	A	A					

TRUST BOARD
Matters Arising Action Log
October 2022

	Complete & for removal
	In progress
	Overdue

Actions for Completion

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
7th July 2022	17	**Medical Education Annual Report** NED-PM to discuss communications regarding the positive feedback received regarding medical education with the Communications and Marketing Manager (CMM).	NED-PM	NED-PM and CMM met to reflect on the positive medical education report and CMM to meet with the Medical Education Development Manager to build a plan to promote this report. Remove from tracker.	September 2022	

The Walton Centre NHS Foundation Trust

Report to Trust Board
6 October 2022

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

Level of Assurance Provided

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

Key Messages

- I am extremely pleased to inform the board that we have been awarded University Hospital status, after being accepted as a member of the University Hospital Association. This is a significant step in the right direction for the Trust to achieving its strategic ambitions.
- New Conservative prime minister and subsequently a new Secretary of State for Health and Social Care.
- Operational pressures continue, winter planning has been the focus. The national pay offer remains a concern and trade unions are currently in the process of balloting their members.
- The sad death of Her Majesty the Queen was appropriately managed as per NHS England (NHSE) guidance. The public bank holiday was observed and caused some operational issues.
- Regional financial concerns continue as Cheshire & Merseyside (C&M) Integrated Care Board (ICB) deficit at month 4 stood at £34m and recent figures for month 5 show this has deteriorated to £45.1m

Next Steps

- This paper is intended for information purposes.

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

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

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Chief Executive's Report

National Update

1. Since the last Trust Board, the political environment has seen significant changes, with the appointment of a new Conservative prime minister and subsequently Secretary of State for Health. It is too early to understand the potential expectation and impact. However, the initial policy paper outlines 'our plan for patients' focusing on:

    - Patients: informed and empowered
    - Prevention: supporting healthier lives
    - Primary care: meeting public expectations
    - Performance and productivity: partnership with NHSE 'A,B,C,DD'.

2. The NHS pay offer is causing significant unrest nationally. There is concern that the government's decision on pay uplifts is not enough to keep pace with cost of living and runs the risk of industrial action and further financial pressure on staff. There is also concern over the financial impact of the pay deal on Trusts. Most unions are in the process of balloting their members, which was delayed during the national official mourning period. The Trust has worked up robust business continuity plans to support with industrial action if required.

3. Operational pressures nationally have remained high with further COVID-19 issues as we have seen a rise in cases. There continues to be ambulance handover delays and increasing demand on urgent care.

4. NHSE winter planning has been submitted and shared at Place and ICS level. Workshops have now been implemented throughout October for winter planning across UEC.

5. Elective recovery remains a key national focus. The Trust continues to perform well and has made significant improvements in seeing and treating patients in a timely manner, with no patients now waiting 104 weeks and only five waiting 78 weeks. The key focus is now on patients who have waited 52 weeks.

Cheshire & Merseyside Integrated Care System (ICS)

6. At a C&M level the pay deal and cost of living crisis is also a key concern. The Walton Centre (TWC) is currently working through the expected impact and are working closely with the ICS and our staff side representatives on expected information and solutions regarding travel expenses. We have also engaged with the Joseph Rowntree Foundation to establish what staff would want as a means of support.

7. The Liverpool Clinical Services Review is now underway, and the CEO and Medical Director have attended a workshop where key principles for collaboration were discussed as well as areas where the review lead Carnall Farrar have identified as opportunities for collaboration. There are currently 12 areas of opportunity that are being worked through and prioritised.

8. Liverpool University Hospitals NHS Foundation Trust (LUHFT) have now started the move into the new Royal Hospital building. There are coordinated plans between LUHFT and the Liverpool Place / ICS regarding the move and the potential impact on other parts of the health and social care system. It is recognised that the offers of mutual aid within the winter plans

of the Specialist Trusts could be required during this period. We are trying to work closely with LUHFT on the transfer of the Outpatient clinics TWC provides at the Royal Liverpool.

Covid-19

9. Although there appears to be a slight rise in Covid-19 numbers nationally TWC have seen no significant issues, with very small numbers of patients and staff currently affected. There are concerns that we will see increased numbers of Covid over the next four weeks with the temperatures dropping, people moving indoors and closing windows; schools being opened after the summer and groups mixing following the Queen's funeral.

10. The Emergency Planning Resilience and Response self-assessment is due to be submitted the 28 October 2022. The total number of core standards have increased post Covid-19 and the Trust has self-assessed as partially compliant, achieving 80% of the standards. The report has been discussed at Business Performance Committee and is on the consent agenda today at Trust Board.

Trust Update

Trust Strategy

11. Due to the official mourning period following the Queen's death, the launch of the Trust strategy was delayed until 29 September. On the launch day a Trust-wide Teams meeting will be hosted by Jan Ross, CEO, Max Steinberg, Chair and Dr Andy Nicolson, Medical Director, followed by an all-staff communication and individual walk rounds of the hospital, visiting every ward and department handing out summary leaflets of the strategy. The full document was then sent to stakeholders, alongside a letter from the CEO or Chair and a briefing document circulated to the Board for use in stakeholder meetings.

12. I am extremely pleased to inform the board that the Trust officially became a member of the University Hospital Association on 13 September 2022. This is a significant step forward in achieving our strategic ambitions and there is a paper at Board describing the detail and next steps.

13. The TEA (Talking Engagement Action) sessions with staff have all now taken place. Each session was introduced by a member of the Executive team with an overview of the new Trust Strategy. The data has now been collated and shared with the executive team and the CEO. HR and the communications team are working on the actions and feedback.

Branding and Marketing

14. Our Branding project has now kicked off. The strategy team from Re interviewed six senior staff in mid-September who represented different areas of the hospital and level of involvement/understanding in the project. Feedback from both the interviewees and the agency was very positive and we are now planning for the second stage of the project, the Board workshop.

15. Metro Mayor Steve Rotheram visited TWC last week, visiting the Complex Rehabilitation Unit, Radiology, the Neuro VR machine and then holding a round-table event with senior clinical and operational staff. The visit went well overall, albeit the strategy was not discussed in detail due to timings of the visit and the rescheduled strategy launch.

16. The Dan Carden MP visit, scheduled for Friday 9 September, was cancelled due to the death of HM The Queen. This will be rearranged in due course.

17. The Annual Members' Meeting was held on Thursday 8 September, attended largely by Governors and some members and staff. Despite it being offered as a virtual as well as in-person event, very few people joined online. The future delivery and logistics will be reviewed ahead of the 2023 AMM.

Estates & Facilities

18. The Heating and Pipework project remains on track and we have now commenced phase 5 of the project, this phase includes the old Lipton ward, Neurophysiology, Therapies and Radiology and any issues or concerns will be picked up as part of the Heating and Pipework group which is chaired by the Chief Operating Officer.

19. The Bed Repurposing project has now moved into the next phase, the new Lipton and Caton short stay unit is now complete and open for patients, and the new Rapid Access Neurology Assessment (RANA) work has been commenced and is due to open November 2022.

20. There are three planned Estates capital projects for this year which include the air handling units, the CCTV and security upgrade and the Critical Care ponta systems (the structures behind the beds that hold the monitors and electrical supply). A working group has been set up to plan for these three projects and will be chaired by the Chief Operating Officer.

Business as Usual

Quality

21. Caton achieved silver in their ward accreditation (previously bronze) and Dott ward achieved gold status.

22. Patient and family centred care 6 steps has been re-launched on the Aspiring Ward Managers programme which was well received.

23. We are on target with Infection prevention trajectories and a focussed piece of work is being undertaken into E-Coli / catheter acquired infections.

24. Complaints at ward level are reducing and the focus is currently on waiting times and appointments, which the divisions are working on.

25. We have been successful in being chosen as a hospital for hydration pilot in Cheshire & Merseyside and have already started seeing improvements in focused work undertaken, led by the Matrons.

26. We have been chosen to pilot the electronic competencies for ITU across the Network.

Finance

27. The Trust is delivering above plan for its Income & Expenditure (I&E) financial plan year to date by £0.1m after performance in Month 5. Some of this has been driven by the assumed

recovery of the Elective Recovery Fund (ERF) to plan for reporting purposes though this has yet to be confirmed formally by NHSE. The Trust will continue its efforts to deliver challenging ERF and Cost Improvement Programme (CIP) targets across the rest of the financial year in order to deliver its full year plan of a £2.9m surplus.

28. Unidentified CIP currently stands at £1m although work is on-going to identify schemes to reduce this. Capital expenditure remains behind plan (£1.0m) with the Heating and Pipework and Digital Aspirant schemes forming the majority of spend, however the prioritisation process for capital expenditure has been progressed and schemes have been identified that will now be able to move to business case approval and start to spend. The Trust (along with all providers and ICS's) has been undertaking the HFMA 'Improving NHS Financial Sustainability' self-assessment which is mandated by NHSE (with any potential additional future funding being linked to completion of it). The self-assessment has now been completed by the Deputy Chief Finance Officer, assessed by the senior finance team and approved by executives. The next stage is an independent audit by Mersey Internal Audit Agency (MIAA) which will take place between October and November (initial scores also have to be submitted to NHSE at the same time as submission to MIAA).

29. At Month 5 the north west is showing a deficit of £156m (providers £153m) against a planned deficit of £24m, so £132m behind plan. Year to date (YTD), efficiency delivery is £212m v £263m plan, however only 27% of delivery is recurrent. Provider capital is £13m behind plan YTD and forecast to deliver to plan but as 5% over programming is built in we need to reduce this to hit the year end plan.

30. The C&M ICB deficit at Month 4 stood at £34m (providers £37m deficit) and recent figures for Month 5 show this has deteriorated to £45.1m (providers £50.9m). Providers are currently £10.7m worse than plan at Month 5, with pay being the key driver of the variance (£53.5m) offset by over-performance on income (£33.2m) and underspends on non-pay items (£9.6m). CIP is being delivered but this is heavily dependent on non-recurrent schemes. Forecast outturn is still showing a deficit of £30.4m which is in line with the agreed plan. Figures are currently awaited for capital and wider northwest performance.

31. ERF performance continues to be awaited and specialised commissioners are meeting with the national team to understand year to date performance. As noted, it is not expected that clawback will take place for Quarter 1 and Quarter 2 although confirmation is awaited. There are potential changes to ERF in Quarter 3 and Quarter 4 that the national team are considering. Energy continues to be an area of pressure for providers and further work is required to understand the impact of the price cap that will be implemented and is expected to be in place for 6 months (for some businesses). It is likely that long term financial planning guidance will be released in December, though it is not known whether this will apply to individual providers or ICB's.

Performance/ Operations

32. The Trust is in a good position for performance, all diagnostic and cancer targets have been achieved continuously throughout the Covid-19 pandemic and 104-week waits have now been eradicated. The focus is now on patients who have waited 78 weeks and we currently have five patients to be listed.

33. The sad death of her majesty the Queen invoked a 10-day public mourning period which ended with an additional bank holiday on the day of her funeral. The Bank Holiday had not been included in planning.

34. The mourning period was well managed in the organisation with a book of condolences, a remembrance service for staff and relevant meetings stepped down as per NHSE guidance. The public bank holiday was observed and caused some operational issues, all urgent patients were treated and some services, where it was felt relevant, continued.

35. Further planning guidance was received in July 2022 in relation to the recovery of elective service with next steps and with two new ambitions of elective recovery to focus on. The next two performance ambitions are:

    - to return the number of patients waiting more than 62 days from an urgent referral for suspected cancer back to pre-pandemic levels (by March 2023)
    - to eliminate routine elective waits of over 78 weeks (by April 2023), alongside increasing activity to above pre-pandemic levels.

36. The guidance is clear that these are the two areas of focus until April 2023 supported by:

    - Patient initiated follow up
    - Mutual Aid
    - Reduction in Did not attend (DNA)

Recommendation

To note

Author: Jan Ross, Chief Executive Officer

Date: 22/08/22

The Walton Centre NHS Foundation Trust

Report to Trust Board
6th October 2022

Report Title	University Hospital Status / membership
Executive Lead	Jan Ross CEO
Author (s)	Jan Ross CEO
Action Required	To decide

Level of Assurance Provided

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

Key Messages

- Following lengthy discussion and a robust application process, on the 13th September 2022 the Trust was invited into the membership of The University Hospital Association.
- A key part of our strategy has been to increase academic capabilities and research activity and this accolade / membership will support this vision.

Next Steps

- The Trust board is asked to note this membership.
- The executive team will work closely with our Head of Communications and Marketing as well as the recently appointed marketing team to establish how to best utilise our membership.
- The Trust Board also need to consider the process for review whether to change the Trust's name.

Related Trust Strategic Ambitions and Themes	**Impact**		
Research	Quality	Workforce	Not Applicable

Strategic Risks

009 Research & Development Ambition	010 Innovative Culture	008 Medical Education Strategy

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

University Hospital Status / Membership

Executive Summary

1. The Walton Centre 'The Trust' has a key strategic ambition to increase academic capacity, capability, and research activity.

2. Within the new Trust strategy, a key strategic aim is research and innovation, with the ambition to increase research studies as well as the number of staff and patients actively involved in trials.

3. An application was made to the University Hospital Association back in 2021, however this was rejected due to a change in criteria that the Trust could not meet. The Trust has worked hard to provide robust evidence to the Association to support a further application and on the 13th September 2022 we were informed that this application was successful.

Background and Analysis

4. The University Hospital Association (UHA) bring together experts and organisations to create a national forum. Through the forum members get the opportunity to share best practice and shape healthcare.

5. University Hospital Trusts are seen as speciality Trusts with significant involvement in research and education. They are perceived as offering the widest range of treatments and adopting innovation and best practices.

6. UHA originated in 1998 following a national election and a new government coming into power. Anticipating significant changes to the NHS as a result, Chief Executives from the largest multi-specialty trusts formed the UK University Hospitals Forum to discuss and prepare for these changes. All of these Trusts had strong involvement in research and undergraduate education.

7. In 2019 the organisation became the University Hospital Association. While the broad issues in the health service are similar to those of two decades previously, the working environment and funding streams can be very different. The increased complexity of care, combined with ever tighter budgets, meant that the national voice of university hospitals had to be more collaborative – and more assertive – than at any previous time.

8. UHA has a membership of 47 University Hospital Trusts. It is led by the Trust's Chief Executives, while from each Trust there are also groups of the Director's of Finance, Nursing, Human Resources, Research and Development, and the Medical Director. They form national groups for the sharing of issues and solutions for key areas in the health service. Each group is assisted by UHA policy staff.

9. Becoming a member of the University Hospital Association is a key milestone in the Trust's wider ambition set out in the newly developed strategy.

10. There is a associated cost of the membership which is circa £3,000 per annum, this has been accounted for in our forecast.

Conclusion

11. The Trust board is asked to note the membership of the University Hospital Association as a key milestone to achieving our overall ambitions set out in the new Trust strategy. This is a positive message and a communications plan will be developed. The next steps would be to agree on whether the title 'University' should be added to the Trust's name. This is a separate NHS England process.

Recommendation

To note

- The positive messages within this paper.
- The membership of University Hospital Association.
- Agree to review the Trust's name.

Author: Jan Ross
Date: October 2022

The Walton Centre NHS Foundation Trust

Board of Directors
7 October 2022

Report Title	**Board Assurance Framework (BAF) Report Q2 2022/23**
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- Q2 BAF is based on the new principal strategic risks approved by Board on 5 May 2022
- It is proposed to increase the scoring of BAF 011 Cyber Security to 15 from 12 in light of increased attacks on NHS systems and bodies

Next Steps

- BAF to be reviewed for quarter 3 in February 2022

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

Strategic Risks		
All Risks	All Risks	All Risks

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors	31 August 2022	K Dowson Corporate Secretary	All risks reviewed by Executives
Research, Innovation & Medical Education Committee	7 Sept 2022	K Dowson Corporate Secretary	Reviewed and commented on risks assigned to the Committee
Quality Committee	15 Sept 2022	K Dowson Corporate Secretary	Reviewed and commented on risks assigned to the Committee
Business Performance Committee	27 Sept 2022	K Dowson Corporate Secretary	Reviewed and commented on risks assigned to the Committee

Board Assurance Framework (BAF) Report Q2 2022/23

Executive Summary

1. This paper summarises the detailed current position against the twelve strategic risks approved at Board on 5 May 2022. The initial, current and target scoring and risk appetites have now all been set and a BAF report developed for each risk.

2. Through the Board Committee process there were minimal changes proposed apart from a proposal, endorsed by Business Performance Committee (BPC) to increase the risk scoring of BAF risk 011 Cyber Security.

3. The Committee are asked to consider whether the BAF entries are an accurate reflection of current risk exposure.

Background and Analysis

4. There are now twelve principal risks identified on the Board Assurance Framework (BAF). This follows the development of new strategic risks by the Board which align to the new Trust Strategy 2022-25 approved at Board on 1 September 2022. All the BAF risks have been reviewed in detail and updated by the appropriate Executive Leads and at the Executive Team meeting on 31 August 2022. Tracked changes are marked on each BAF risk.

5. The new strategic ambitions which form the strategic objectives for the Trust are:
   - **Education, training and learning** - Leading the way in neurosciences education and training
   - **Research and Innovation** - Delivering high-quality clinical neuroscience research, in collaboration with universities and commercial partners
   - **Leadership** - Developing the right people with the right skills and values to enable sustainable delivery of health services
   - **Collaboration** - Clinical and non-clinical collaborations across and beyond the ICS, building on existing relationships and services
   - **Social Responsibility** - Supporting our local communities and providing services for patients within and beyond Cheshire and Merseyside

6. These ambitions are supported by seven enabling Substrategies: Quality of Care, People, Digital, Estates, Facilities and Sustainability, Finance and Commercial Development, Communications and Marketing and Charity.

7. 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. A summary of each BAF risk assigned to the Committee is included in the appendices.

8. 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.

9. A number of actions have been identified for each BAF risk to address the gaps in controls or assurances identified. Target dates for completion have been included and where there was a clear map across from the actions in the 2021/22 BAF these were included. These have been updated for Q2.

10. The BAF risks have been reviewed by the assigned Board Committee and this has taken place during September.

Quarter 2 Summary of Changes

11. A summary of the current risk scores and risk appetites are in Table 1. The previous risk score has been included where the new risk is very close or the same as the risks in the 2021/22 BAF. The risk descriptors which define the scoring of the risks and the risk appetite are included at Appendix 1.

12. The risk description for BAF004 has been updated to reflect the changing focus of operational recovery.

    If the Trust does not deliver its agreed weighted activity for the year ~~and meet pre-pandemic levels of activity~~ then patient care and experience will be impacted and there will be financial and reputational impacts for the Trust.

13. It was felt that it would be prudent to increase the risk scoring of BAF risk 011 Cyber Security following recent cyber-attacks on a number of other NHS bodies which had had a negative impact; therefore the likelihood of attacks had increased. The proposal is to increase the score from 12 to 15 (3 x 5), with the likelihood moving from 4 (Likely) to 5 (Almost Certain). The Trust remains confident that the Trust has significant protective measures in place to prevent or significantly reduce the impact of any such attack, but it should be noted that some of the corrective actions are dependent on partners, particularly the Integrated Care System (ICS) who were not yet fully staffed.

Table 1

Risk ID	Risk Appetite	Title	Q4 22/22	Q1 22/22	Q2 22/23	Q3 22/23	Q4 22/23
001	**Cautious**	**Quality Patient Care** Impact on patient outcomes and experience	**n/a**	**12**	**12**		
002	**Open**	**Collaborative Pathways** Inability to develop further regional care pathways	**n/a**	**9**	**9**		
003	**Open**	**System & Finance** Inability to deliver financial plan and targets within the system	**8**	**9**	**9**		
004	**Cautious**	**Operational Performance** Inability to deliver the operational plan	**9**	**9**	**9**		
005	**Cautious**	**Leadership Development** Inability to attract, retain and develop sufficient numbers of qualified staff	**n/a**	**16**	**16**		
006	**Open**	**Prevention and Inequalities** Inability to improve equitable access to services	**n/a**	**9**	**9**		

007	**Cautious**	**Capital Funding** Inability to secure capital funding to maintain the estate to support patient needs	**6**	**9**	**9**		
008	**Open**	**Medical Education Offer** Inability to develop a national training offer	**n/a**	**12**	**12**		
009	**Open**	**Research and Development** Inability to develop and attract world class staff	**12**	**12**	**12**		
010	**Adventurous**	**Innovative Culture** Inability to attract a world class workforce	**n/a**	**12**	**12**		
011	**Averse**	**Cyber Security** Inability to prevent Cyber Crime	**16**	**12**			
012	**Cautious**	**Digitalisation** Inability to deliver the Digital Aspirant plan and associated benefits	**8**	**6**			

14. There is now notably more variation in the risk appetite assigned to each risk which reflects that these risks are linked to the new strategy for the Trust. This is because the Trust may need to consider taking more risks to achieve these ambitious objectives.

15. There has been a focus through Q2 on ensuring that there are clearly linked operational risks that align to the strategic risks. This piece of work is progressing although not yet complete for all the risks, progress is summarised below:

    - Operational linked risks previously in place – BAF001, BAF004 and BAF005
    - New operational risks – BAF009
    - Pending operational risks (awaiting confirmation on operational risk register) – BAF003, BAF008, BAF010, BAF012
    - Emerging risks - BAF002, BAF006, BAF007, BAF011 and BAF012 remain in development

Conclusion

16. The new BAF reflects the risks relating to the achievement of the new strategic ambitions and the actions that have been started to reduce these risks.

Recommendation

- To review the current BAF content
- To consider the control and assurance gaps and identify any further actions required or additional assurances to be presented
- To agree the revised description for BAF004 Operational Performance
- To agree the revised scoring for BAF011 Cyber Security

Author: Katharine Dowson
Date: September 2022

Board Assurance Framework Glossary

ADO	Associate Director of Operations
ANTT	Aseptic non-touch technique
BMA	British Medical Association
BPC	Business and Performance Committee
C&M	Cheshire and Merseyside
CDRD	Clinical Director of Research & Development
CEO	Chief Executive Officer
(D)CFO	(Deputy) Chief Finance Officer
CIP	Cost Improvement Plan
CMAST	Cheshire & Merseyside Acute and Strategic Trusts (Provider Collaborative)
(D)CN	(Deputy) Chief Nurse
COO	Chief Operations Officer
(D)CPO	(Deputy) Chief People Officer
CQC	Care Quality Commission
CRL	Capital Resource Limit
CRN	Clinical Research Nurse
DHSC	Department of Health and Social Care
DME	Director of Medical Education
EPR	Electronic Patient Record
ERIC	Estates Returns Information Collection
ERF	Elective Recovery Fund
FoSH	Federation of Specialist Hospitals
FFT	Friends and Family Test
GDPR	General Data Protection Regulations
GMC	General Medical Council
HCP	Health & Care Partnership (Cheshire& Merseyside) in place to 30 June 2022
HEE(NW)	Health Education England (North West)
HFAI	Health Facility Acquired Infection
HiMSS	Healthcare Information and Management System (Digital Maturity Model)
IC	Innovation Coordinator
ICB	Integrated Care Board
ICO	Information Commissioners Office
ICS	Integrated Care System (Cheshire & Merseyside) in place from 1 July 2022
IG	Information Governance
IT	Information Technology
IOM	Isle of Man
IPC	Infection Prevention and Control
IPR	Integrated Performance Report
ITU	Intensive Therapy Unit
KPI	Key Performance Indicator
LoA	Letter of Authority
LHP	Liverpool Health Procurement
LUHFT	Liverpool University Hospitals Foundation Trust
MD	Medical Director
MHRA	Medicines and Healthcare Products Regulatory Agency
MIAA	Mersey Internal Audit Agency (Internal Auditors)

MSSA	Methicillin-sensitive Staphylococcus Aureus
MoU	Memorandum of Understanding
NHSD	NHS Digital (information, data, IT systems)
NHSE	NHS England
NHSEI	NHS England and NHS Improvement
NHSI	NHS Improvement
NHSP	NHS Providers
NHSX	NHS X (IT transformation)
NICE	The National Institute for Health and Care Excellence
NRC	Neuroscience Research Centre
NWC	North West Coast (Innovation Agency)
RAG	Red-Amber-Green (scoring)
RCA	Root Cause Analysis (Investigatory Technique)
RN	Registered Nurse
PMO	Project Management Office
QIP	Quality Improvement Programme
RIME	Research, Innovation and Medical Information (Committee)
SFI	Standing Financial Instruction
SOP	Standard Operating Procedure
SORD	Scheme of Reservation and Delegation
SPA	Supporting Professional Activities
SPARK	Single Point of Access to Research and Knowledge
SRO	Senior Responsible Officer
TEL	Training, Education and Learning
UoL	University of Liverpool
WCFT	The Walton Centre NHS Foundation Trust

Appendix 1 – Risk Descriptors

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 Negligible	2 Minor	3 Moderate	4 Major	5 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 breach 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 Rare	2 Unlikely	3 Possible	4 Likely	5 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.

Risk ID: 001	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Quality Patient Care If the Trust does not deliver high quality day to day care for patients, then this will lead to adverse outcomes for patients and family and a deterioration of patient and family experience which would reduce staff morale and impact on the reputation of the Trust.		Date of next review:	October 2022
		CQC Regulation:	Regulation 12 Safe Care and Treatment
		Ambition:	Quality of Care
		Assurance Committee:	Quality Committee
		Lead Executive:	Chief Nurse

Linked Operational Risks (highest scoring only)		
21	If adherence is not made ot the appropriate controls set out in relation to pseudomonas, then there is a risk to patient safety and reputation.	16
543	If delays in completion of IT projects continue, then there is a risk to patient safety, specifically the risks of a loss, duplication and inaccurate key date on reports generated by the EPN system, resulting in a lack of clinical confidence in the accuracy of reports.	15
900	If patient receive the incorrect nutrition and hydration or inappropriate food textures, then there is a risk to patient safety, care and experience	12
Risk Appetite	**Cautious**	

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

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Poor outcomes for patients - Poor patient and family experience - Reputational damage - Increased incidents - Increased morbidity and mortality - Quality standards not met - Lower CQC rating - Lower staff morale - More difficult to recruit workforce - Increased staff turnover - Widening of health inequalities - Worsening staff and patient survey results - Worsening Friends and Family Test results	- Number of complaints received - Zero Never Events in 2020/21, two in 2021/22 - Increase in Nosocomial Infections - Increased incidence of HCAI in 2022/23 - Mortality rates better than national average - Staff vacancy rates (nursing now minimal) - Staff retention – turnover figures - Improved performance in inpatient survey in 2021, moving from ninth to eighth position - Integrated Performance Report – Quality metrics in a good position - Friends and Family Test - CARES Assessments – Cairns Ward achieved Gold in June 2022
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 Improvement Strategy 2020 – 23 – approved Sept 2019 2. KPIs for Year 3 of the Quality Strategy approved March 2022 3. Theatre Utilisation Programme 4. IPC BAF reviewed at Trust Board quarterly - ~~March~~ June 2022 5. Trust Recovery Roadmap 6. Partial patient visiting recommenced March 2022 7. Ward Accreditation Programme in place for 2022/23 8. Implementation of Tendable Audit System for ward based Quality metrics for 2022/23 9. Board Walkabout Programme – reporting to Quality Committee 10. NICE Exception Report 11. CQC Mock Inspection – May 2022 12. Specialist Nurse Support in place e.g tissue viability and IPC 13. Health and Wellbeing Strategy approved at Board June 2022 14. Patient and Family Centred Plan in place 15. HCAI plan for 2022-23 approved by Board June 2022 16. Enhanced senior nursing structure 17. Pulse Survey reflecting staff morale 18. Flushing Audits 19. Hand Hygiene Audits 20. ANTT Training	1. Impact of Covid-19 variants on staff sickness levels 2. Lack of open-ended national guidance on Covid-related IPC 3. Lateral flow testing not generally available to the public ~~4. Key plans for HCAI and Clinical Audit not yet approved for 2022/23~~ 5. Timely completion and reporting of NICE exception reports ~~6. Lack of awareness of patient and family centred plan and methods to implement it~~ 7. Theatre utilisation programme not achieving its objectives as planned

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 Hospital Management Group - monthly Hand Hygiene Audits – monthly Staff and Patient stories to Board and Quality Committee monthly Infection Prevention and Control Group – monthly **Level 2** Integrated Performance Report Quality metrics – Quality Committee – monthly Quarterly reports from Governance Team (incidents & risks, Patient Experience Team, Pharmacy, Pathology, Tissue Viability, Mortality and Morbidity) – Quality Committee IPC Annual Report to Board – June 2022 Safeguarding Annual Report to Board – June 2022 Annual Governance Report 2021/22 to Quality Committee – May 2022 Medicines Management Annual Report to Board – June 2022 Quality Strategy Progress Report to Quality Committee – Sept 2022 Visibility and Walkabout update quarterly report to Quality Committee ~~from July 2022~~ Sept 2022 Quality Account to Board June 2022 Ward Accreditation and Tendable reports to Quality Committee – July 2022 **Level 3** CQC Inspection Report 2019 Monthly reporting to CQC Relationship Manager Review meetings with Commissioners – Quarterly National Inpatient Survey Results –- published October 2021 CQC Mental Health Inspection – December 2020 CQC Interventional Radiology Inspection – published December 2021 Getting it Right First Time (GIRFT) reports Investors in People Gold Award 2020 (reaccredited 2021) Anaesthesia Clinical Services Accreditation (ACSA) visit 2021	1. Alignment of Quality Improvement Strategy to all Strategies 2. End of Life Care 3. Quality Impact Assessments 4. NICE Exception Reporting

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Action 2022/23 Quality Improvement Strategy Priorities presented for closure to Quality September 2022	CN	~~July 2022~~ September 2022	In progress
2	New HCAI plan for 2022/23 to be approved by Board	CN	June 2022	~~In progress~~ Complete
3	Patient and Family Centred Care initiative to be launched	CN	September 2022	Complete
4	Clinical Audit Plan 2022/23 to be approved: approved as part of annual report to quality and Audit Committees.	MD	June 2022	~~In progress~~ Complete
5	Review of NICE exception reporting process presented to Quality Committee July 2022	MD	July 2022	~~In progress~~ Complete
6	Review process for gaining assurance for End of Life Care. UPDATE New group established, strategic implementation plan to be completed	MD	~~September 2022~~ October 2022	In progress
7	To develop and launch a new Quality Impact Assessment tool	CPO	July 2022	~~In progress~~ Complete
8	New Quality Substrategy to be written and ratified by Quality Committee. Draft to December Quality Committee (February Board)	CN	February 2023	In progress
9	Monitoring of Clinical Audit Plan and review of impact of audit to be developed	MD	October 2022	In progress

Risk ID: 002	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Collaborative Pathways If the Trust does not succeed in developing and leading well led high quality standardised regional care pathways and networks then patient care and experience may deteriorate and the Trust will not achieve its ambition of providing outstanding and equitable patient care		Date of next review:	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Collaboration
		Assurance Committee:	Quality Committee
		Lead Executive:	Medical Director

Underlying Operational Risks	Consequence	Likelihood	Rating
None currently identified – work in progress to develop these			
Initial	Moderate 3	Possible 3	9
Current	Moderate 3	Possible 3	9
Target	Moderate 3	Unlikely 2	6
Risk Appetite: Open			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Equality of care for patients due to variation in system delivery and capacity - Potential for increased morbidity and mortality rates - Patient safety incidents - Patient outcomes worsen - Length of stay increases - Resource impact of excess unnecessary investigations - Sustainability of Trust - Inadequate funding to support development and growth in line with strategic ambition - Deterioration of patient and family experience - Increase in long waiters	- Immature system governance, new people and new ways of working create uncertainty in the system - Regional governance arrangements determined at national/ regional level with limited consultation with Health and Care Bill still in process through Parliament - Development of Provider Collaborative Model arrangements - ICS Strategy not in place - New commissioning arrangements not yet fully known although roadmap to specialist commissioning now published - Unwarranted variation in services - Health inequalities between different postcodes - Pressure on staff resources to develop new pathways and capacity regionally to support and drive change

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. Revised Trust Strategy 2022-25 in final stages of development 2. Trust engagement on C&M ICS meetings and in regional roles including Collaboration at Scale and regional networks, place-based partnerships and Provider Collaborative 3. Host of C&M Rehabilitation and Critical Care Networks and Neuroscience Programme Board 4. Successful delivery of regional services: Neurology / Neurosurgery / Thrombectomy/ Spinal Surgery 5. Existing relationships with partner organisations through current neurology / neurosurgery model 6. Existing relationships ongoing with Specialised Commissioning through the transitional period (2022/23) 7. Engagement with other specialist trusts both at local and national level 8. Communications and Engagement Strategy 2022-25	1. Profile of Trust and communication of specialist offer 2. Promotion of success of current regional services 3. Perception of specialist Trust's ability to deliver system-wide services 4. Some of Walton Centre patient population lies outside ICS (C&M) and therefore does not align with population basis for commissioning / funding allocations 5. Engagement with other providers can be challenging to promote new ways of working

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 Monthly reporting to Board on ICS development and development of strategy, processes and systems and also of operationalisation of 24/7 Thrombectomy and spinal surgery Weekly C&M ICS CEO meeting Regular ICS Chair meetings **Level 2** Monthly Chair and CEO reports to Board Project update e.g. Spinal Services to Executive Directors meeting on a regular basis Clinical Effectiveness and Services Group monthly meeting reviews and reports to Quality Committee through Chair's assurance report Regional Thrombectomy Meeting Spinal Provider Board with LUHFT Project Boards with partners eg Pain Collaborative HCP Transformation Board oversight of network boards Complex Rehabilitation Board	1. Measurement of the impact of the influence of The Trust and FoSH 2. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR. 3. Lack of clarity on future of specialist commissioning – NHSE have published a roadmap for proposed services for delegation to the ICS from April 2023. MD and CEO involved in regional and national discussions regarding proposals. 4. Outcomes dependent on other statutory bodies 5. Comprehensive stakeholder engagement 6. System oversight of networks – currently under review

Level 3 GIRFT reviews of specialist services e.g. spinal, cranial neurosurgery, neurology monitored through Neurosciences Network Programme Board Regional neuroscience services monitored through Neurosciences Network Programme Board	

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Participation in review of Complex Rehabilitation Network – led by Liverpool Clinical Commissioning Group UPDATE Waiting for response from CCG	MD	~~September 2022~~ January 2023	In progress
2	Benefits realisation analysis of 24/7 Thrombectomy UPDATE Executives to review in September, Quality Committee in October	COO	~~September 2022~~ October 2022	Not yet started
3	Benefits realisation analysis of delivery regional spinal services	COO	December 2022	Not yet started
4	Leading Pain Collaborative Working Group to review of regional services and equity of access	MD	~~December 2022~~ April 2023	In progress
5	Recommendations from GIRFT (Getting it Right First Time) action plans for spinal /cranial/ neurosurgery to be completed. UPDATE full actions completed once new surgical day ward work is complete	MD	~~September 2022~~ November 2022	In progress
6	Ensure the services and clinical pathways of the Trust are communicated effectively across the region by raising the profile of the Trust	CEO	April 2023	New Action
7	Appropriate linked operational risks are to be developed and entered onto risk register with risk manager	MD	November 2022	In progress

Risk ID: 003	**Date risk identified** April 2022	**Date of last review:**	July 2022
Risk Title: System & Finance If the Trust does not deliver its financial plan for 2022-23 the Trust's standing and influence in the system will be diminished and this may result in less resource and opportunities in the future for the Trust to grow and meet it strategic ambitions.		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Collaboration
		Assurance Committee:	**Business Performance Committee**
		Lead Executive:	Chief Executive

Operational Risks		
135	If the move to the blended payment approach and population based commissioning allocations continue then this may lead to a risk of reduced allocations for the Trust.	16
Further operational risks regarding CIP and ERF in development.		
Risk Appetite	**Open**	

	Consequence	Likelihood	Rating
Initial	Moderate 3	Likely 4	12
Current	Moderate 3	Possible 3	9
Target	Moderate 3	Unlikely 2	6

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Loss of decision-making responsibilities / influence as move to system based working and financial targets with a consequent impact on delivery of objectives, accountability and reputation. Board remains accountable for delivery of performance and finance - Loss of autonomy - Potential deterioration of the Trust's financial position through funding / tariff changes - Change in funding provision for specialist services - Increased complexity to approaches with different tariff systems (Wales and Isle of Man) - Move of commissioning from NHSE Specialised Commissioning to ICS may lead to a lack of local service knowledge around decision-making - Equity of access to care for patients - Inadequate funding to support development and growth in line with strategic ambition - Reputational impact if isolated due to financial performance - Prioritisation of Neurosciences funding by ICS compared to other funding priorities	- Developing system governance, new people and new ways of working create uncertainty in the system - Regional governance arrangements determined at national/ regional level from 1 July 2022 - Development of Provider Collaborative Model arrangements underway - Recent NHSI/E consultation on system funding models - Tariff consultation on population-based funding. - Lack of detailed understanding how on commissioning will occur in future. - Requirement to meet system financial targets - Liverpool Providers Review underway (supplier confirmed) - ICS Strategy not in place - Larger acute trusts with underlying structural deficits in the ICS. - Trust basis for funding based on historical local tariffs and disproportionate costs of delivery may not be taken into account for services leaving trust with a financial gap - Unidentified elements of Cost Improvement Programme - Inconsistent achievement of activity to deliver Elective Recovery Fund

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.~~ Revised Trust Strategy 2022-25 approved ~~in final stages of development~~ 2. Communication and Engagement Strategy 2020-25 3. Trust engagement on C&M ICS meetings and in regional roles including Collaboration at Scale and regional networks, place based partnerships and Provider Collaborative 4. Host of C&M Rehabilitation and Critical Care and Major Trauma Networks and Neuroscience Programme Board 5. Existing relationships ongoing with Specialised Commissioning through the transitional period (2022/23) 6. Trust has fed back on consultations to changes in commissioning 7. Engaged with other specialist trusts both at local and national level through Federation of Specialist Hospitals (FoSH) and through FoSH Finance Group which is reviewing impact of the new financial framework on the system and engaging with the wider system on potential changes 8. Progression of financial and commercial development substrategy to explore alternative sources of income 9. Tight management of financial position to ensure end of year position achieved and efficiency targets met 10. Healthcare Procurement Liverpool (HPL) established to improve efficiencies and provide value for money 11. Provider Selection Regime for procurement of healthcare services introduced with Health and Care Act	1. Profile of Trust and communication of specialist offer 2. Perception of specialist Trusts 3. A significant proportion of the Walton Centre patient population lies outside C&M, therefore does not align with population basis for commissioning / funding allocations 4. Regional governance arrangements potentially result in greater influence for larger providers 5. Review of stakeholder analysis 6. ICS funding priorities not yet confirmed

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 Monthly reporting to Board on ICS development and development of strategy, processes and systems Regular review of operational risks at Board level and on-going review of mitigations Review of financial position at every Board and ongoing monitoring through financial controls and processes. Weekly C&M ICS CEO meeting Regular ICS Chair meetings Regular C&M ICS Directors of Finance planning meetings	1. Measurement of the impact of the influence of The Trust and FoSH 2. The new system currently applies to England and there are currently different systems in Wales / IOM i.e. PBR. 3. Lack of clarity on future of specialist commissioning 4. Outcomes dependent on other statutory bodies

Level 2
Monthly Chair and CEO reports to Board
Risks review by FoSH
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
External Audit of Annual Accounts and going concern considerations
Internal Audit of financial processes and control systems including HPL
ICS triangulation benchmarking C&M providers across finance, performance and workforce
Independent financial sustainability work to be carried out at the Trust in line with national requirements and report in November 2022

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Continue to work with the ICS on system development and engage through regional roles in ICS.	ALL	Ongoing	In progress
2	Review of out of HCP referrals / activity to understand the largest Clinical Commissioning Groups and formulate what can be done to continue activity into 2022/23 with the Trust. Update - This will now form part of the Finance and commercial development strategy (currently in development).	CFO	~~Mar 21~~ ~~Sep 21~~ June 2022	Complete
3	Continue to work with FoSH and specialist commissioners to deliver the specialist commissioning roadmap	CEO/CFO	Ongoing	In progress
4	Continue to work collaboratively across the ICS and offer mutual aid as appropriate	COO	Ongoing	In progress
5	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. Waiting for ICS guidance	CFO / COO	~~Sep 21~~ ~~June 22~~ December 2022	~~On track~~ On hold
6	Prepare a Branding and Marketing Strategy to promote the successes of the Trust and cement its reputation as a centre of excellence and ensure key decision makers engaged	CEO	September 2022	In progress
7	Input into the Liverpool Providers Review	CEO	~~Tbc~~ October 2022	In progress
8	Independent financial sustainability review to be carried out on the trust's self-assessment of its financial sustainability by MIAA by 30.11.22 with any improvement actions to be completed by 31.01.23.	CFO	February 2023	New Action
9	Development of Provider Collaborative Memorandum of Understanding	CEO	October 2022	New Action
10	Develop a medium-term plan to identify the timing of financial gaps and efficiencies	CFO	March 2023	New Action

Risk 004	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Operational Performance If the Trust does not deliver its agreed weighted activity for the year ~~and meet pre-pandemic levels of activity~~ then patient care and experience will be impacted and there will be financial and reputational impacts for the Trust.		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 16- Assessing and monitoring Service Provision
		Ambition:	Leadership
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Operating Officer

Linked Operational Risks		
43	If demand in capacity continues, in addition to the current position, of 102+ 52 week breaches due to COVID-19, there is a risk of further deterioration of Trust performance against national access standards and waiting times.	16
323	If capacity pressures, associated with workforce, theatres and ward beds continue then there is a risk the Trust will fail to deliver activity associated targets and financial plan	16
921	If an appropriate solution to the unexpected retirement and resignation in the next 3 months, of two consultant neuro ophthalmologists is not identified, then there will be a risk to patient care/treatment as well the sustainability of services who require neuro ophthalmology input across Neurology and Neurosurgery	16
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
Initial	Major	Possible	
	4	3	12
Current	Moderate	Possible	
	3	3	9
Target	Minor	Unlikely	
	2	2	4

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 lead to 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. - 104, 78 and 52 ~~52 & 36~~ week wait standard not met - Financial sanctions for not meeting targets to receive Elective Recovery Fund allocation - Reputational impact - If ERF not received, impact on system finances as well as Trust finances which my worsen reputation in ICS	- Average Wait Performance - Overdue Follow up waiting list in Neurology - Reduction in overall activity due to the impact of Covid-19 - IPC pathway control for electives - Increasing waiting list size - Volume of 52-week waiters - 104-week waiters following transfer of spinal patients - Good performance against trajectories – meeting ERF targets - Impact of further Covid variants on patient numbers, IPC requirements and staff sickness - Vacancies particularly in specialist roles and in nursing - Cancelled operational activity

Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	Key Gaps in Control: Where we are failing to put controls/systems in place?
1. COVID-19 Recovery Plan Phase 3 2. Performance Dashboard in real-time 3. Cheshire & Merseyside Restoration of Elective Activity Meeting – Weekly 4. Cheshire & Merseyside Operational Leads – Elective Recovery & Transformation Programme meeting – Weekly 5. Submission of Recovery and Restoration plans for 2022/23 6. Stretch recovery target set for 104% of 2019/20 activity 7. Daily COO-led performance catch up which focuses on performance targets and addressing issues that may impact on delivery such as operating list cancellations 8. Divisional recovery plans 9. 104/ 78 and 52 week recovery plan 10. Regular Spinal meetings at Divisional level and escalations to appropriate commissioners. 11. All 52-week plus waiters have been clinically reviewed and validated (March 2022) 12. Rapid Access Neurological Assessment (RANA) supporting system partners 13. Staff wellbeing programme 14. Regular meetings with specialist commissioners and partners re Thrombectomy to escalate initial issues e.g. ambulance response times 15. Waiting List Initiatives and additional hours worked over contracted	1. Activity plans do not take into account impact of sickness 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. National Shortage of ODP theatre staffing currently requiring agency staff to support this gap 4. Reliance on other organisations capacity to provide services 5. National guidance on plan to return to pre-Covid infection and control pathways (implementation planned from early July 2022) 6. Pension tax implications for consultants which may preclude interest in Waiting List Initiatives

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 – improvement in 52 and 104 week waits Weekly Performance Meeting Divisional Performance Management Review Meetings – quarterly Daily monitoring of critical staff absences at Huddle Live monitoring of performance dashboard	1. Thrombectomy demands on staff rotas 2. Transfer of Thrombectomy patients to and from the Trust in a timely manner 3. Sickness of critical staff 4. Recruitment and retention of key staff and succession planning 5. 52 week spinal waiters are not fully clinically validated yet and are not included in 52 week figures 6. Challenging follow up outpatients target, to reduce by 25%

Level 2 Activity reported monthly in Integrated Performance Report (IPR) to Trust Board Workforce metrics on turnover, vacancies and staff sickness reported monthly in IPR to Board **Level 3** Meetings with Commissioners – monthly Internal Audit review of Waiting List Management - April 2022 System review of 52+ week waiters – April 2022 Check and challenge sessions with ICS on operational and workforce plans	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Implementation of Covid-19 Recovery Plan to increase activity – plan is in progress and progress monitored through BPC	COO	~~Sept 2022~~ March 2023	On track
2	Ongoing testing re average waits and discussion with NHSI to determine if pilot will continue. NHSI pilot ongoing.	COO	~~March 2022~~ March 2023	Pilot Extended
3	Job Planning for new spinal consultants for 2022/23	MD	September 2023	On track
4	Bed repurposing project to increase efficiency and respond to changing demand – Caton Ward is due to open 26/07/2022 with new model	COO	July 2022	Complete
5	Overdue follow up waiting list is to be monitored by the division by undertaking a validation exercise and a review of the patients to determine which patients can be moved over to PIFU. Dedicated project manager in post from May 2022	COO	November 2022	Ongoing
6	Thrombectomy working group to review at 6 month point to address any ongoing issues and report to Executives – paper to executives in September 2022	COO	~~June 2022~~ ~~July 2022~~ September 2022	~~On track~~ In progress
7	Full integration of spinal team into WCFT	MD	August 2022	~~On track~~ Completed
8	Completed clinical validation of spinal patients transferring into WCFT- this is on track. 104 and 78 week waits validation has now been completed further validation has now been commenced on 52 week waits	COO	August 2022	On track
9	Review of Waiting List Initiative (WLI) process in response to new BMA guidance regarding WLI payments	COO	August 2022	On track

Risk ID: 005	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Leadership Development If the Trust does not provide the right environment or opportunities for staff to develop, learn and progress the organisation will not have well led services or experienced staff. This will reduce the Trust's ability to provide well led, high quality services and lead to poor staff experience, higher vacancy rates and the requirement for additional resource to recruit and train new staff.		Date of next review:	October 2022
		CQC Regulation:	Regulation 18 Staffing
		Ambition:	Leadership
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked operational risks		
140	If the Trust fails to achieve the agreed internal compliance target rate for all statutory and mandatory training topics, there is a risk to the achievement of CQC standards and regulatory requirements.	12
221	If staffing levels fall below established levels, due to high sickness rate, government vaccination guidance and vacancies, then there is a risk to patient safety &experience and staff safety.	12
Risk Appetite	**Cautious**	

	Consequence	Likelihood	Rating
	Major	Likely	
Initial	4	4	16
	Major	Likely	
Current	4	4	16
	Major	Possible	
Target	4	3	12

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Reduced staff morale - Staff Turnover increases - Gaps in workforce will include hard to fill specialist roles - Costs of recruitment and training - Business continuity - Reputational damage - Sickness increases if vacancies increase - Staff capacity to attend training and development and complete annual appraisals	- Staff Turnover - Vacancy Levels - Sickness Absence - Statutory and Mandatory Training metrics - Quarterly Pulse Survey results - Feedback from staff engagement sessions - Appraisal Rates - Lack of engagement with national development opportunities - Staff Survey responses
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. Mandatory Training Annual Plan 2. People Strategy 3. Regional Workforce Plan 4. Health and Wellbeing Strategy approved June 2022 5. Wellbeing Guardian in post 6. BAME Strategic Advisory Committee exercise 7. Staff Survey /Action Plan 8. Partnership working with universities to recruit newly qualified staff 9. Regional collaborations e.g. International Recruitment 10. WCFT Health and Wellbeing Programme 11. National Nursing Bursary – 2020/21 12. Hybrid training models developed to enable ongoing delivery of training with social distancing 13. Monthly deputy's engagement sessions 14. Annual Training Needs Analysis 15. E-rostering 16. Senior Leadership Team meetings held in Neurology and Neurosurgery 17. Aspiring ward manager programme starting 9 Sept 2022	1. Sickness levels including Covid, leading to pressures on workforce to cover and training and development can be seen as lower priority 2. Celebration of successful development outcomes 3. Consistent development offer for all band and all staff groups 4. Consistent national shortage in some staff groups 5. Lack of consistency across system in application of Agenda for Change staff pay bands

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 Staff training and development reports sent monthly to mangers Review of ward staffing pressures by ward manager and DDON - monthly Staff Listening Events Staff Support sessions provided by NOSS as and when required HR\Finance\Nursing Vacancy renew meetings **Level 2** Integrated Performance Report – Trust Board monthly People Strategy – quarterly update to BPC (linked to People Plan) Quarterly Staff Pulse Survey Workforce report to People Group **Level 3** Outcomes of Staff Survey. 2022 Staff Survey to commence September 2022 Investors in People Accreditation 2021 – Gold Status Investors in People Wellbeing Award 2021 – Gold Status review 2022 Exit Interviews Review MIAA April 2022 Flexible working MIAA Review 2022	1. Delivery of National People Plan 2. New People Substrategy 2022-25 is in development – anticipated completion November 2022

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Recommendations of Exit Interviews Review	CPO	March 2023	In Progress
2	Communications Plan to celebrate development successes e.g. Apprenticeships	Head of Business HR	September 2022	In Progress
3	Potential in 'Talent for Growth' courses	DCPO	November 2022	In Progress
4	Staff engagement events took place July to August 2022	DCPO	September 2022	~~In Progress~~ Complete
5	More focused communication including Health and Wellbeing Newsletter. Now complete	DCPO	July 2022	~~In Progress~~ Complete
6	Refresh of building rapport programme. New cohort launched to complete in December 2022	CPO	January 2023	In Progress
7	Review of Performance and Development Report paperwork (annual appraisal)	Senior Education Manager	September 2022	In Progress
8	Deliver a leadership development programme with AQuA for divisional management. Agreed triumvirate training for September to November 2022 (Action Learning Sets February 2023)	CPO	~~September 2022~~ February 2023	In Progress

Risk ID: 006	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Prevention and Inequalities If the Trust does not support its local community to prevent adverse health outcomes and prioritise wellbeing work for staff, then it will require more resource in the long-term to address the issues that arise from health inequalities for our staff and population.		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Social Value: Supporting local communities and staff
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Executive

Linked Operational Risks			Consequence	Likelihood	Rating
455	If controls are not put in place to manage violent and aggressive patients, who are violent and aggressive then there is a risk to staff safety. (Neurology Division / Neuro Surgery Division)	12			
			Initial	Major	Possible	12
			Current	Moderate	Possible	9
			Target	Moderate	Unlikely	6
Risk Appetite		**Open**			

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Poor patient outcomes - Deteriorating staff morale and wellbeing - Unable to retain staff - Reputation of Trust - Financial cost of staff leaving - Loss of goodwill and staff engagement - Fluctuating capacity and disruption to services - Failure to adapt to the changing health needs of the population - Failure to achieve duty to improve population health outcomes - Increasing pressure on services due to increasing acuity of patients - Loss of trust with local communities - Increase in violence and aggression towards staff - Inequitable patient waits for treatment	- Variance in outcomes for different socio-economic groups and those with protected characteristics - Aging Population - Deprivation Indices - Staff Survey Results - Incident Reporting - Vacancy/ turnover/ retention rates - Increase in long term sickness - Violence and Aggression incidents - Mandatory and Statutory Training compliance - Increasing waiting times for treatment following Covid-19
Key Controls or Mitigation: What are we currently doing to control the risks? Provide the date e.g. when the policy/procedure was last updated	**Key Gaps in Control:** Where we are failing to put controls/systems in place or where are we failing to make them effective?
1. Health and Wellbeing Strategy – approved June 2022 2. Health and Wellbeing programme (includes Shiny Minds Resilience Training) – approved 2018 3. NHS Prevention Pledge adoption and action plan 4. Violence and Aggression Strategy - approved April 2022 5. Trust signed up to the C&M Healthcare Partnership Social Value Charter – May 2022 6. ~~Commitment to becoming an anchor organisation~~ Trust signed up to the C&M Healthcare Partnership Anchor Institution Charter – June 2022 7. Founder member of Liverpool Citizens 8. Weekly operational monitoring of waiting list 9. People Substrategy 2022-25 in draft 10. Wellbeing Guardian 11. Member of the Everton Minds Partnership Committee 12. Trust Sustainability Plan 2022-25 in line with the C&M Integrated Care System Green Plan 2022	1. Health Inequalities and patient access strategy 2. Identified Executive Lead for Health Inequalities 3. National issue with complex long-standing causes that cannot be easily turned around 4. Liverpool population recognised as area of high deprivation
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 Health, Safety and Security Group – quarterly review of Violence and Aggression data and monitoring of annual risk assessments Safeguarding Group review of escalation concerns – every two months Violence and Aggression Group – every two months People Group – every two months **Level 2** Annual Governance Report – Quality Committee Quality IPR – Quality Committee – monthly Workforce IPR – BPC – monthly Board oversight of progress against NHS Prevention Pledge Quarterly Pulse Survey Staff Partnership Group with Trade Unions	1. Agreed KPIs for measuring patient access and outcomes against deprivation index 2. As only neuroscience provider Walton Centre will have a high proportion of highly complex patients with associated behavioural challenges

Health Equalities programmes of work report into Business Performance Committee through The People Group Chair Report **Level 3** Staff Survey 2021 CQC Inspection Report 2019 Investors in People - Gold accreditation for 'we invest in wellbeing' standard – accreditation received under the new framework in June 2021 and annual review undertaken in June 2022	

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	To establish a number of measures for patient and staff outcomes linked to deprivation data UPDATE: Still in diagnostic phase, results to be presented via a strategy or action plan by year end.	CEO	~~July 2022~~ December 2022	In progress
2	To work with partners to establish a Citizen's Panel for Liverpool	CPO	October 2022	In progress
3	To understand the process to become accredited as an anchor organisation	CEO	July 2022	~~In progress~~ Complete
4	To implement the Violence and Aggression Strategy	CN	April 2023	In progress
5	To implement the Health and Wellbeing Strategy	CPO	April 2023	In progress
6	To achieve C&M Healthcare Partnership Social Value Award	CPO	November 2022	New Risk
7	To achieve Social Value Business Quality Mark Level 1	CPO	November 2022	New Risk
8	To achieve Social Value Business Quality Mark Level 2	CPO	November 2023	New Risk
9	To deliver against the 10 identified priority C&M NHS Prevention Pledge outcomes	CPO	December 2022	New Risk
10	To achieve NHS Veteran Accreditation	CPO	April 2023	New Risk
11	To achieve LCR Fair Employment Charter Accreditation	CPO	September 2022	New Risk
12	To open a physical Health and Wellbeing Hub within the Trust	CPO	September 2022	New Risk
13	Align cost of living support for staff to the Joseph Rowntree Foundation guidance for in work poverty	CPO	October 2022	New Risk
8	Develop further operational risks in regard to health inequalities and staff wellbeing that impact the strategic risk and add to Trustwide risk register	CPO	November 2022	New Action

Risk ID: 007	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Capital Investment If the Trust does not maximise its opportunities to acquire capital funding then it may not have enough resource to deliver its estates strategy and provide a fit for purpose environment for staff and patients leading to poor staff morale, poor patient experience and the risk of increased backlog maintenance		Date of next review:	October 2022
		CQC Regulation:	Regulation 15 Premises and Equipment
		Ambition:	Value for Money
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief Finance Officer

Linked Operational Risks			Consequence	Likelihood	Rating
323	If the aging Theatre air handling unit (AHU) fails to deliver correct air flow then there is a risk upon the Departments ability to run Theatre list.	16	Major	Possible	
			Initial: 4	4	16
220	If the theatre lights fail, due to the age >20 years, and repairs cannot be conducted/ completed there is a risk that the theatre will be unusable for surgery (theatre 1-5 affected). In addition, if flaking paint falls from the theatre lights there is a risk that this could decontaminate the sterile area during surgery	16	Moderate	Possible	
			Current: 3	3	9
			Moderate	Unlikely	Rating
			Target: 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?*
- Financial impact on revenue budgets if new risk to patient safety emerges - Unsafe environment for staff, patients and visitors - Compromised quality of care - Poor patient experience - Business continuity - Reputational damage - Financial impact - Legal Compliance - Overspend on capital against CRL would have to be covered by underspend by other Trust's in the system	- Capital Resource Limit (CRL) allocations have been set by ICS which is oversubscribed - Risk assessed backlog maintenance register - End of year opportunities for additional money were available late in 2021/22 which the Trust was able to utilise - Additional capital requests emerging following allocation for year

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 Groups reviews specific capital risks and all capital business cases – Executive Chair 2. Capital Risk Register 3. SFI's/SORD have appropriate approval levels for capital expenditure so CFO / COO are sighted on expenditure 4. Process for approving expenditure is documented in SORD i.e. which group needs to approve etc. 5. Executive led capital prioritisation with operational finance and clinical staff 6. Monthly reporting of capital expenditure to Board 7. Estates Strategy – approved 2015 8. Operational Plan submitted for 2022-23 9. Revenue and Capital budgets - Ongoing 10. Costed Backlog Maintenance Register and Programme - updated May 2022 11. Estates related policies • Electrical Safety Policy: 2021-2023 • Water Management Policy: 2021-2024 • Fire Safety Policy: 2019-2022 • Control and management of Contractors: 2021-2024 • Health & Safety Policy: 2019-2022 12. Site based partnership/SLA with LUFHT last review 2016 13. Contractual agreements with specialist contractors 14. Water Management Action Plan inc. Legionella actions 15. Premises Assurance Model – completed 2021 16. Heating replacement scheme Phase 4 in design stage 17. Sustainability plan update in progress – draft approved by BPC and Board in December 2021 and to be submitted to NHSIE in January 2022	1. Estates Strategy requires review and refresh to ensure it is aligned to the overarching Trust Strategy and future need post Covid-19 2. Further work on capital risk register to ensure estates risks recognised 3. Unplanned replacement of equipment that fails will lead to additional spend against plan or increase revenue spend 4. Some capital items are not specified in detail and therefore there is an ability for teams to substitute items in year which means capital spend is difficult to prioritise 5. Limitations of regional approach to capital allocations 6. Reliance on specific items which cause delays if not available 7. Priorities may change in year which may lead to pressures against the plan 8. Market prices may differ from estimates once equipment is purchased 9. Clarity of how future revenue costs associated with capital and digital investment will be funded in the long term. 10. Limited access to certain areas prevents visual inspection 11. Policies require review to ensure that they are reflective of current legislation 12. C&M Hospital Cell and response not wholly aligned to the Trust's strategic objectives 13. System capital management leaves little flexibility for Trust to invest surplus cash 14. Programme for Pipework replacement incomplete 15. The national Premises Assurance Model (PAM) outcomes 16. Service Level Agreement (SLA) with LUFHT due review

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 reforecasting of capital position and discussion at Capital Management Group Daily Safety Huddle Water Safety Group – reporting into IPC Committee	1. Allocations are system based from ICS so no longer freedom to generate surplus to spend on capital priorities 2. Timeliness of national/ system decisions on capital reduces the time in which it can be spent as cannot be carried forward into future years

Health & Safety Group Contract review meetings with LUHFT – monthly Heating and Pipework Project Board – monthly Medical Devices, Estates and Facilities Group (6 per year) **Level 2** Capital Programme approved by Trust Board Monthly updates received by BPC and Trust Board on capital BPC and Board approve higher value business cases as per SORD Estates Strategy monitored by BPC and updates received **Level 3** 6 Facet Survey – updated May 2022 CQC Inspection Report Aug 2019 Fire Brigade post-incident review of Fire Processes - 2019 Annual ERIC Returns - annually Reinforced Aerated Autoclaved Concrete (RAAC) review 2021 Premises Assurance Model (PAM) Assessment 2021	3. Capital allocations based on one year – limiting decision-making, resource allocations on longer term projects 4. Revised Estates Strategy delayed pending new Trust Strategy 5. Limited Aintree University Hospital planned maintenance/KPI reporting in place 6. Lack of reporting of sustainability data / KPIs 7. Business case for replacement of air handling unit not yet approved

	Corrective Actions: **To address gaps in control and gaps in assurance**	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Prepare capital bids to be ready for additional allocation in year. Additional £1.3m capital allocation awarded	COO	~~September 2022~~ Completed	~~In progress~~ Complete
2	Prioritise list of capital items to be ready should additional ICS capital become available	CFO	~~September 2022~~ Completed	~~New Action~~ Completed
3	Internal desk top review of SLA with LUHFT before discussions with LUHFT	COO/CFO	September 2022	New Action In Progress
4	Ensure that maintenance contracts are all up to date, so equipment is covered.	COO	March 2022	Complete
5	Work with NW specialist trusts North West QIP for specialist trusts to consider wider solutions for hard and soft FM. This work continues to progress with Soft Facilities Management Services being tackled in 1st wave	COO	~~March 2020~~ March 2023	Delayed
6	Develop an in house out of hours Estates Service to provide sufficient cover and continue contract monitoring of Aintree University Hospital via monthly meetings. Estates are currently reviewing resource and cost impacts in advance of recommendation	COO	~~March 2020~~ September 2022	~~Delayed~~ In Progress
7	Integrate Trust Sustainability Plan into Estates, Facilities and Sustainability Substrategy review and develop local action plan	ADO ~~COO~~	September 2022 November 2022	Ongoing
8	WC Estates Strategy to be incorporated into wider "system" strategy currently being led by LUHFT	COO	September 2022	Ongoing
9	Ongoing monitoring of Phase 5 Heating and Pipework Programme. Due to start in June 2022.	COO	March 2023	Ongoing
10	Design process initiated for upgrade works to Theatres 1-5 due to non-compliant Air Handling Units. Executive team has provided permission to proceed to tender stage	COO	April 2022	Complete

Risk ID: 008	Date risk identified: April 2022	Date of last review:	July 2022
Risk Title: Medical Education Offer If the Trust does not have the right staff with the right skills and the right processes and training, it will not be able to deliver its ambition of developing a national medical education training offer in Neurosciences and will not deliver its strategic ambitions		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks			**Consequence**	**Likelihood**	**Rating**
In development - in process of being signed off by the risk team.		**Initial**	**Major** 4	**Likely** 4	**16**
		Current	**Moderate** 4	**Possible** 3	**12**
		Target	**Minor** 4	**Unlikely** 2	**8**
Risk Appetite	**Open**				

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
• Failure to achieve key strand of Trusts Strategic ambition as leading in education. • Loss of current and future HEE/DHSC income streams for medical education • Failure to take advantage of opportunity to harness Trust's international profile and grow education offerings outside of HEE training programmes • Reduced ability to attract consultants and staff with a specialist interest in medical education • No obvious trajectory for developing future educationalists • Failure to build on Trust's external reputation as centre of academic excellence and subsequent ability to attract highest calibre undergraduate and postgraduate medics • Inability of Trust to grow innovative education programme and TEL delivery	• Difficulties recruiting to internal lead educator roles • Limited capacity to develop current resource and offer on a national scale • Inability to attract high quality medical education staff • Challenge in managing competing pressures of clinical service delivery and dedicated student support/supervision time. • Resource capacity limited with regards to hosting elective/observer programmes • Plan not yet in place to deliver national program • Training, Education and Learning programme in its infancy, infrastructure to be established to support implementation / expansion

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 via to Research, Innovation and Medical Education (RIME) Committee. 2. Lead educator roles established with Director of Medical Education (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. 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 standardise and assure processes. 7. New structure for delivery of education was consolidated in 2021 8. Consultants are now formally recognised for undergraduate educational supervision and remunerated through job planned activities 9. Guardian of safe working quarterly report to Board.	1. Plan to deliver a national programme of medical education is not currently in place 2. Assessment of resource required to develop national offer needs to be undertaken.

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) **Level 2** • Medical Education Quarterly and Annual Reports to RIME Committee • HEENW Annual Education Return Board report • End of Placement Feedback – Undergraduate • Placement Exit Survey – Postgraduate	1. Support from key strategic partners for national programme. 2. Governance for development of a national offer to be developed and agreed. 3. Infrastructure is limited to support new and emerging work streams e.g. TEL and simulation 4. Coordination and management of medical elective and observer placements based on historic admin process, no data to evaluate satisfaction or quality

Level 3 • GMC National Training Survey – 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	Effectiveness of new SPA funded enhanced education roles to be reviewed after 12 months UPDATE August 2022: Review completed. Medical Education Group to review in September	DME	~~July 2022~~ September 2022	In progress
2	Medical Education SOPs to be reviewed/ratified by Director of Medical Education/relevant groups. Initial action complete, however two additional procedures have emerged	DME/CPO	~~Ongoing~~ ~~June 2022~~ October 2022	In progress
3	Educational Appraisal Lead is a new role (as part of the enhanced education roles created summer 2021), underpinning improved educator support. An appointment is still to be made; discussions are ongoing with potential candidates. UPDATE August 2022: Appointment made, subject to job planning	DME/MD	~~Ongoing~~ ~~June 2022~~ October 2022	On track
4	Education Fellows are helping the admin team overcome silo working with practical support to ensure equitable allocation of clinical experiences for Undergraduate and Postgraduate learners. Success to be evaluated via student and junior doctor satisfaction survey	DME / Clinical Education Fellows	~~May 2022~~ Complete	Complete
5	Development of strategic plan to widen/strengthen the Medical Education offer	CPO	Jan 2023	~~New Risk~~ In Progress
6	Scope out the potential to enhance the national offering through simulation and technology enhanced learning offerings, including the new neurosurgery VR	DME	Nov 2022	New Risk
7	Review governance and financial costing of electives and observers to support the national offering	Medical Education Development Manager /DME	May 2023	~~New Risk~~ In progress
8	Appropriate operational risks are to be developed and entered onto risk register with risk manager	Medical Education Development Manager	~~July 2022~~ September 2022	~~New Risk~~ In progress

Risk ID: 009	Date risk identified: April 2022	Date of last review:	July 2022
Risk Title: Research and Development If the Trust does not develop the research department business model it will not attract the right staff or the research projects necessary for the Trust to become a world-class centre for Neurosciences and innovation		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Innovation and Research
		Assurance Committee:	Research, Innovation & Medical Education (RIME) Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks			Consequence	Likelihood	Rating
	In development				
		Initial	Major 4	Likely 4	16
		Current	Major 4	Possible 3	12
		Target	Major 4	Unlikely 2	8
Risk Appetite	**Open**				

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
• Unable to recruit and retain the most ambitious clinical staff • Unable to meet the Clinical Research Network target • Negative impact to Trust's reputation and ability to attract commercial sponsors • Failure to attract the right research projects • Unable to secure sufficient grant-based funding • Damage to key strategic partnerships (e.g. LHP, ICS) during a time of both significant changes to regional systems and increased external scrutiny (e.g. CQC). • Deleterious impact on Neuroscience Research Centre (NRC) workforce, lack of sufficient workplace capacity and capability to maintain, grow and develop the research function • Financial model becomes unsustainable and unable to balance income streams, notably commercial income • Inability to secure sufficient grant-based funding • Ineffective development of the ~~internal~~ research strategy, through a lack of awareness and mitigation of external macro environmental influences and pressures	• 10 studies have been declined in the past two years (down from 25) • 27 studies in backlog which currently cannot be opened (down from 50) • Lack of study back-up nurses to ensure study continuity • Ability to recruit consultants with research interests • Failure to recruit to trials • Staff stress-related sickness absence • Challenges in team capacity due to sickness • Unable to meet timelines for setting up studies • Delays in meeting recruitment targets

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 (under review) ~~2.~~ CAPA audit (Corrective Actions Preventative Actions) ~~MHRA Inspection Audit,~~ 3. External peer review of WCFT protocols, sponsor studies 4. New partnerships with universities, other trusts and system level collaborations 5. Prioritisation of commercial trials and development of new income streams 6. Charitable funds allocation for research (recurring) 7. GCP (Good Clinical Practice) training for research active staff monitored	1. Ongoing redesign of Neuroscience Research Centre (NRC) and associated implications for the human resource, including the teams capacity, capability and clarity of purpose to deliver strategic objectives 2. Implications of the NRC redesign upon the development/ implementation of strategic objectives 3. Current R&D governance model unable to deliver research on a bigger scale. 4. Completion of audit action plans paused due to lack of resource 5. Clarity of purpose and roles in the emerging system infrastructure 6. Income generation model approved but contracts to be negotiated 7. Review/development of principles for time dedicated to research

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 • Principal Investigators Forum • Sponsorship & Governance Oversight Group • Research Capability Funding Group • GCP record **Level 2** • Research updates to RIME Committee • RIME Committee Chair's Report to Board of Directors **Level 3** • MHRA Inspection Audit • CQC Inspection report 2019 • Kings College external review of NRC 2020	1. Organisational change and service redesign still in implementation phase, impact to be assessed 2. Committee memberships / ToRs under review and effectiveness to be assessed in due course ~~3. Organisational change process suspended due to COVID-19 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	NRC organisational service change process supported by Human Resources. UPDATE: Head of NRC in post from August 2022 to complete process	CPO &CDRD	~~June 2022~~ ~~(due to COVID 19)~~ November 2022	~~On hold~~ ~~On track~~ In progress
2	Senior Neuroscience Research Group in place. UPDATE August 2022: PI Forum now in place and in process of being embedded	CPO & CDRD	~~September 2020~~ June 2022	~~On track~~ Complete
3	Head of LHP SPARK, in an interim role to support with a review of governance practices including audit action plans and developing the administrative capabilities to support research on a bigger scale. Support extended to November	CDRD	~~April 2022~~ August 2022 November 2022	~~On track~~ In progress
4	CRN providing short term clinical research nursing leadership support and completing scoping exercise to establish capability and capacity of the team. Support extended to December.	CDRD	~~August 2022~~ December 2022	On track
5	Strengthen links and collaborate with key local research partners such as universities to clarify NRC place in external local system	CDRD	~~October 2022~~ December 2022	~~New action~~ In progress
6	Develop plan to promote research agenda with patients, carers and staff	~~CPO & CDRD~~ Head of NRC	January 2023	~~New action~~ In progress
7	Review systems for medical education educator and other models emerging for capturing /quantifying activity to inform the development of a framework for robust governance /enhanced management of consultant time/ engagement in research activities	CDRD	January 2023	~~New action~~ In progress
8	Review of effectiveness of RIME Committee to be completed	Corporate Secretary	September 2022	On track
9	Input into the review of Liverpool Health Partnership model	CEO	~~September 2022~~ October 2022	~~On track~~ In progress
8	Develop R&D operational risks impacting the strategic risk and add to Trustwide risk register	CPO	November 2022	New Action

Risk ID: 010	Date risk identified: April 2022	Date of last review:	July 2022
Risk Title: Innovative Culture If the Trust does not develop a culture where staff are empowered to innovate it will not be able to attract and retain a world class workforce to support the Trust's ambitions		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Research and Innovation
		Assurance Committee:	Research Innovation and Medical Education (RIME) Committee
		Lead Executive:	Chief Executive

Linked Operational Risks		Consequence	Likelihood	Rating
No linked risks – in development will be ready for Q3	**Initial**	Major	Likely	
		4	4	16
	Current	Major	Possible	
		4	3	12
	Target	Major	Unlikely	
		4	2	8
Risk Appetite	**Adventurous**			

Key Impact or Consequence	Performance: *What evidence do we have of the risk occurring i.e. likelihood?*
- Not continuing to be at the forefront of innovative neurosciences treatment in order to improve patient care - Inability to retain or attract clinical staff if unable to fulfil their innovation ambitions - Insufficient workplace capacity and resourcing to ensure innovative practices, treatments and boundary scanning - Risk aversion and complacency - Innovations will not be fully implemented, acknowledged and celebrated - Reputational impact - External scrutiny e.g. CQC well led	- National Staff Survey 2021 themes; wellbeing, development and reward and recognition - Limited understanding of culture and sub-cultures in Trust - Reduced resource capacity due to Covid-19 pandemic pressures - Commercial management vacancy - Lack of staff and leadership engagement - Insufficient succession planning or development opportunities in innovation

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 Strategic Objectives set for 2019/22 – majority of short and medium-term objectives completed 2. Innovation Implementation Plan 2022-25 to be included within the wider People Substrategy 2022-25 (due for approval Q3 2022) 3. Innovation Communication Plan to be revised as part of the Innovation Strategic Implementation Plan 2022-25 ~~Trust Strategy launch in September May 2022 as part of wider People Substrategy~~ ~~4. Innovation Strategy Communication Plan to be revised in line with renewed Innovation Strategy~~ 5. Phase one of the Innovation Pipeline review completed with phase two being undertaken in September 2022 6. Review of Innovation Group completed 7. Innovation Lead ~~identified~~ in post 8. Investors in People Gold accreditation for 'we invest in wellbeing' standard (June 2021) 9. Investors in People Gold accreditation for 'we invest in people' standard (November 2020) 10. Pulse and National Staff Surveys 11. Staff 'TEA' (talk, engage, action) sessions with Executive Team July-August 2022	1. Innovation project pipeline alignment to Trust Strategy priorities 2. Clinical and corporate divisional engagement of; internal initiatives, spread and adoption of external innovations and address risk aversion 3. Workforce capacity to have time to develop and implement initiatives 4. Wider engagement with Trust stakeholders and patient groups 5. Financial and Commercial Substrategy development 6. Spinal Improvement Programme income generation model contracts to be finalised 7. Single project management office to be established 8. Competitor Analysis to be completed

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~~ Innovation Group • Monthly Innovation Team meetings • Regular meetings with procurement, IT, IG, service improvement, clinical and other teams as required • Collaborative working arrangement with external partners **Level 2** • RIME Committee approval of funding applications and oversight of project pipeline activity • RIME Committee Chair Report to Trust Board and Council of Governors • Executive Team approval of innovation business cases • Trust Board endorsement of innovation business cases **Level 3** • Board level membership at Innovation Agency NWC	1. Benchmarking assessment and validation of innovation function 2. Risk appetite and strategic approach to innovation management 3. Organisational readiness enabling entrepreneurship, creativity and multi-disciplinary collaboration 4. Limited knowledge of intellectual property 5. Industry foresight and horizon scanning 6. Customer awareness and behaviours 7. Measurement of return of investment of innovations 8. Systematic process for measuring outcomes and continual improvement 9. Benefit realisation for innovative business cases not yet feasible due to lack of defined metrics 10. ~~Innovation Group not currently operating within formal governance~~ 11. Consistent legal processes/ advice for more common organisational working arrangements

• Innovation cited in CQC Inspection report 2019	

	Corrective Actions: To address gaps in control and gaps in assurance	**Action Owner**	**Forecast Completion Date**	**Action Status**
1	Benchmarking assessment of innovation function via Investors in Innovations Standard aligned to ISO 56002 Innovation Management System – international industry standard **Update August 2022**: Approved in principle by Executive Team on 8 June 2022, funding to be identified	CPO/IC	~~June 2022~~ tbc	In progress
2	Revise Trust Innovation Strategy **Update August 2022**: Innovation Strategic Implementation Plan for 2022-25 developed as part of the People Substrategy 2022-25 currently under development	CPO/IC	September 2022	In progress
3	Develop innovation communication plan in line with Innovation Strategic Implementation Plan 2022-25	IC	September 2022	In progress
4	Address innovation/commercial resource to align with revised Trust and innovation strategies and changes to service - Business Development Manager role to be recruited **Update August 2022**: Business Development Manager role is to be a 6-month appointment to ascertain if business development focus on NHS market is viable. Job Description and Person Specification complete, position to be advertised in September 2022.	CPO	~~June 2022~~ ~~September~~ October 2022	In progress
5	Review of innovation project pipeline to align to revised Trust Strategy priorities **Update July 2022**: Phase one of the review completed with phase two being undertaken in September 2022	IC	~~June 2022~~ October 2022	In progress
6	Review of Innovation Group function, responsibilities and membership in line with revised Innovation Strategy and RIME Committee review	IC	September 2022	In progress
7	Further stakeholder and patient engagement through revised Innovation strategic implementation and communication plans	IC	September 2022	In progress
8	Develop Innovation Risk Register	IC	September 2022	In progress
9	Five Year Workforce Plan	CPO	December 2022	In progress
10	Single project management office established	~~CPO~~ ADO	December 2022	In progress
11	Benefits realisation of Multitom Rax Business Case to be presented to Executive Team and Trust Board **Update August 2022:** Initial Business Realisation Report take to Executive Team in November 2020 and no further update currently. Update report to be taken in January 2023 to include outcome of Siemens software trial.	CPO/IC	~~April 2021~~ ~~April 2022~~ ~~2022 Q3~~ January 2023	~~Delayed due to COVID~~ On track
12	Spinal Improvement Programme income generation model contracts to be finalised Update January 2022: COVID added > 1 year delay due to resourcing and project complexities limiting progress. Contracting in progress **Update August 2022**: Significant rewrite of contract required and currently awaiting final version which is expected to be received in September 2022.	CPO	~~October 2020~~ ~~March 2021~~ ~~August 2021~~ ~~October 2021~~ ~~February 2022~~ ~~June 2022~~ September 2022	~~Delayed due to COVID~~ ~~On track~~ In progress
13	Innovation included within the ~~NHS Pulse and Staff Surveys~~ staff engagement surveys	CPO/IC	September 2022	In progress
14	Competitor analysis to be initiated and presented to Trust Board **Update August 2022**: Competitor analysis to be undertaken following recruitment to Business Development Manager post	~~CPO~~CFO	~~TBC~~ ~~(due to COVID-19)~~ ~~July 2022~~ October 2022	~~On hold~~ ~~Delayed due to COVID~~ In progress
15	Development of Financial and Commercial Substrategy	CFO	November 2022	New Risk (In progress)
16	Developing appropriate legal resource with a new partner that includes corporate advice, contract advice and litigator advice (value)	CPO	September 2022	New Risk (In progress)

Risk ID: 011	Date risk identified: April 2020	Date of last review:	July 2022
Risk Title: Cyber Security If Cyber Security attacks continue to evolve and grow then the Trust may be subject to a successful attack which may lead to service disruption, loss of data and financial penalties		Date of next review:	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	3 – Financially Strong
		Assurance Committee:	Business Performance Committee (Audit)
		Lead Executive:	Chief Finance Officer

Linked operational Risks		
686	If the Trust encounters a cyber security incident, then there is risk of potential data breaches or malware attack.	8
Risk Appetite	Averse	

	Consequence	Likelihood	Rating
Initial	Major 4	Almost Certain 5	20
Current	Moderate 3	Likely 4 5	~~12~~ ~~15~~
Target	Minor 2	Likely 4	8

Key Impact or Consequence

- 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/Network and Information Systems Directive
- Reputation risk due to loss of trust from patients, service users and other organisations the Trust supplies services to

Performance:

What evidence do we have of the risk occurring i.e. likelihood?

Carecerts Alerts

Month	2022	2021
Jan	26	16
Feb	15	25
Mar	25	19
Apr	18	33
May	17	34
June	20	23
July	15	20

Category	2022
Information	89
Low	6
Medium	19
High	6
Insecure Software	20

- Cyber security attacks are increasing, and ongoing work is required to keep up to date
- Log4j High Vulnerability identified at global level
- Heighten Cyber level due to Russian conflict
- Cyber attack on AdvanceOne multiple systems including 111

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

1. Firewall in place and kept up to date on an ongoing basis
2. Security Information and Event Management (SIEM) monitors all live systems
3. Latest version of Antivirus Installed on All Computers
4. Vulnerability Protection across Server Fleet
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 in place
11. ISO27001 Accreditation process - Annual
12. Informatic Skills Development Accreditation Level 1
13. HIMMS Level 5
14. Data Security and Protection Toolkit
15. Member of the Cheshire and Mersey Cyber Security Group - Ongoing
16. Pilot for NHS Digital Programmes relating to Cyber security - Ongoing
17. CareCERT Processing on a regular basis - Ad Hoc
18. Network groups for IG - Radiology etc.
19. Proactive monitoring of national cyber alert status
20. Daily National update Advance
21. Interoperability – Upgrade to the latest supported Microsoft Windows Operating System to continue to receive critical security updates Mar 22
22. NHS Mail – National mail protection
23. Backups – Transition to immutable “offline” backups to protect against Ransomware attacks
24. Datacentre – Currently upgrading to latest VMware platform to continue to receive critical security updates
25. SQL – Migration of SQL instances underway to the latest supported Microsoft SQL platform to continue to receive critical security updates
26. Alerts and communications plan in place to educate and remind staff about IT security
27. Updated version of Antivirus rolled out April 2022

Key Gaps in Control:

Where we are failing to put controls/systems in place or where are we failing to make them effective?

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
3. Increased activity due to geo-political events
4. Recommendations from MIAA Cyber Security Internal Audit are overdue and not yet complete

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 Review of CareCERTs - Weekly Annual Cyber Security Awareness Presentation to Board **Level 2** Monthly report from Information Governance Forum to Business Performance Committee Annual Report of Senior Information Responsible Officer - Trust Board Report to Audit Committee **Level 3** ISO27001 – accreditation, external audit annually MIAA audits of Data Security and Protection Toolkit –Substantial Assurance External Penetration Testing – May 2021 Date planned for 22 Regional Desktop Exercise – April 2022 Internal Desktop Cyber Exercise – May 2021 Date planned for 22 Trust Board Cyber Security Training – April 2021 Full Cyber Library completed by C& M HCP – August 2021	1. Third party assurances required regarding satellite sites 2. Ongoing work with NHS Digital to inform funding requirements 3. Local skillsets limited resourcing (001) 4. Log4J National systems status still unknown

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	On-going work with NHS Digital to inform funding requirements for Cyber Security post-Covid Working on regional solution 2022/23 with Digital Lead, awaiting ICS input UPDATE: Awaiting new Chief Digital Information Officer to join ICS	CFO	~~June 2022~~	On hold
2	Collaboration with C&M and NHS Digital and Specialist Trusts Some additional functions put into place, looking at expanding further post Covid. Revisiting with ICS with new digital lead and Cyber skillsets UPDATE: Awaiting new Chief Digital Information Officer to join ICS	CFO	~~August 2022~~	~~In progress~~ On hold
3	Expand Cyber service to underpin current processes with MIAA / C&M ICS Desk top exercise complete, penetration test ~~booked for July~~ complete	CFO	July 2022	Complete
4	Attainment of HIMMS level 6 through Digital Aspirant programme UPDATE ongoing although reliance on LUHFT Pharmacy upgrade to complete closed loop may impact forecast completion date.	CDIO	April 2023	In progress
5	Transcription of operational risks from local IT risk register to Datix	CDIO	October 2022	New Action

Risk ID: 012	Date risk identified April 2022	Date of last review:	July 2022
Risk Title: Digital If the Trust fails to deliver the benefits of the Digital Aspirant funding then the Trust may fail to secure digital transformation leading to poor staff experience, a deterioration of patient safety, reputational damage, financial penalties and missed opportunity.		**Date of next review:**	October 2022
		CQC Regulation:	Regulation 17 Good Governance
		Ambition:	Digital/ Cyber Security: To keep up with digital opportunities and threats
		Assurance Committee:	Business Performance Committee
		Lead Executive:	Chief People Officer

Linked Operational Risks				Consequence	Likelihood	Rating
20	If the Trust does not have sufficient IT capacity, then there may be a risk to the achievement of the Trust strategic ambitions, particularly in relation to service improvement, quality and transformation.	8	Initial	Moderate 3	Likely 4	12
			Current	Moderate 3	Unlikely 2	6
			Target	Moderate 3	Unlikely 2	6
Risk Appetite	**Cautious**					

Key Impact or Consequence	**Performance:** *What evidence do we have of the risk occurring i.e. likelihood?*
- Investment does not result in anticipated benefits for patient care and safety - Missed objective - Reputational damage due to poor use of resources - Poor patient experience - Long term revenue commitments for under-par systems - Staff do not understand/use systems - Sanctions from regulators	- Trust bid successfully for Digital Aspirant funding approved by NHS Digital. This funding will help to deliver the EPR and wider Digital Strategy between 2021 and 2023 - Insufficient staff resource/sickness to deliver full performance - Impact of Covid on supply chain causing delays in delivery and equipment shortages ~~- 2021/22 programme spending delivered~~

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. Projects underway: i. Outpatient Transformation Project ii. Inpatient Transformation Project iii. Theatres Project iv. Paper Light Project 2. Digital Transformation Board aligned to governance groups across the organisation 3. IT Technical Programme of work 4. Cyber Security Programme 5. PMO Function underpinning the Digital Strategy 6. Collaboration with other Specialist Trusts regarding IT/Digital to review opportunities to work together / standardise approaches. 7. EPR rollout plan for 2021/22 completed, 2022/23 underway 8. Digital Transformation Programme (LoA/MoU NHSD/X) 9. Digital Aspirant status to allow Digital Transformation 10. HiMSS Level 5 achieved (working towards Level 6) 11. Digital Strategy 12. Representation on ICS Digital Programme Boards 13. Regular reporting to NHS Digital of progress against digital aspirant funding 14. ~~Quarterly~~ Monthly report to Business Performance Committee 15. Monthly reporting to Executives 16. FM2 completed and signed off by NHSEI, FM3 underway	1. Difficulties in recruiting due to source skills shortage in area 2. Directions of C&M Health and Social Care Digital Strategy 3. Change in national priorities around Digital post-Covid response may not be aligned to Trust digital priorities 4. Lack of digital expertise on board

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 Information Governance & Security Forum – monthly ~~Digital Prioritisation Group - quarterly~~ ~~Clinical Risk Group~~ ISMS Group Monthly ISMS Risk Group Monthly **Level 2** ~~Quarterly updates on digital~~ Monthly update on digital transformation progress to BPC Specialist Trust Digital Group Executive Team review of C&M Hospital Cell Digital Objectives C&M Chief Information Officers Digital Collaboration Group National Chief Information Officer Weekly Meetings	Ensuring new Digital Strategy is fully compliant with NHS Digital Aspirant funding objectives. Workshops facilitated by MIAA Q2-3 2021/22. New Digital Substrategy not yet approved

Level 3 Critical Applications Audit – Jan 2020 Healthcare Information and Management System Level 5 achieved 2021/22 NHS Digital Maturity Minimum level achieved NHS EPR maturity achieved Information Security Management Systems Certification IS27001 accreditation December 2021 Independent review of Trust approach to Digital Strategy by NHS Digital 2018/19 Acceptance of approach and contribution to ICS by C&M Digit@LL NHSX monitoring Digital Aspirant via CORA against LoA. Data Security and Protection Toolkit annual audit and submission ~~Information Security Management Systems Certification IS27001 accreditation September 2020~~	

Corrective Actions: To address gaps in control and gaps in assurance		**Action Owner**	**Forecast Completion Date**	**Action Status**
1	New Digital Substrategy with MIAA / C&M ICS to be approved by Board. Initially paused while Trust Strategy approved now awaiting confirmation of ICB digital strategy which has delayed Substrategy by a further month	CPO	~~May 2021~~ ~~December 2021~~ ~~September 2022~~ November 2022	In progress
2	HIMMS level 6 UPPDATE: Paused due to reliance on LUFHT Pharmacy upgrade to complete closed loop	CDIO	October 2023	~~In progress~~ Paused
3	Deliver final FM3 sign off by NHSEI	CDIO	September 2022	In progress
4	MIAA Technical Services Gap Audit (audit committee Aug 22) corrective actions	CDIO	December 2022	In Progress
5	Transcription of risks from ISMS risk register to Datix	CDIO	October 2022	New Action

The Walton Centre NHS Foundation Trust

Report to Trust Board
6th October 2022

Report Title	Integrated Performance Report
Executive Lead	Lindsey Vlasman - Chief Operating Officer
Author (s)	Mark Foy – Head of Information & Business Intelligence
Action Required	To note

Level of Assurance Provided

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

Key Messages

- See summary for performance overview

Next Steps

- Ongoing

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

Strategic Risks

001 Quality Patient Care	004 Operational Performance	003 System Finance

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Integrated Performance Report

Executive Summary

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

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
Referral to Treatment Long Waits
28 Day Emergency Readmissions
% of Patients on a PIFU

Opportunity for improvement
Theatres
Activity Restoration

Underperforming
N/A

Workforce Indicators

High Performing
N/A

Opportunity for improvement
Mandatory Training
Turnover

Underperforming
Appraisal Compliance
Sickness/Absence

Quality Indicators

High Performing
Complaints
CAUTI
VTE
Hospital Acquired Pressure Ulcers
Risk Adjusted Mortality
Friends and Family Test
Moderate Harm Falls
Infection Control

Opportunity for improvement
N/A

Underperforming
N/A

Finance Indicators

Key Performance Indicators	June	July	August
% variance from plan - Year to date	2.0%	3.9%	18.2%
% variance from plan - Forecast	0.0%	0.0%	0.0%
% variance from efficiency plan - Year to date	1.0%	6.3%	5.3%
% variance from efficiency plan - Forecast	-28.9%	-21.1%	-21.0%
Capital % variance from plan - Year to date	63.7%	56.0%	51.6%
Capital % variance from plan - Forecast	0.0%	0.0%	0.0%
Capital Service Cover *	2.2	2.5	2.9
Liquidity **	32.5	33.1	34.6
Cash days operating expenditure ***	87.2	91.6	93.1
BPPC - Number	83.8%	84.4%	85.5%
BPPC - Value	81.0%	82.6%	83.8%

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

Conclusion

2. As listed above many of the indicators are high performing either against a set target, local improvement or external benchmarking, with only a couple indicators underperforming.

Recommendation

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

Author: Mark Foy – Head of Information & Business Intelligence
Date: 27/09/2022

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Board KPI Report
October 2022

Data for August 2022 unless indicated

Explanation of SPC Charts and Assurance Icons

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

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

All SPC charts will follow the below Key unless indicated

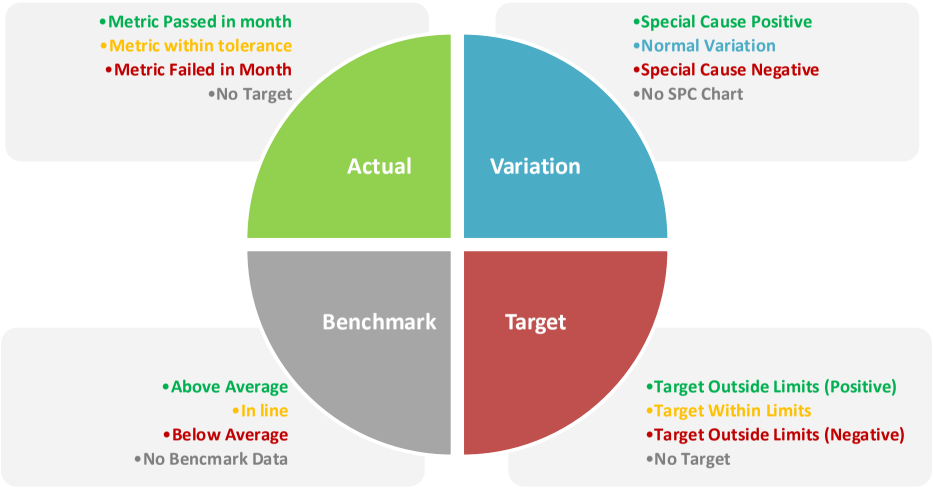
Actual | UCL | Average | LCL | National Average | Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

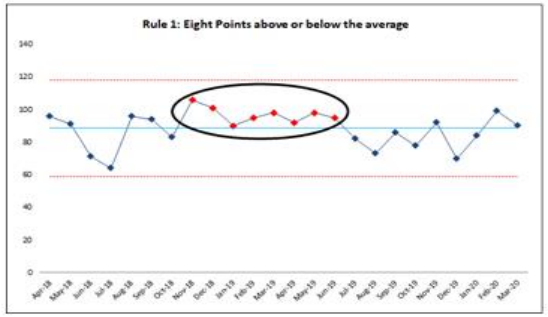
All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.

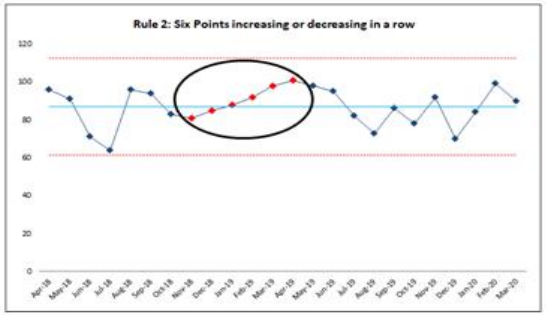


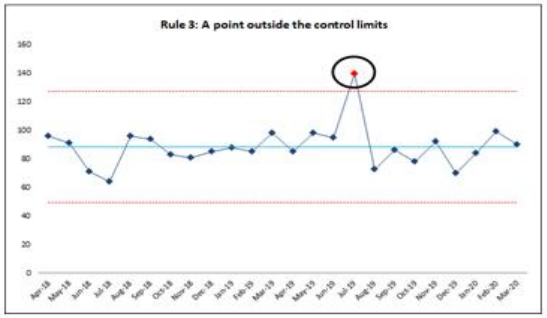
SPC Chart Rules

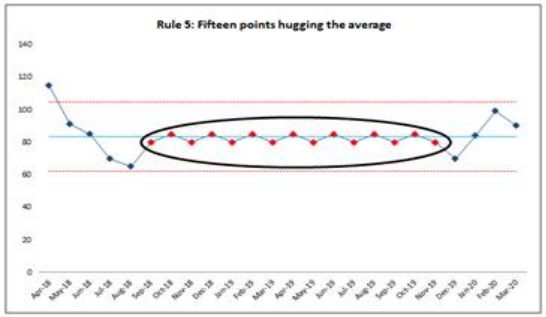
The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

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









The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Operations & Performance Indicators

Operational

Responsive - Referral to Treatment

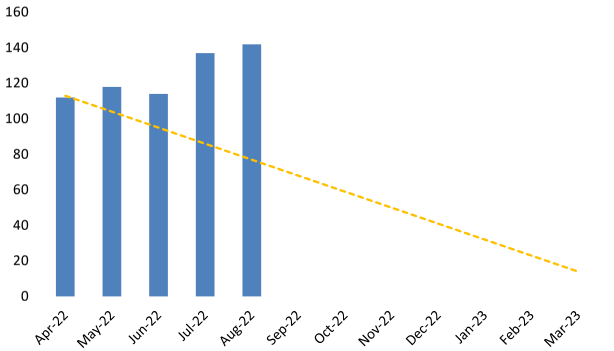
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

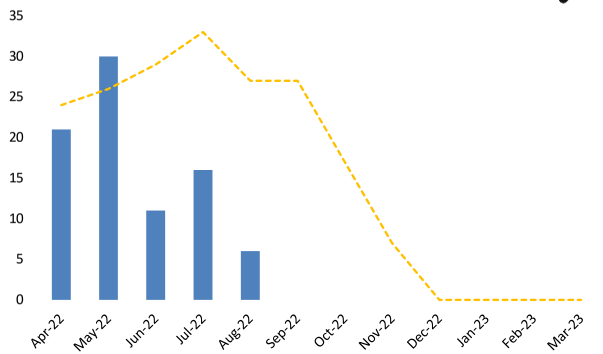
As part of plans to restore services to pre-COVID levels, each Trust was required to submit a trajectory along with timescales for reducing long waits. This includes having zero patients waiting longer than 104 weeks by July due to capacity issues.

During May the Trust received a further waiting list of over 200 patients as part of the Spinal Service Transfer. This has resulted in the total open pathways increasing significantly. There was a significant number of long waiters included in these which were not included in our long waiter reduction trajectory who are contributing to the under performance.

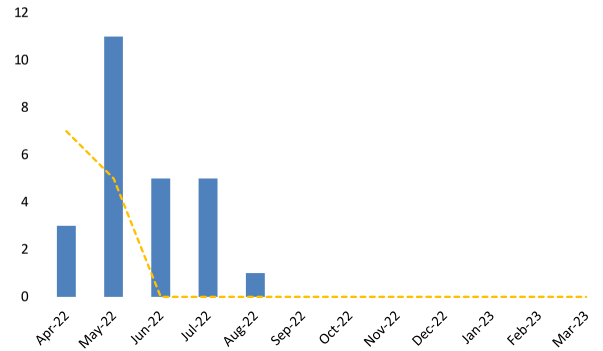
Number of Pathways waiting 52+ weeks at month end



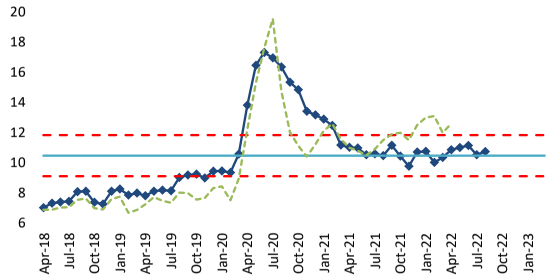
Number of Pathways waiting 78+ weeks at month end



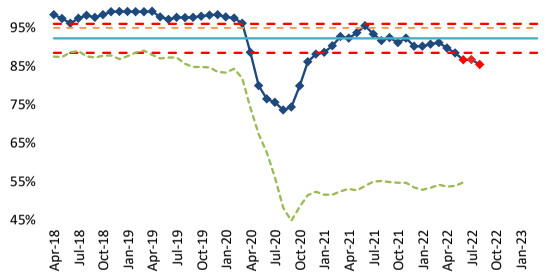
Number of Pathways waiting 104+ weeks at month end



RTT English Average Open Wait (Weeks)



RTT Welsh Open Performance



Operational

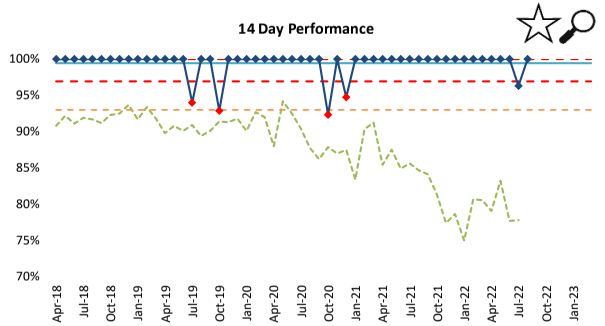
Responsive - Cancer Standards

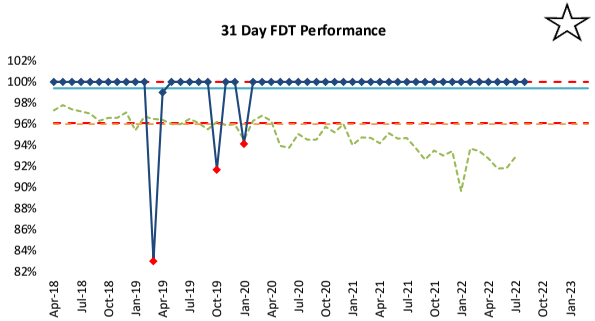
The Walton Centre NHS Foundation Trust

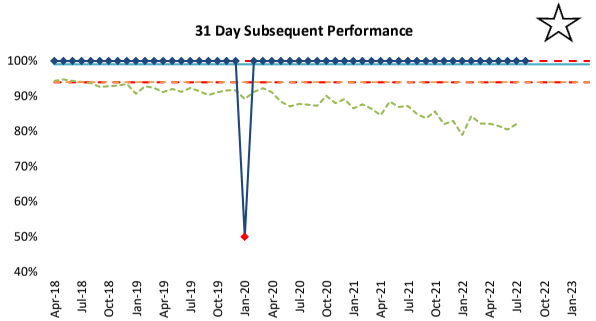
Excellence in Neuroscience

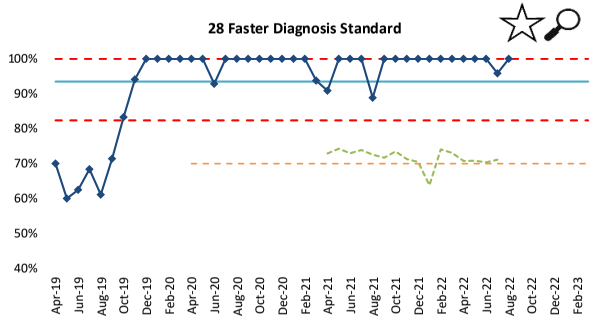
Responsive - Access Standards	Target	Actual	Assurance
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	100%	
28 Day Faster Diagnosis Standard	70%	100%	

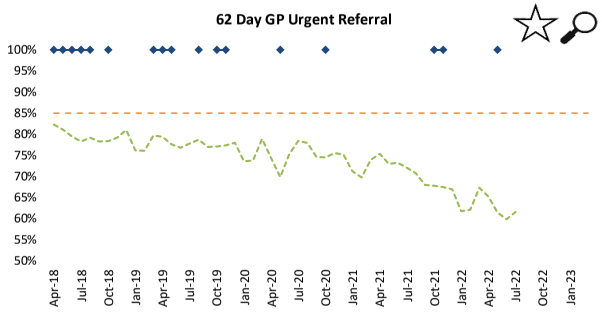
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, therefore COVID-19 has not impacted their care and treatment.

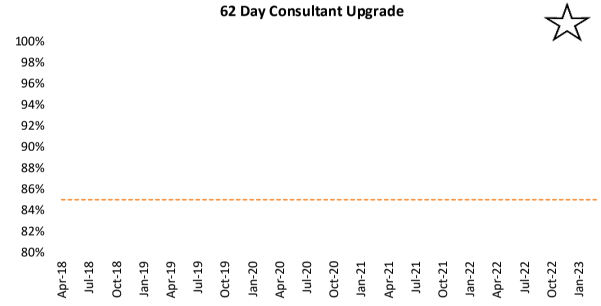












Operational

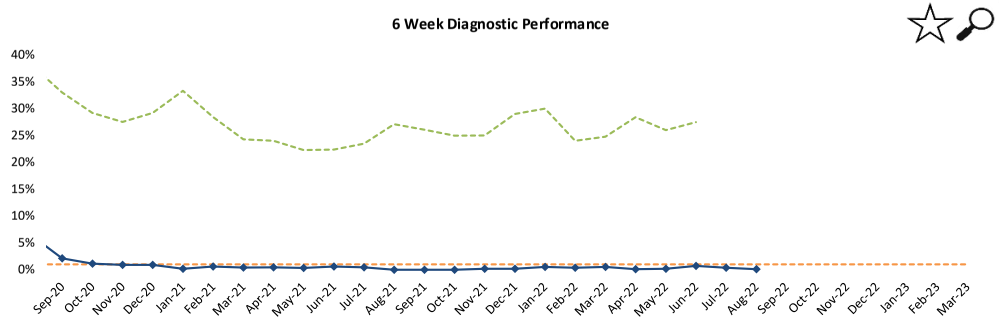
Responsive - Diagnostics

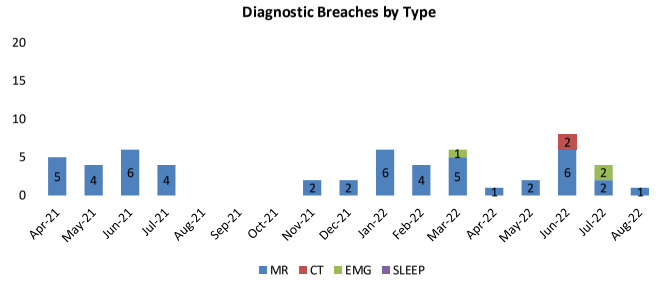
The Walton Centre NHS Foundation Trust

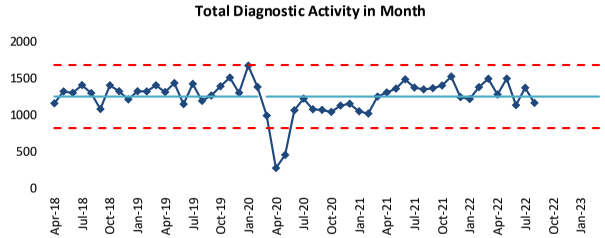
Excellence in Neuroscience

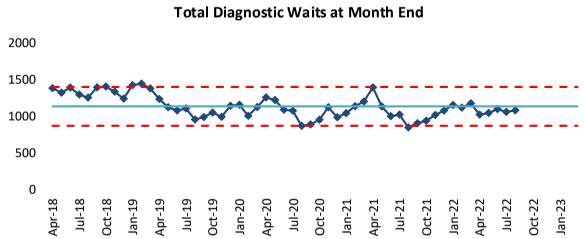
Responsive - Access Standards	Target	Actual	Assurance
Diagnostic 6 Week Performance	1%	0.38%	

Achievement against the Diagnostic 6 week standard has been met in month. There was one 6 week breach in month.









Operational

Effective - Theatres

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

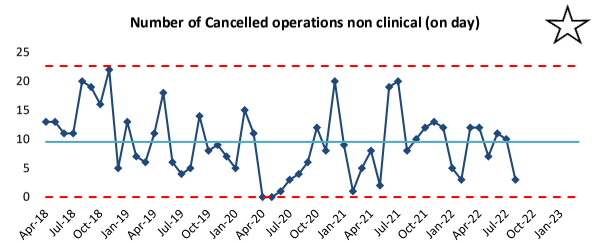
Effective - Theatres	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	10	
% Cancelled operations non clinical on day	0.80%	0.29%	
28 Day Breaches in month	0	2	

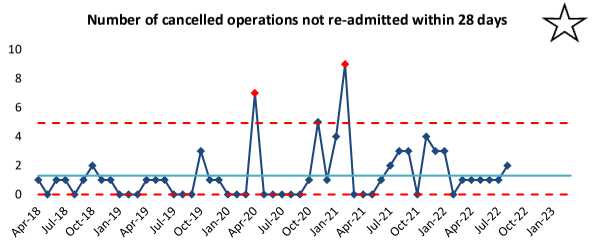
Non Clinical Cancellations

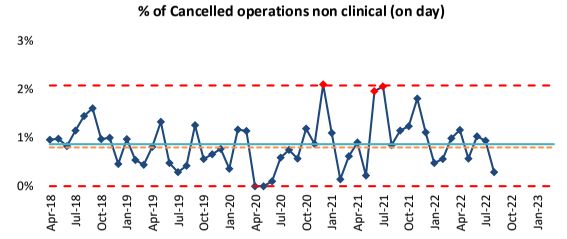
There were three patients cancelled at last minute for non-clinical reasons, the reasons for the cancellations were: list overrun (1), surgeon unavailable (1) and ICU/HDU beds unavailable (1).

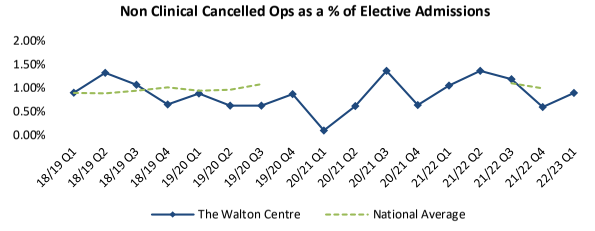
The Trust is in line with the national average for the percentage of non clinical cancelled operations based off latest publi shed data.

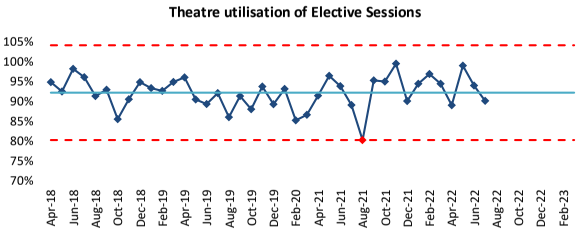
In July we also had several procedures cancelled due to covid positive patients which impacted utilisation.

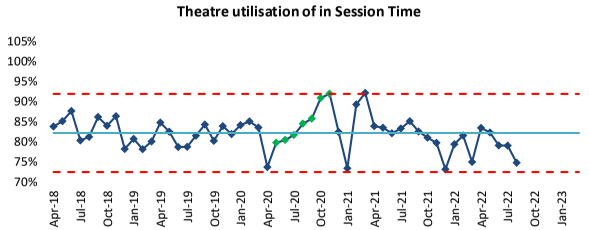












Operational

Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

August 22 Overall Activity Performance

POD	Actual 22/23	Plan 22/23	Actual (% of 19/20)	Target* (% of 19/20)	YTD (% of 19/20)
Daycase	908	831	120.1%	104%	104.49%
Elective	244	272	93.1%	104%	82.36%
Elective & Daycase Total	**1152**	**1103**	113.2%	**104%**	98.95%
Non Elective	168	-	93.3%	-	93.20%
New Outpatients	4307	3958	113.2%	104%	105.62%
Follow Up Outpatients	7106	7284	97.6%	100%	98.58%
English Admitted Stops	226	263	89.3%	110%	79.32%
English Non Admitted Stops	2017	1685	124.5%	110%	104.85%
Total English Stops	**2243**	**1948**	**119.8%**	**110%**	**101.50%**

***Target a guide for ERF purposes**

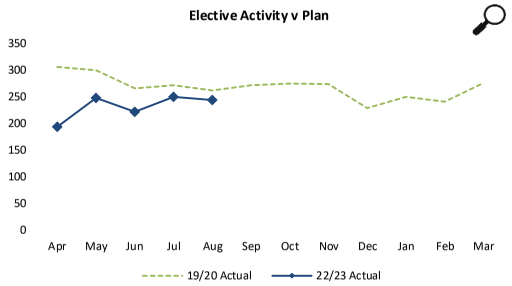
Operational planning for 2022/23 set Trusts the ambition to increase new outpatient appointments, Elective and Daycase activity to 110% of 19/20 level by March 2023 which is measured using RTT Stops.

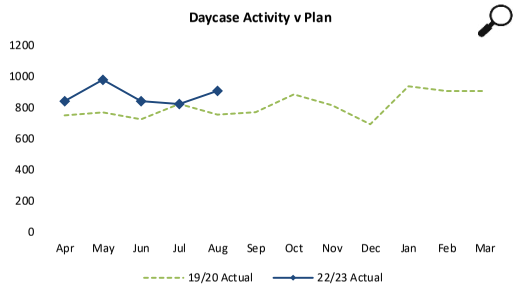
ERF is calculated using Value Weighted Activity and is set 104% of 2019/20 levels.

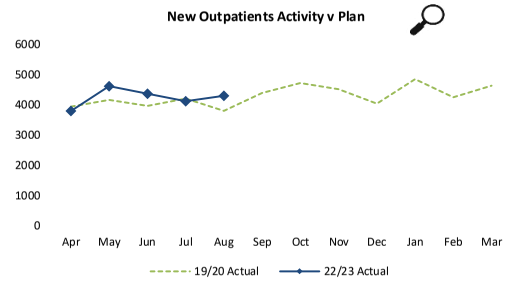
Trusts are also asked to achieve the ambition of reducing follow up outpatient appointments compared to 2019/20.

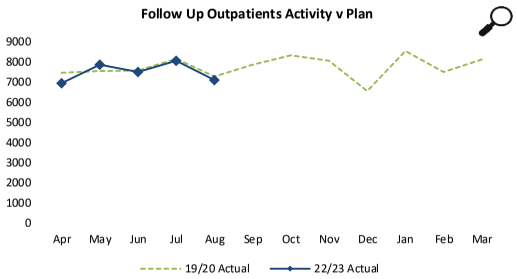
There is no target set against Non Elective activty.

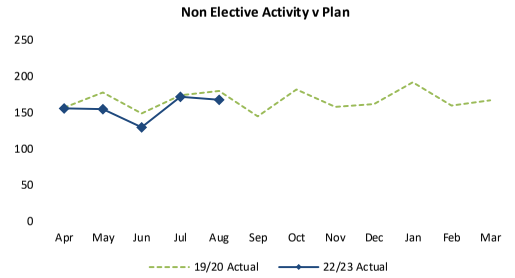
The information on this slide is raw activity for all Walton Centre patients and is unweighted.

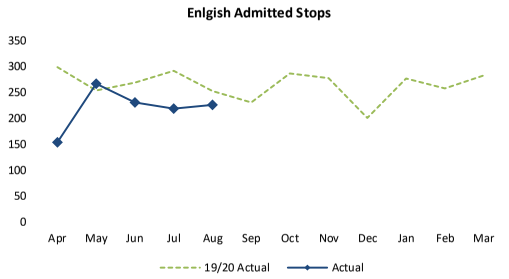


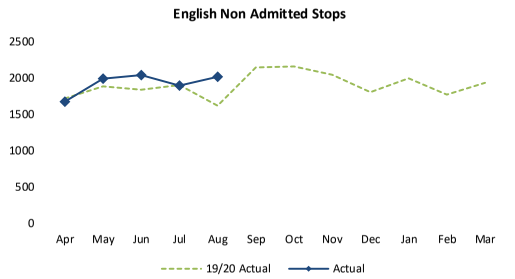










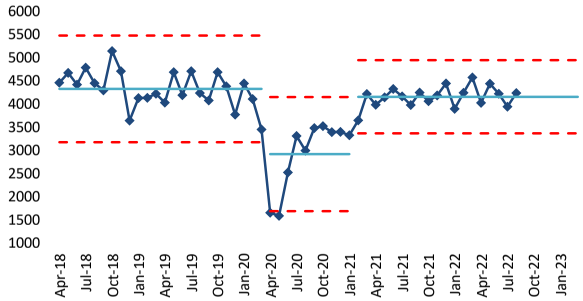


Operational

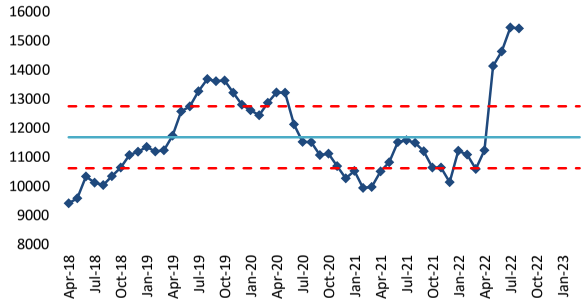
Effective - Activity (Leading Indicators)

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Total New Referrals Received

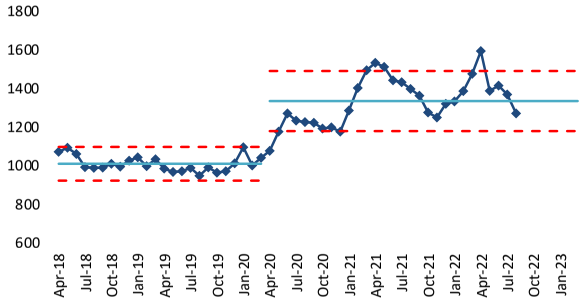


New Outpatient Waiting List

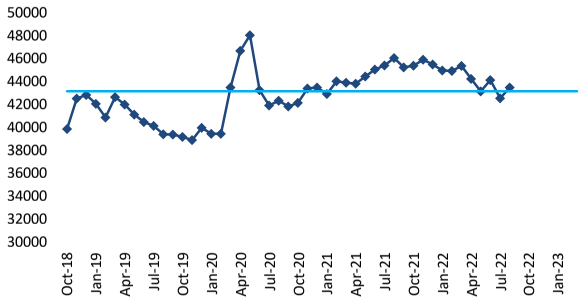


*Spinal transfer patients added to OPWL

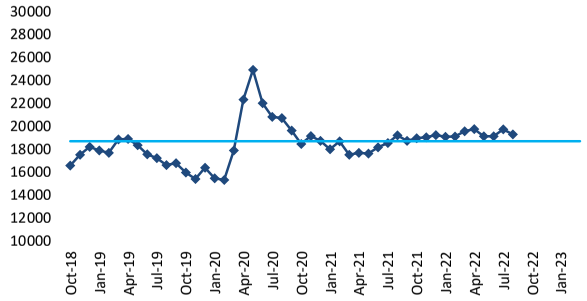
Inpatient Waiting List



Follow Up Outpatient Waiting List



Follow Up Outpatient Waiting List (Overdue)



Operational

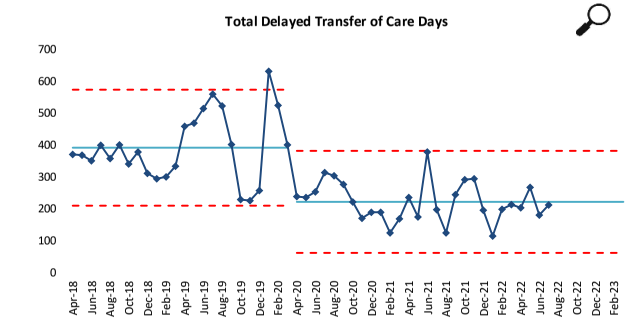
Effective - Flow

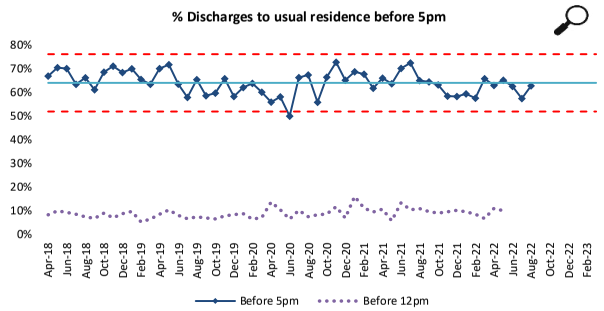
The Walton Centre NHS Foundation Trust

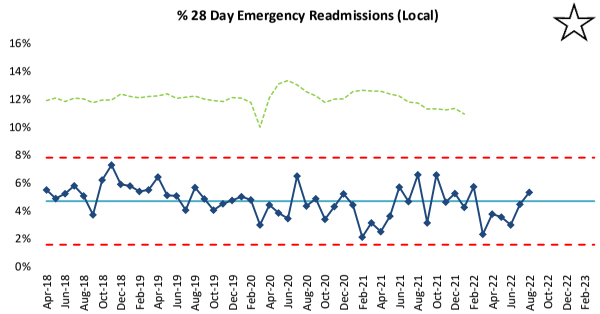
Excellence in Neuroscience

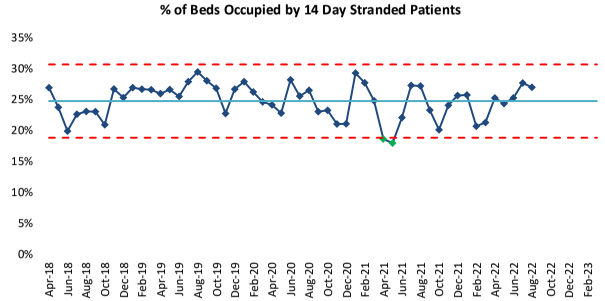
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	5.34%	
Total Delayed Discharge Days	-	213	
% Discharges by 5pm	-	64.06%	
% 14 Day Stranded Patients	-	27.00%	

All indicators are stable and within normal variation. These indicators form part of Patient Flow Transformation and are monitored through that workstream.









Operational

Effective - Outpatient Transformation

The Walton Centre NHS Foundation Trust

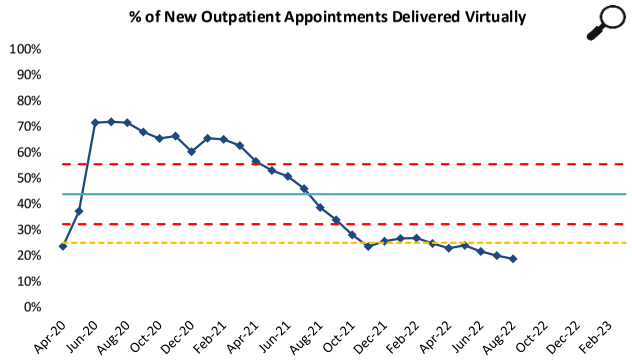
Excellence in Neuroscience

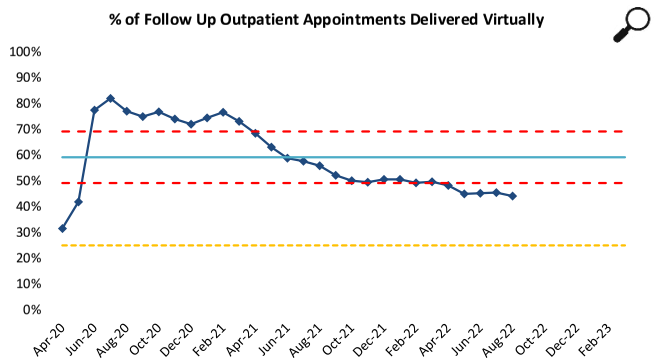
Virtual Appointments

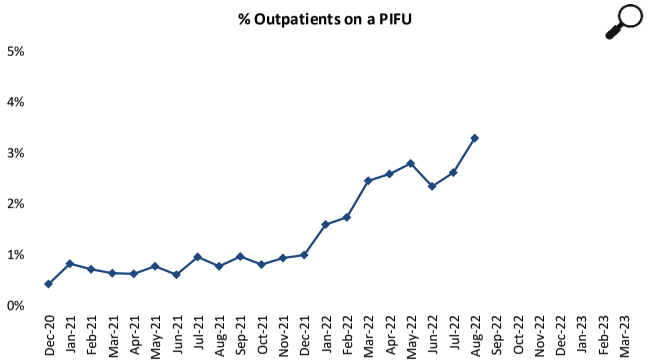
The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. We are currently above this target. Following a switch to deliver mainly virtual appointments during Covid-19 the Trust is reverting appropriate clinics back to face to face where clinically necessary but is expected to remain above the target.

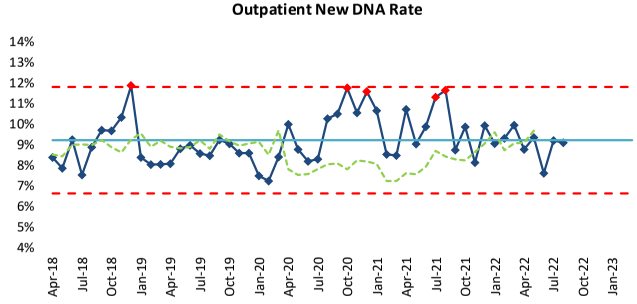
Patient Initiated Follow Up (PIFU)

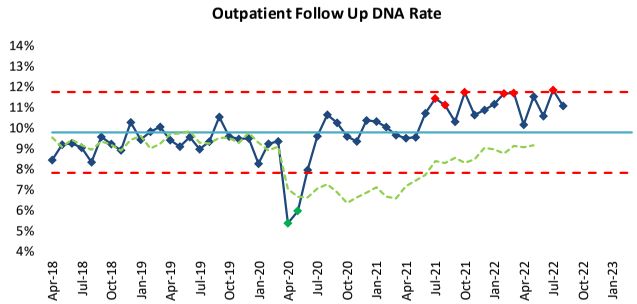
As part of national Outpatient Transformation schemes the Trust the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. In August 22 3.30% of total outpatients were on a PIFU.

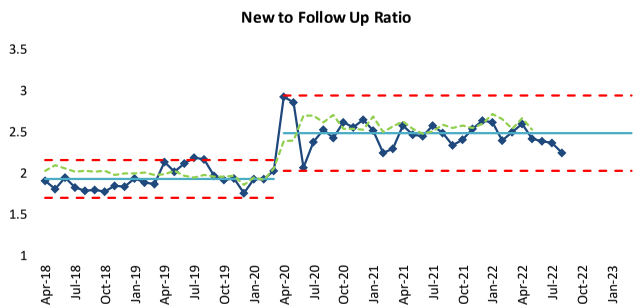












Workforce Indicators

Workforce

Well Led - Workforce KPIs

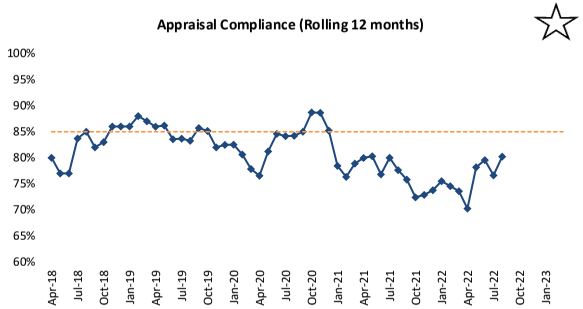
The Walton Centre NHS Foundation Trust

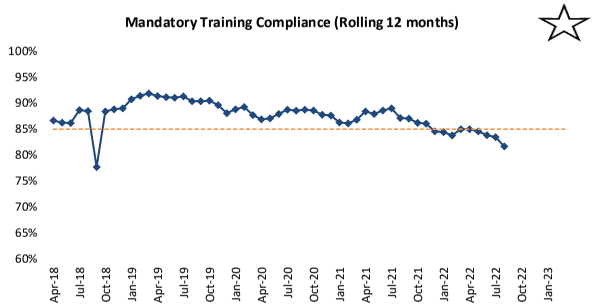
Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	76.64%	
Mandatory Training Compliance	85%	83.47%	

Appraisal Compliance

The Walton Centre PDR target has been set at 85%. Targeted chasing and the offer of further support with appraisals will continue. Following feedback from managers regarding the appraisal process, the paperwork is due to undergo review, however, this is on pause awaiting the outcome from the recommended standardised appraisal system outlined in the Messenger report, "Leadership for a collaborative and inclusive future".





Workforce

Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	7.03%	
Trust Turnover	-	16.95%	
Nursing Turnover	-	12.39%	
Other Staff Turnover	-	18.01%	

Sickness/Absence

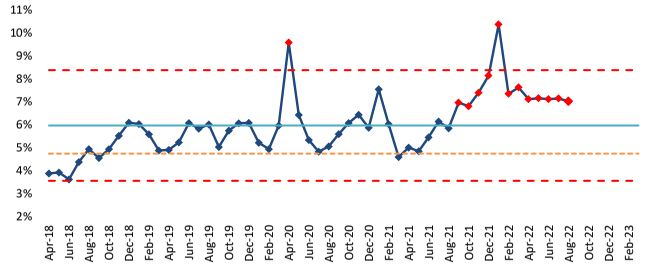
The Trust has seen a significant increase in Sickness/Absence levels which is above the 4.75% target. Sickness continues to be managed and sickness reports are shared monthly with managers and support is provided by HR advisors, who have monthly meetings with ward managers in place. Themes and trends are discussed at People Group with no outlying themes noted.

Turnover

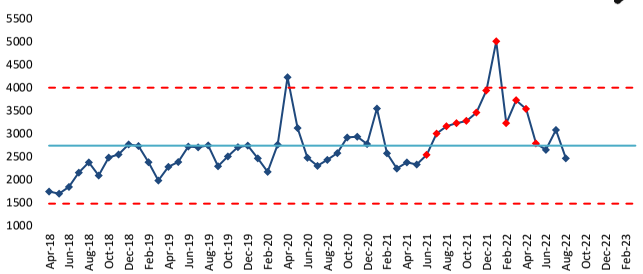
Overall Turnover for the Trust has significantly increased recently, largely driven by Corporate Services and Non Nursing Staff within Divisions. Nursing turnover is within normal variation and the trust is fully established in this area.

Other staff turnover has increased steadily and reflects the pressures within the wider labour market. This is exacerbated by other NHS providers not adhering to principles of agenda for change.

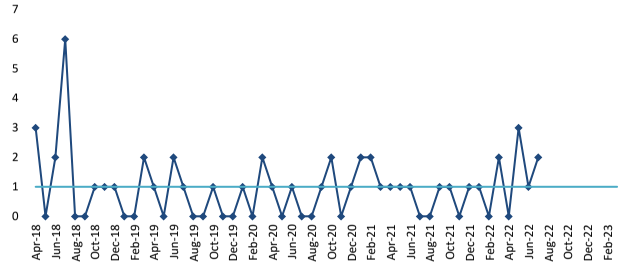
Sickness/Absence (Monthly)



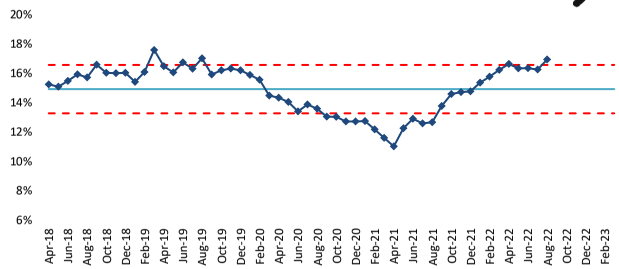
Lost Days due to Sickness/Absence (Monthly)



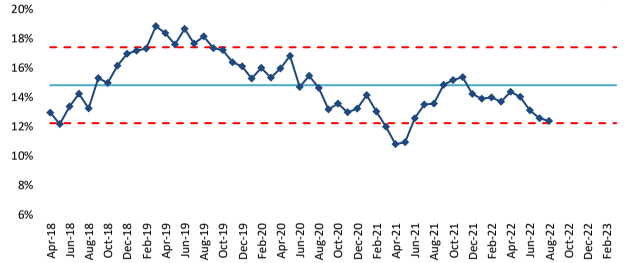
Medical Leavers



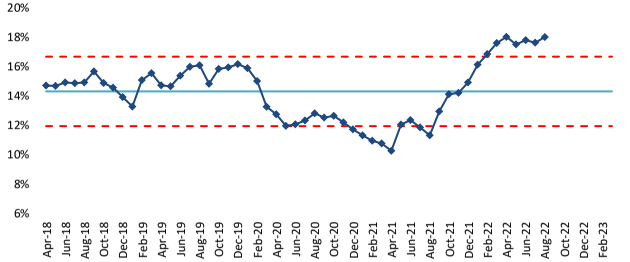
Trust Turnover (Rolling 12 months) - All Staff Groups



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



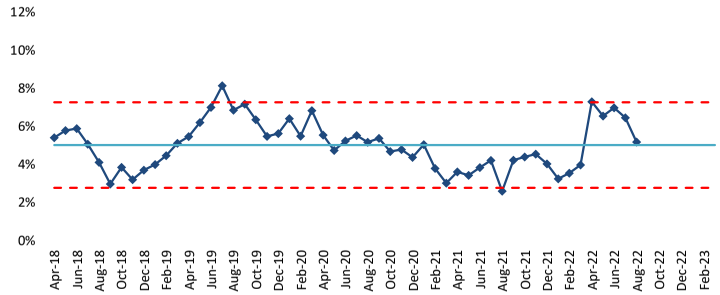
Quality of Care

Well Led - Workforce KPIs

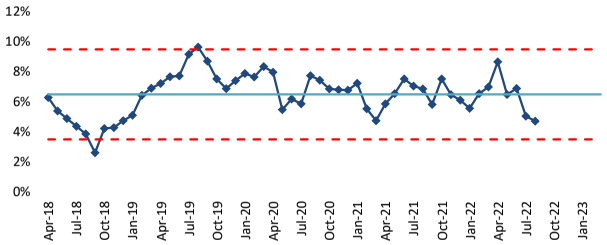
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

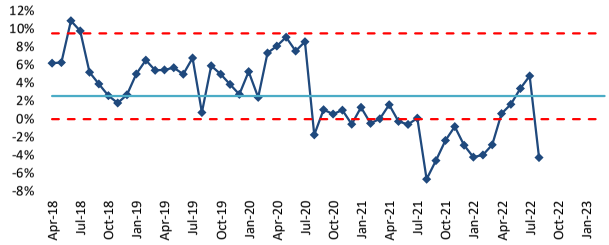
Overall Vacancy Level %



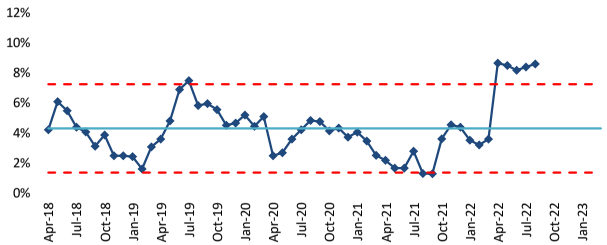
Nursing Vacancy Level %



Medical Vacancy Level %



Other Staff Vacancy Level %



Vacancy Rates

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

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

Quality Indicators

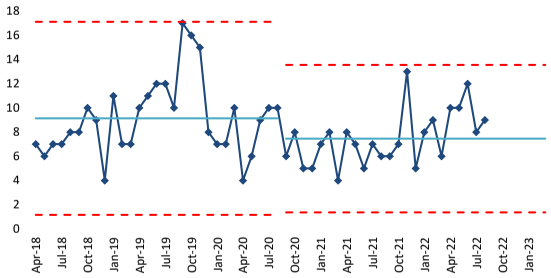
Quality of Care

Caring - Complaints

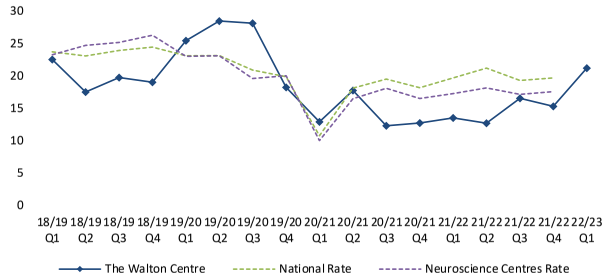
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

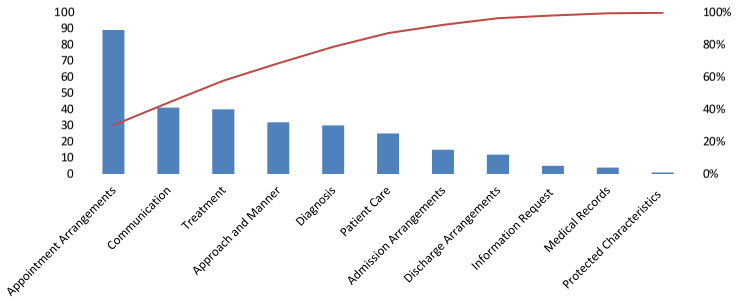
Total New Complaints Received in month



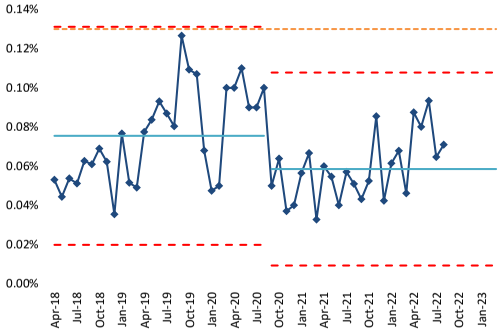
Quarterly Complaints per 1000 WTE



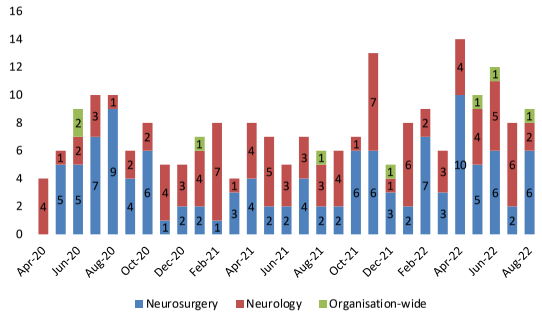
Complaints by Subject Apr 19 to present



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	66	32	24
20/21	42	23	6
21/22	45	19	11
22/23	12	11	9

In August 2022 the Trust received 9 new complaints; 2 Neurology and 6 Surgery and 1 Trust wide. Of the 9 complaints received; 3 related to admission or discharge arrangements and 3 related to treatment or care, 2 related to communcation and 1 to security.

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 0 to 13 at an average of 6 per month. The number of complaints received has significantly dropped during recent months.

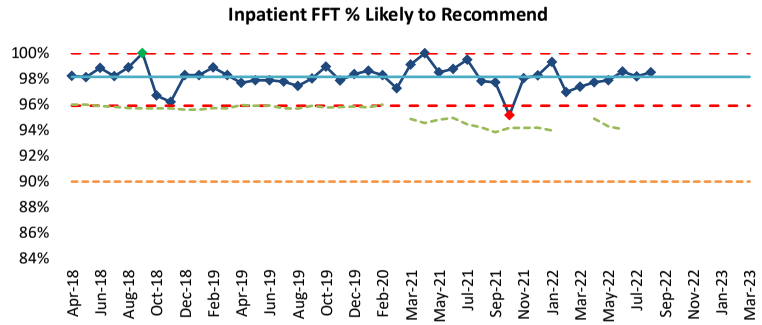
Due to the reduction seen the Trust is now below both the national and peer average up to the latest published period of benchmarking data (Q4 2021/22). However locally there has been an increase in the rate in Q1 2022/23.

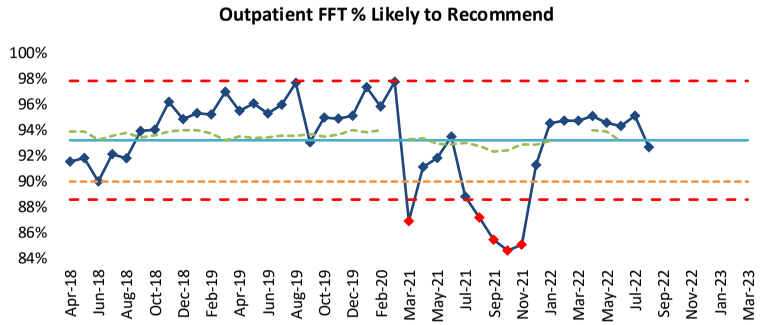
Quality of Care

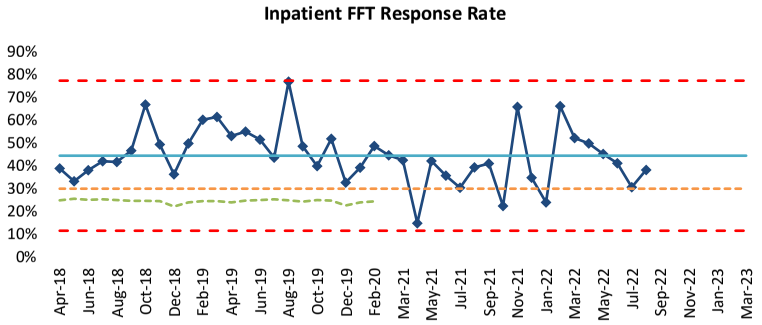
Caring - Friends & Family Test

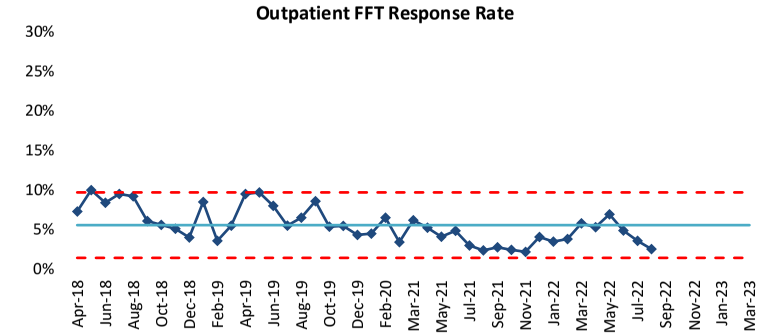
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience









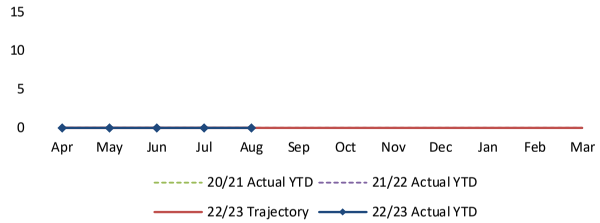
Quality of Care

Safe - Infection Control

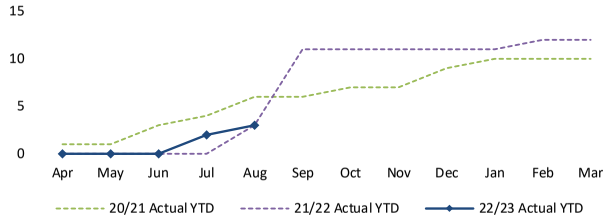
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

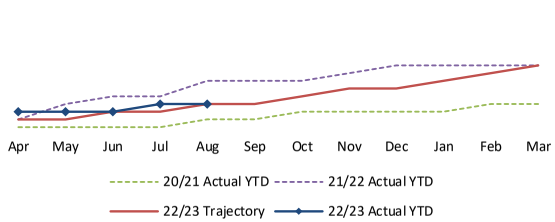
MRSA Bacteraemia



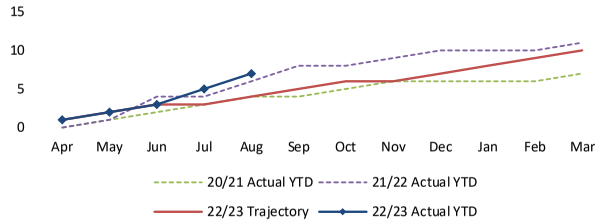
CPE



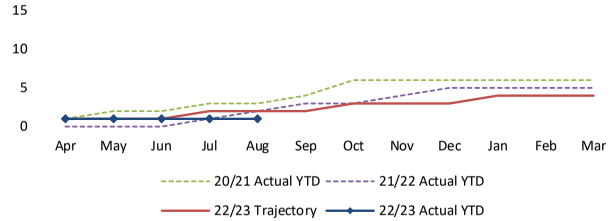
C.Diff



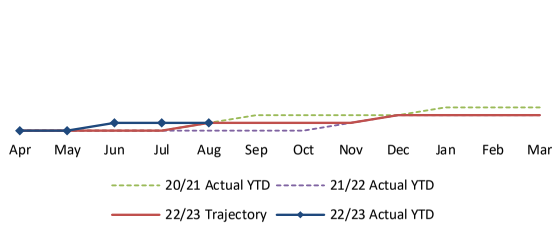
E.Coli



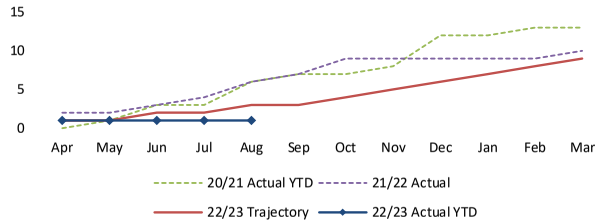
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2022/23

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

August Breakdown by Ward

2 x E Coli - Chavasse, Cairns

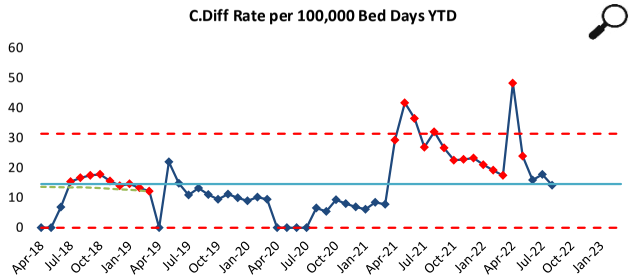
1 x CPE - Cairns

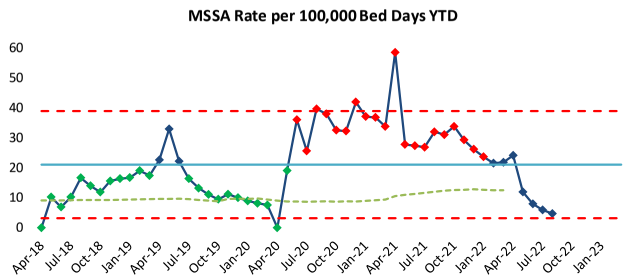
Quality of Care

Safe - Infection Control

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience



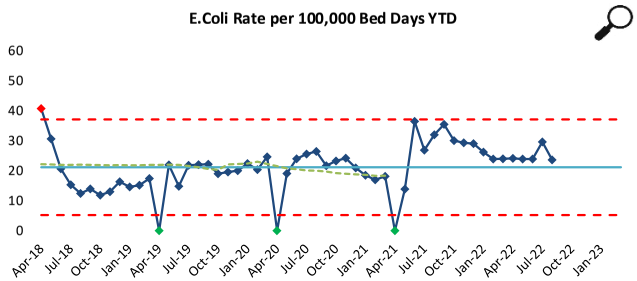


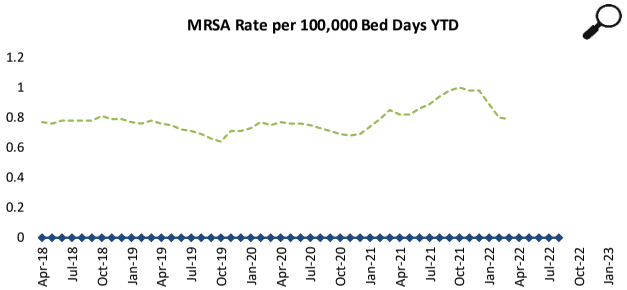
There have been three C.Diff year to date at a rate of 14.23 per 100,000 bed days.

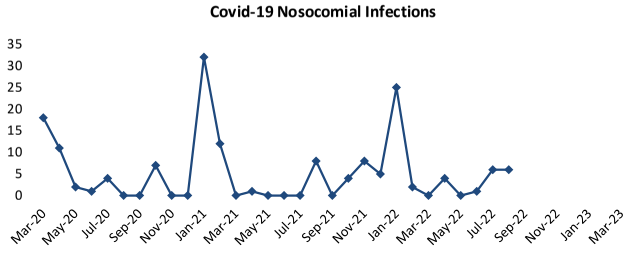
E. Coli cases are at seven during 22/23 at a rate of 23.71 per 100,000 bed days

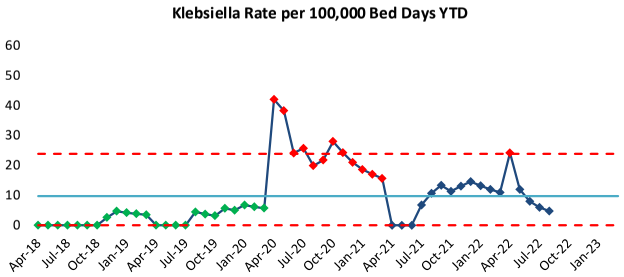
There has been one MSSA, Pseudomonas and Klebsiella respecitvely YTD. All at a rate of 4.74 per 100,000 bed days. The MSSA rate is below the national average for the first time since April 2020.

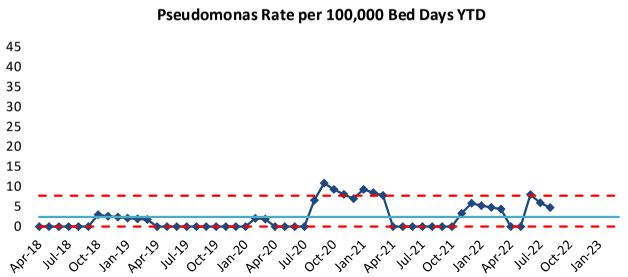
Covid-19 Nosocomial infections are lab confirmed PCR results only. There were six in August.











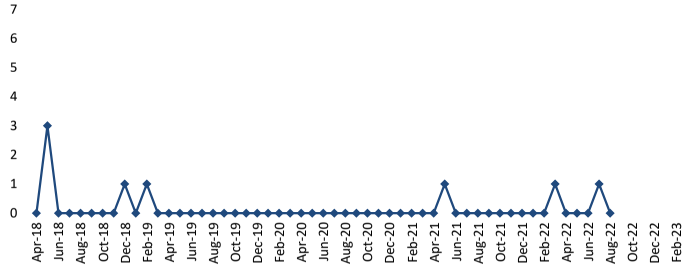
Quality of Care

Safe - Harm Free Care

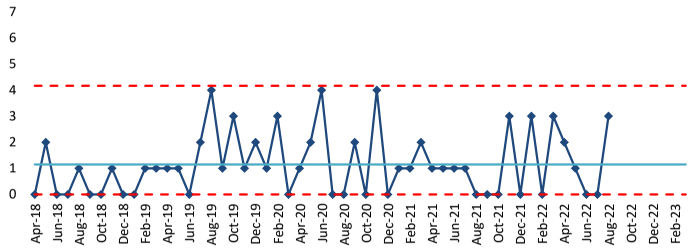
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

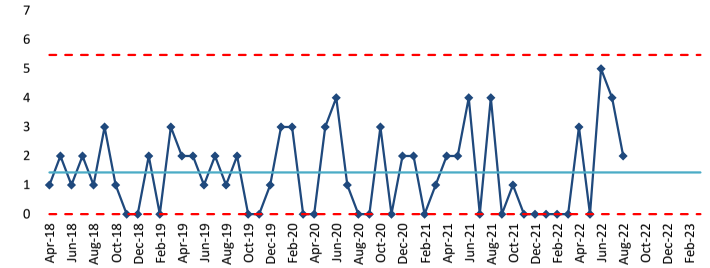
Total Moderate or Above Harm Inpatient Falls



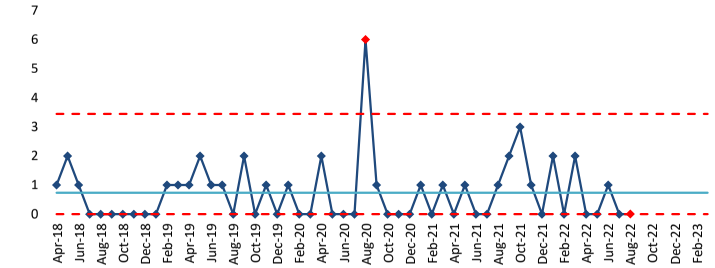
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4, Unstageable & Mucosal)



CAUTI Incidences



VTE Incidences



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

Pressure Ulcers
There were three Hospital Acquired Pressure Ulcers in month

CAUTI
There were two CAUTI incidence in month

VTE
There were zero VTE incidences in month

All harm measures are within normal variation.

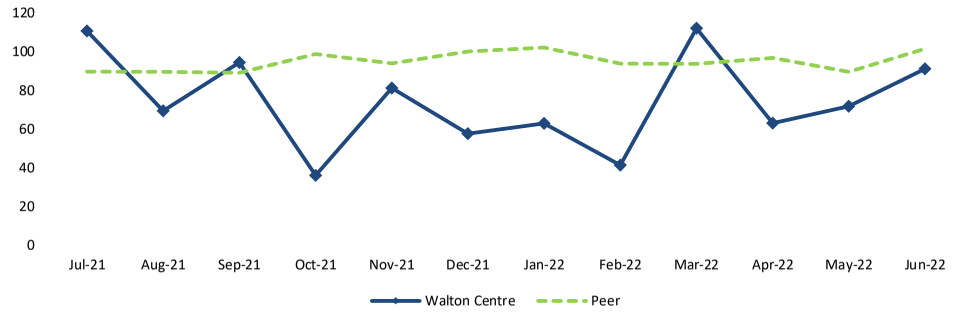
Quality of Care

Safe - Mortality

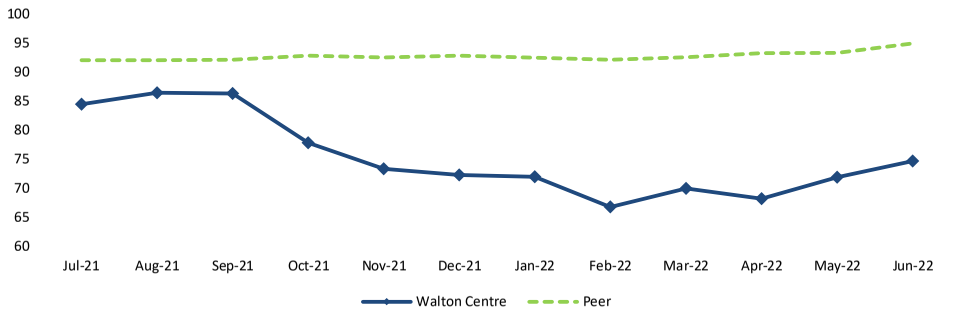
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

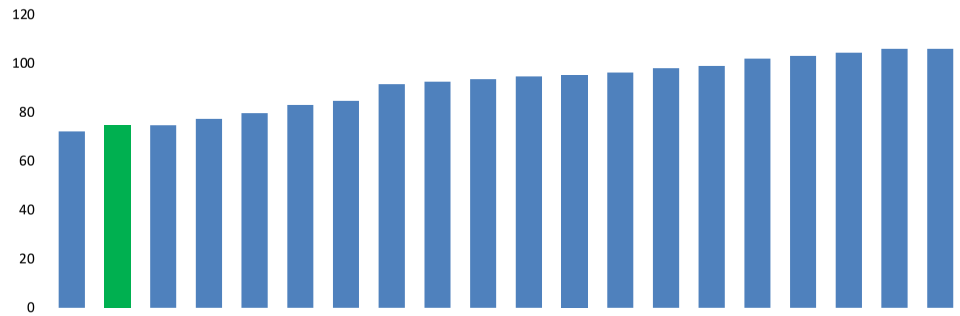
RAMI 2019 by Month



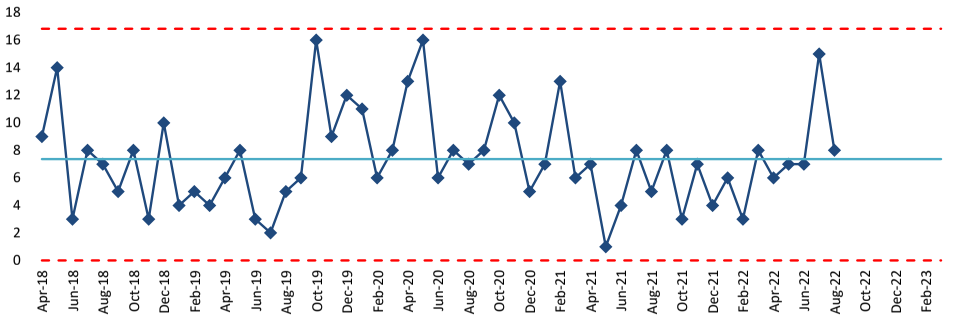
RAMI 2019 Rolling 12 Month



RAMI 2019 Rolling 12 Month Peer Distribution



Crude Mortality



As at June 2022 the rolling 12 month RAMI19 figure is 70.10. During the period there were a total of 69 observed deaths against 92 expected deaths. Compar ed to peers The Walton Centre has performed significantly better during the period.

RAMI19 excludes deaths following a positive covid-19 result. During the rolling 12 month period there have been 3 deaths following a positive covid-19 result. In the most recent two months there has been two.

Crude mortality is within normal variation

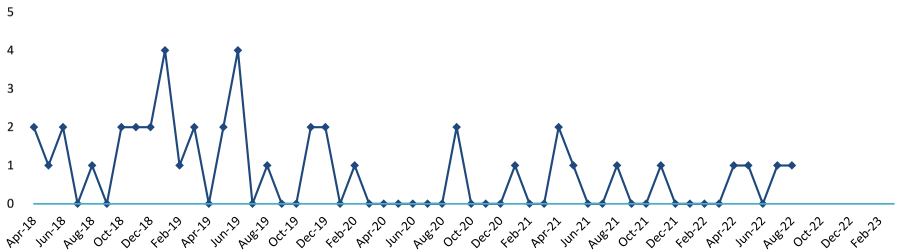
Quality of Care

Safe - Governance

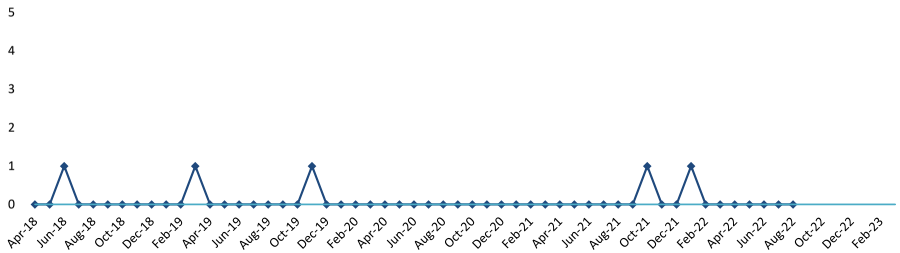
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Total SUIs Reported



Total Never Events Reported



Ward Scorecard

August 2022

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

	Safe Staffing				Harms				Infection Control			
	Day Registered	Day Non Registered	Night Registered	Night Non Registered	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	100.3%	108.5%	98.9%	127.4%	0	0	2	0	0	0	1	0
Caton	92.6%	99.9%	98.3%	123.0%	2	0	2	0	0	0	0	0
Chavasse	93.0%	114.1%	98.7%	111.4%	0	0	0	0	0	0	1	0
CRU	90.7%	113.0%	97.5%	139.4%	0	0	0	0	0	0	0	0
Dott	94.6%	100.5%	97.8%	122.6%	0	0	0	0	0	0	0	0
Horsley ITU	132.5%	81.0%	133.7%	69.7%	1	0	0	0	0	0	0	0
Lipton	103.8%	95.7%	122.8%	137.4%	0	0	0	0	0	0	0	0

WELL LED

Finance

Key Performance Indicators	June	July	August
% variance from plan - Year to date	2.0%	3.9%	18.2%
% variance from plan - Forecast	0.0%	0.0%	0.0%
% variance from efficiency plan - Year to date	1.0%	6.3%	5.3%
% variance from efficiency plan - Forecast	-28.9%	-21.1%	-21.0%
Capital % variance from plan - Year to date	63.7%	56.0%	51.6%
Capital % variance from plan - Forecast	0.0%	0.0%	0.0%
Capital Service Cover *	2.2	2.5	2.9
Liquidity **	32.5	33.1	34.6
Cash days operating expenditure ***	87.2	91.6	93.1
BPPC - Number	83.8%	84.4%	85.5%
BPPC - Value	81.0%	82.6%	83.8%

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

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

THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Operating income from patient care activities	13,198	13,717	519	66,042	65,591	(451)	158,610	157,451	(1,159)
Other operating income	643	567	(76)	3,217	2,858	(359)	7,728	7,751	23
Donated Income	0	0	0	0	0	0	0	0	0
Total Operating Income	**13,841**	**14,284**	**443**	**69,259**	**68,449**	**(810)**	**166,338**	**165,202**	**(1,136)**
Employee expenses	(7,127)	(6,934)	193	(35,652)	(34,350)	1,302	(84,722)	(82,864)	1,858
Operating expenses excluding employee expenses	(6,476)	(7,039)	(563)	(32,153)	(32,537)	(384)	(77,030)	(77,831)	(801)
Total Operating Expenditure	**(13,603)**	**(13,973)**	**(370)**	**(67,805)**	**(66,887)**	**918**	**(161,752)**	**(160,695)**	**1,057**
EBITDA	**238**	**311**	**73**	**1,454**	**1,562**	**108**	**4,586**	**4,507**	**(79)**
Finance income	20	39	19	100	145	45	240	348	108
Finance expense	(48)	(49)	(1)	(241)	(241)	0	(583)	(577)	6
PDC dividends payable/refundable	(137)	(119)	18	(682)	(693)	(11)	(1,639)	(1,666)	(27)
Other gains/(losses) including disposal of assets	0	0	0	0	(7)	(7)	0	(8)	(8)
Financial performance surplus/(deficit)	**73**	**182**	**109**	**631**	**766**	**135**	**2,604**	**2,604**	**0**
I&E impact capital donations and profit on asset disposals	22	22	0	110	110	0	264	264	0
Adjusted financial performance surplus/(deficit)	**95**	**204**	**109**	**741**	**876**	**135**	**2,868**	**2,868**	**0**

Month 5 – in month £204k surplus compared to £95k planned surplus – an in month favourable variance of £109k.

Year to Date - £876k surplus compared to £741k planned surplus, a YTD favourable variance of £135k.

Income - YTD underperformance of £810k, due to:

- Reduced Welsh activity;
- Risk around coiling consumables and Spinal ERF activity;
- Lower than anticipated salary recharges due to delayed transfer of Health Procurement Liverpool staff (offset in expenditure);
- Offset by increased Isle of Man activity.

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

Expenditure - YTD under-spend of £945k due to:

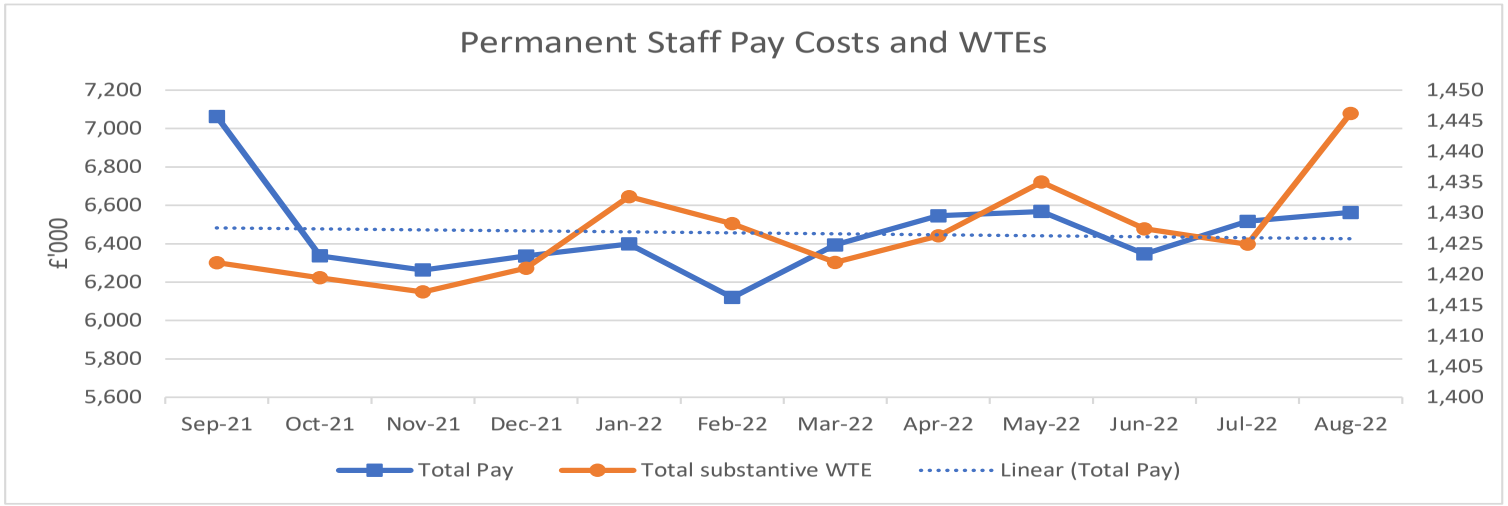
- Non-recurrent vacancy savings;
- Delays in TUPE of Health Procurement Liverpool staff; and
- Reduction in nursing bank spend;
- Offset by of cost pressure on High Cost Drugs and Devices (as botox is no longer an excluded drug creating a cost pressure for the Trust).

STATEMENT OF FINANCIAL POSITION - 2022/23	Plan Aug-22	Actual Aug-22	Variance
	£'000	£'000	£'000
Intangible Assets	672	1,025	353
Tangible Assets	94,203	92,996	(1,207)
Right of use assets - leased assets	85	81	(4)
Receivables	428	434	6
TOTAL NON CURRENT ASSETS	**95,388**	**94,536**	**(852)**
Inventories	1,841	1,756	(85)
Receivables	6,315	4,781	(1,534)
Cash at bank and in hand	34,823	39,367	4,544
TOTAL CURRENT ASSETS	**42,979**	**45,904**	**2,925**
Payables	(25,086)	(28,120)	(3,034)
Borrowings	(1,581)	(1,535)	46
Provisions	(55)	(66)	(11)
TOTAL CURRENT LIABILITIES	**(26,722)**	**(29,721)**	**(2,999)**
TOTAL ASSETS LESS CURRENT LIABILITIES	**111,645**	**110,719**	**(926)**
Borrowings	(21,569)	(21,607)	(38)
Provisions	(700)	(684)	16
TOTAL ASSETS EMPLOYED	**89,376**	**88,428**	**(948)**
Public Dividend Capital	35,731	34,617	(1,114)
Revaluation Reserve	7,377	7,377	0
Income and Expenditure Reserve	46,268	46,434	166
TOTAL TAXPAYERS EQUITY AND RESERVES	**89,376**	**88,428**	**(948)**

STATEMENT OF CASH FLOW - 2022/23	Plan Aug-22	Actual Aug-22	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**1,454**	**1,564**	**110**
Non-cash income and expense:	2,900	3,005	105
Working Capital	(579)	1,107	1,686
Net cash generated from/(used in) operations	**3,775**	**5,676**	**1,901**
Cash flows from investing activities	(8,131)	(6,031)	2,100
Cash flows from financing activities	107	(1,001)	(1,108)
Increase/(decrease) in cash and cash equivalents	**(4,249)**	**(1,356)**	**2,893**
OPENING CASH	**39,072**	**40,723**	**1,651**
CLOSING CASH	**34,823**	**39,367**	**4,544**

Year to Date - £39,367k cash balance compared to £34,823k plan, a YTD favourable variance of £4,544k:

- Opening cash balance against plan: £1,651k
- Operating surplus above plan: £215k
- Payables above plan (inc. deferred income): £1,609k
- Capital programme: £2,055k
- Public dividend capital drawdown below plan: (£1,108k)
- Other balance sheet movements: £122k
- **Total** **£4,544k**



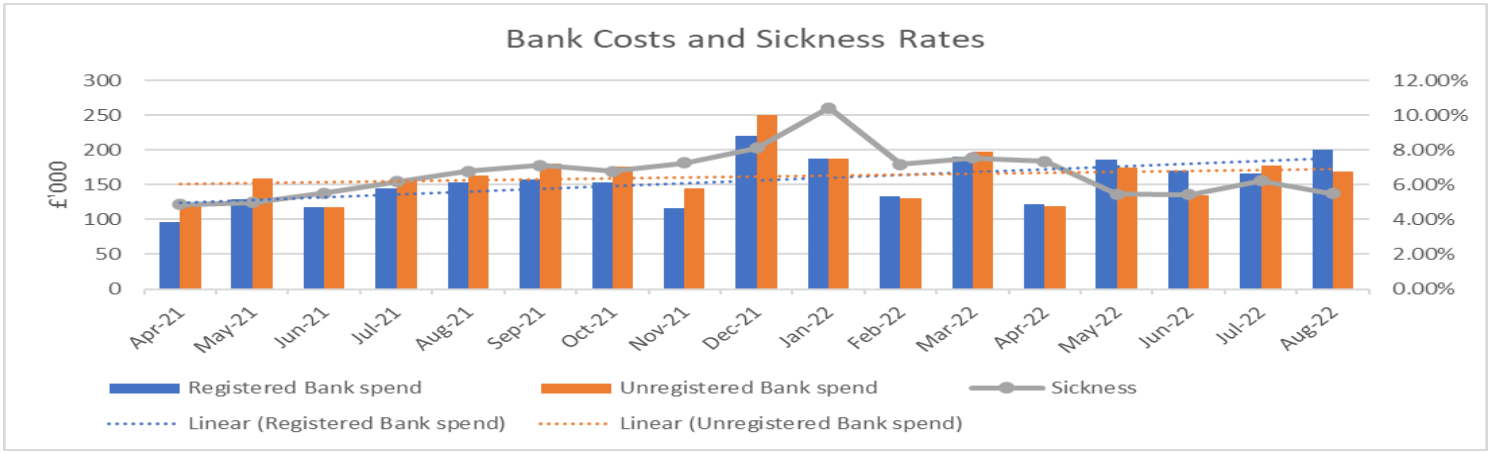
September 2021 increase caused by six months backpay being paid relating to 21/22 pay award. August 2022 WTE increase due to the change in Junior Doctor rota (and more junior doctors than in the previous rotation)

Pay costs:

- Jun: £6,347k
- Jul: £6,517k
- Aug: £6,563k

WTE:

- Jun: 1,427 WTE
- Jul: 1,425 WTE
- Aug: 1,446 WTE



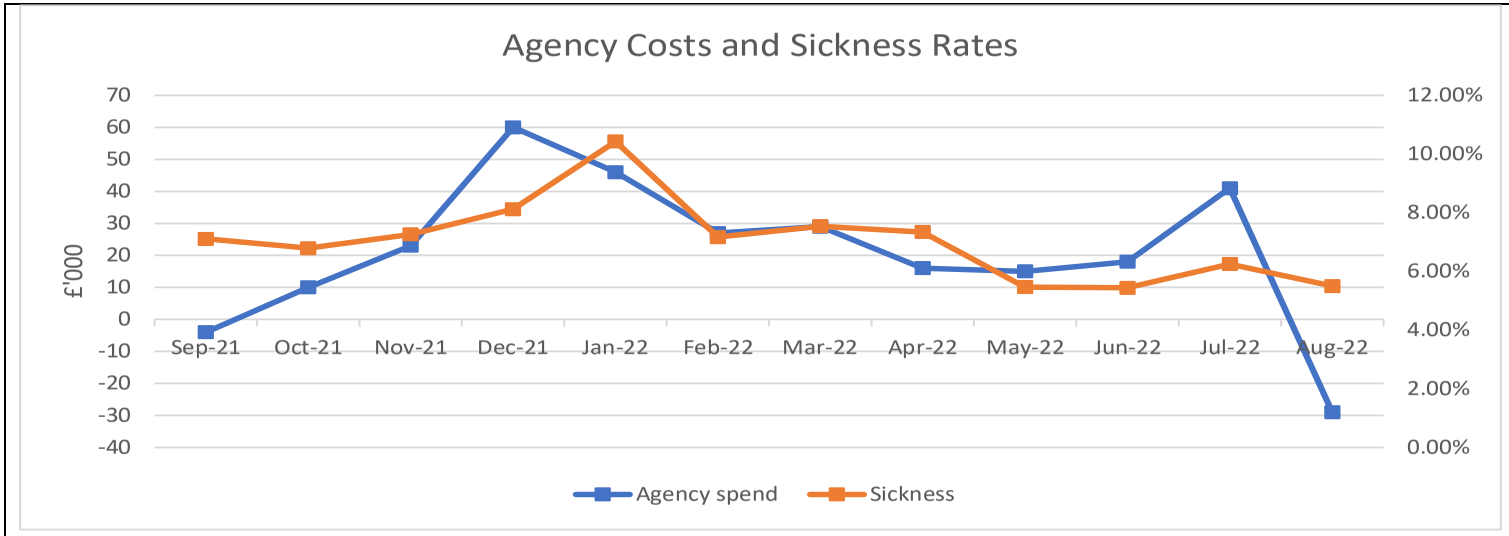
This is a key area of focus for NHSE/I.

Nursing Bank costs:

- Jun: £306k
- Jul: £343k
- Aug: £370k

Sickness rate:

- Jun: 5.4%
- Jul: 6.3%
- Aug: 5.5%



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

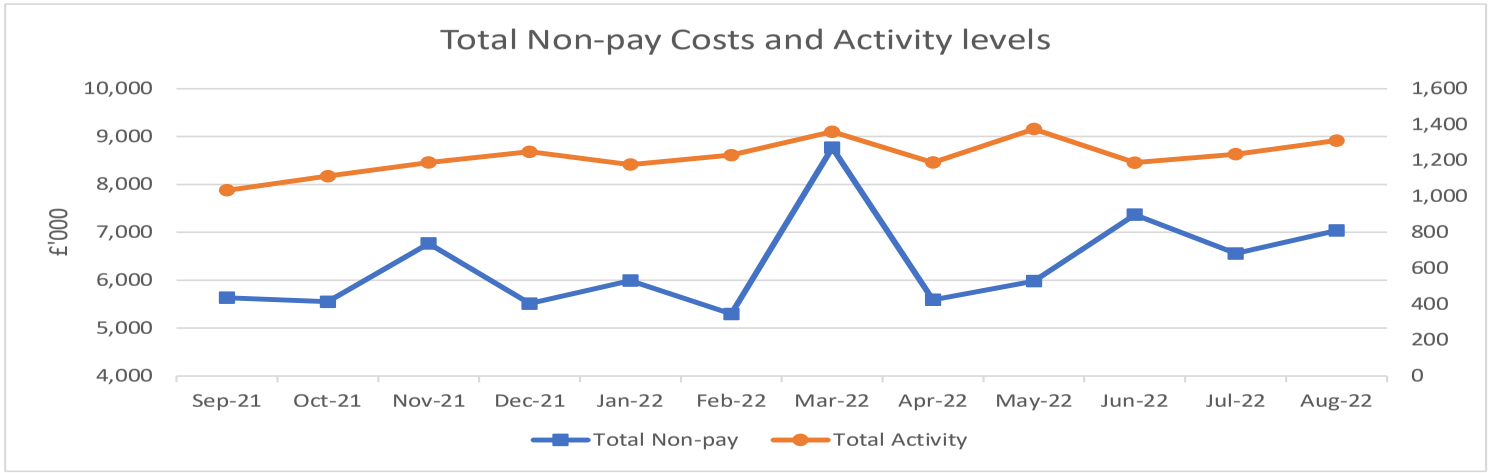
Prior year accrual released in August as all invoices have been received, with actual costs being lower than anticipated at the end of the year

Agency costs:

- Jun: £18k
- Jul: £41k
- Aug: (£29k)

Sickness rate:

- Jun: 5.4%
- Jul: 6.3%
- Aug: 5.5%



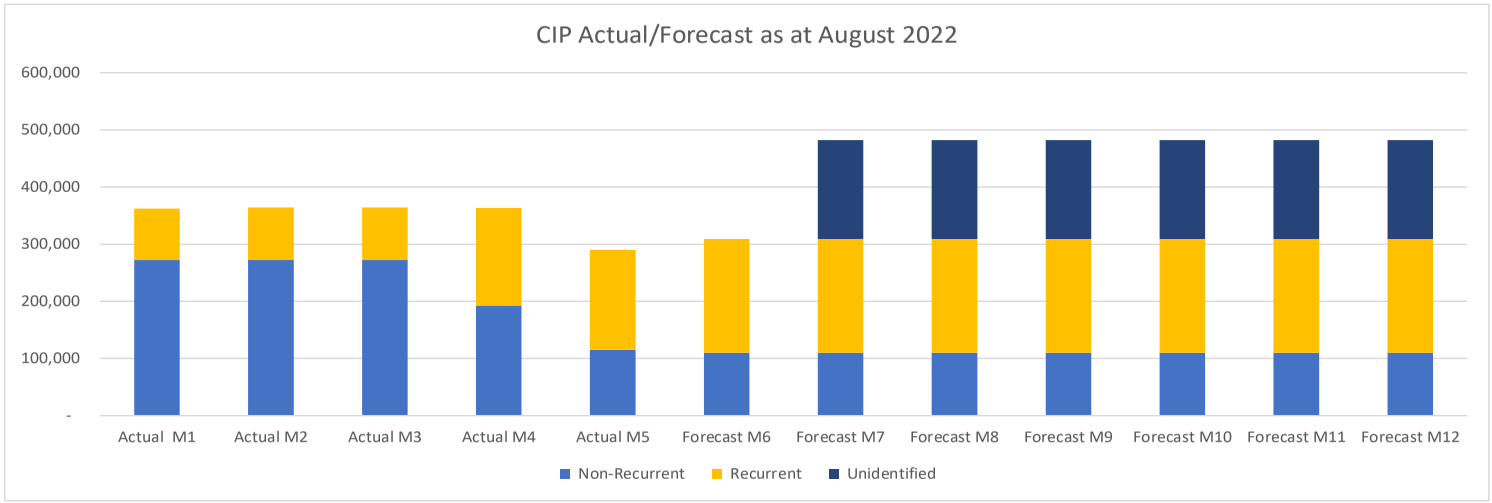
Increased costs in March 2022 are caused by increased consumable spend at the financial year end.

Non-pay costs:

- Jun: £7,369k
- Jul: £6,557k
- Aug: £7,038k

Inpatient activity:

- Jun: 1,188 spells
- Jul: 1,235 spells
- Aug: 1,311 spells



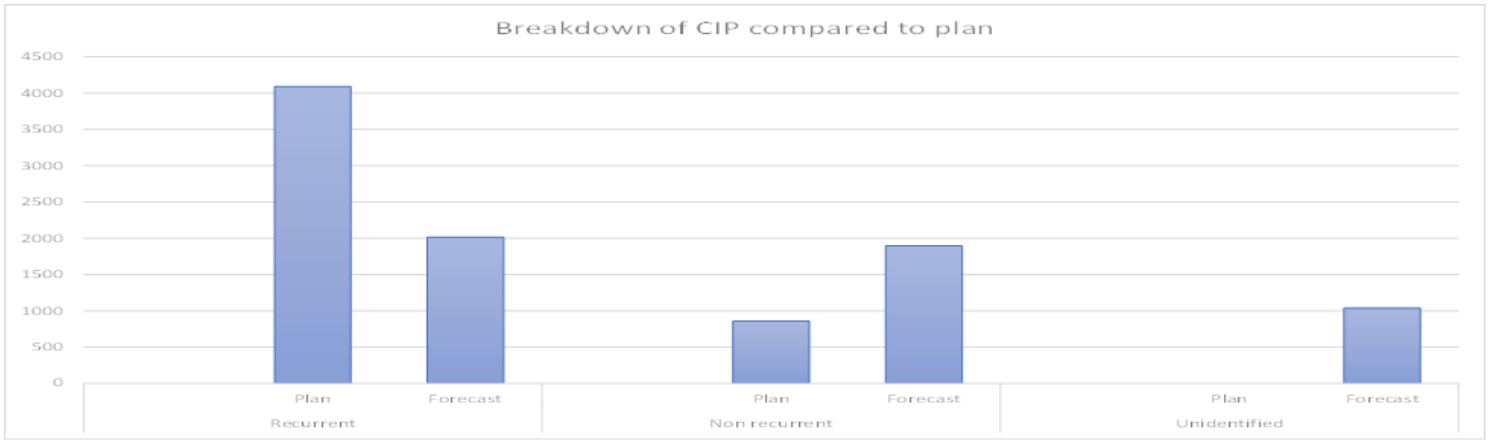
- £1m CIP remains unidentified.
- Further work to be undertaken with clinical and operational teams to identify schemes to achieve this amount.

Recurrent CIP:

- Jun: £274k
- Jul: £445k
- Aug: £620k

Non-recurrent CIP:

- Jun: £816k
- Jul: £1,009k
- Aug: £1,124k



- £4.1m (82.7%) of the CIP plan was required to be delivered recurrently.
- Currently anticipating that only £2.0m (40.7%) will be delivered recurrently with the remainder either non-recurrent or unidentified.

PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Patient Related	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
NHS England	9,185	9,844	659	45,976	46,360	384	110,426	111,469	1,043
Clinical Commissioning Groups	2,108	2,199	91	10,539	10,560	21	25,323	25,343	20
Wales	1,705	1,704	(1)	8,527	8,473	(54)	20,464	20,431	(33)
Isle of Man	140	167	27	699	919	220	1,677	2,177	500
Other Patient Related Income	60	(197)	(257)	301	(721)	(1,022)	720	(1,969)	(2,689)
Total Patient Related Income	**13,198**	**13,717**	**519**	**66,042**	**65,591**	**(451)**	**158,610**	**157,451**	**(1,159)**

To note that patient related income includes ERF income

NON-PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
	Plan	Actual	Variance	Plan	Actual	Variance	Plan	Forecast	Variance
Non-patient Related	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Research & Development Income	65	73	8	326	398	72	783	952	169
Education And Training	269	269	0	1,343	1,398	55	3,223	3,413	190
Employee Benefits Income	219	134	(85)	1,096	583	(513)	2,635	2,013	(622)
Other Non-patient Related Income	90	91	1	452	479	27	1,087	1,373	286
Total Patient Related Income	**643**	**567**	**(76)**	**3,217**	**2,858**	**(359)**	**7,728**	**7,751**	**23**

ERF

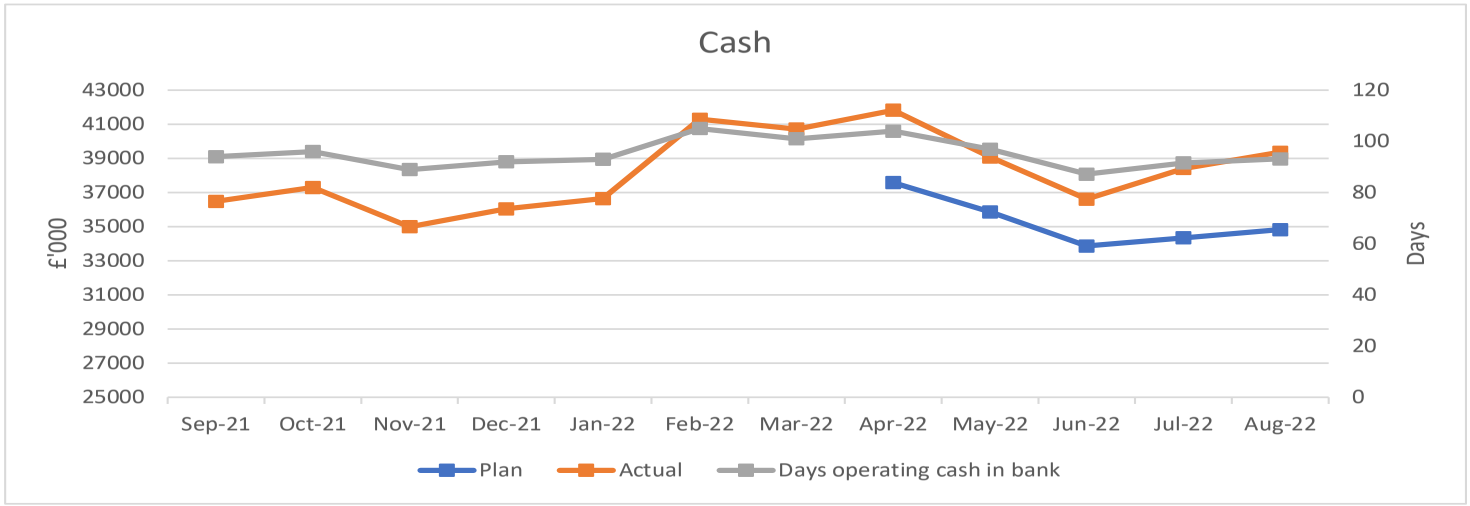
	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Elective Recovery Funding	309	975	666	1,597	1,597	0	3,947	3,947	0

To note: for reporting purposes, Trusts have been asked to include all planned ERF up to month 5.

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	100	343	(243)	500	500	0	1,200	1,200	0
Estates	70	18	52	346	18	328	836	836	0
IM&T	0	10	(10)	0	58	(58)	593	568	25
Neurology	0	0	0	0	25	(25)	0	25	(25)
Neurosurgery	0	(3)	3	0	4	(4)	3,109	3,109	0
Corporate	0	0	0	0	0	0	0	0	0
TOTAL (excl. external funding)	**170**	**368**	**(198)**	**846**	**605**	**241**	**5,738**	**5,738**	**0**
Donated Assets	0	0	0	0	0	0	0	0	0
Digital Aspirant	223	(108)	331	1,114	344	770	2,675	2,675	0
TOTAL (incl. external funding)	**223**	**(108)**	**331**	**1,114**	**344**	**770**	**2,675**	**2,675**	**0**
TOTAL	**393**	**260**	**133**	**1,960**	**949**	**1,011**	**8,413**	**8,413**	**0**

- Capital expenditure in month of £260k, which included a £108k reversal of expenditure from previous months for Digital Aspirant accruals that have now been invoiced.
- Year to date Capital spend of £949k, £344k of which is Digital Aspirant
- Year to date spend on divisional schemes includes
  - Heating and pipework replacement
  - Bed repurposing
  - IT staffing
  - Radiology Syngo equipment
- Further work has been undertaken by the divisions on prioritising and forecasting anticipated capital spend meaning that the 22/23 capital demands is now roughly in line with plan and all schemes are in the process of being mobilised.

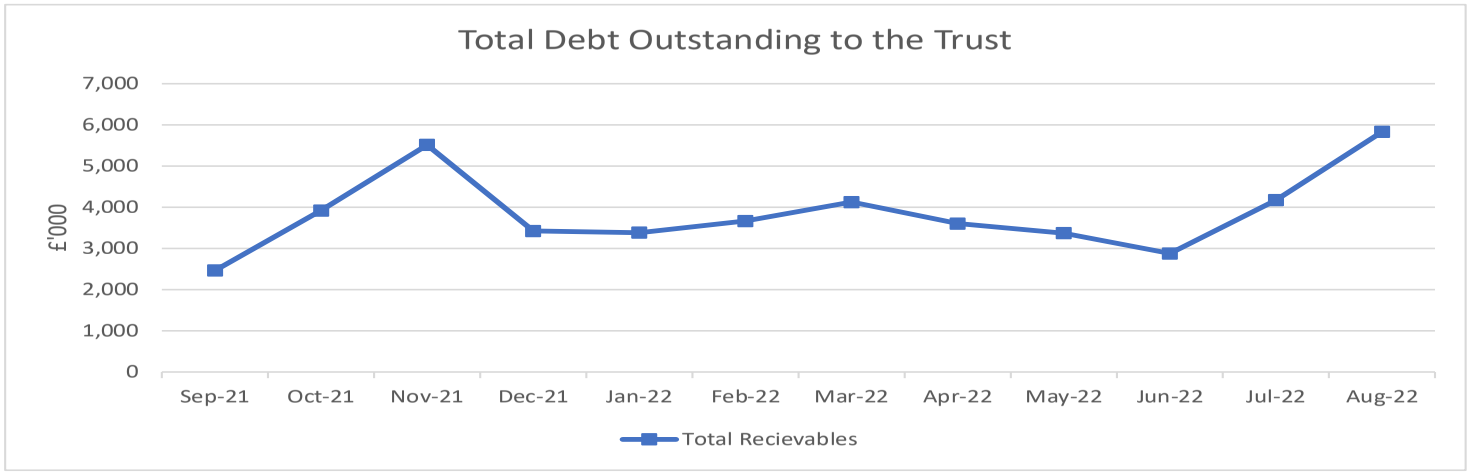


Cash:

- Jun: £36,616k
- Jul: £38,413k
- Aug: £39,367k

Operating expenditure days cover:

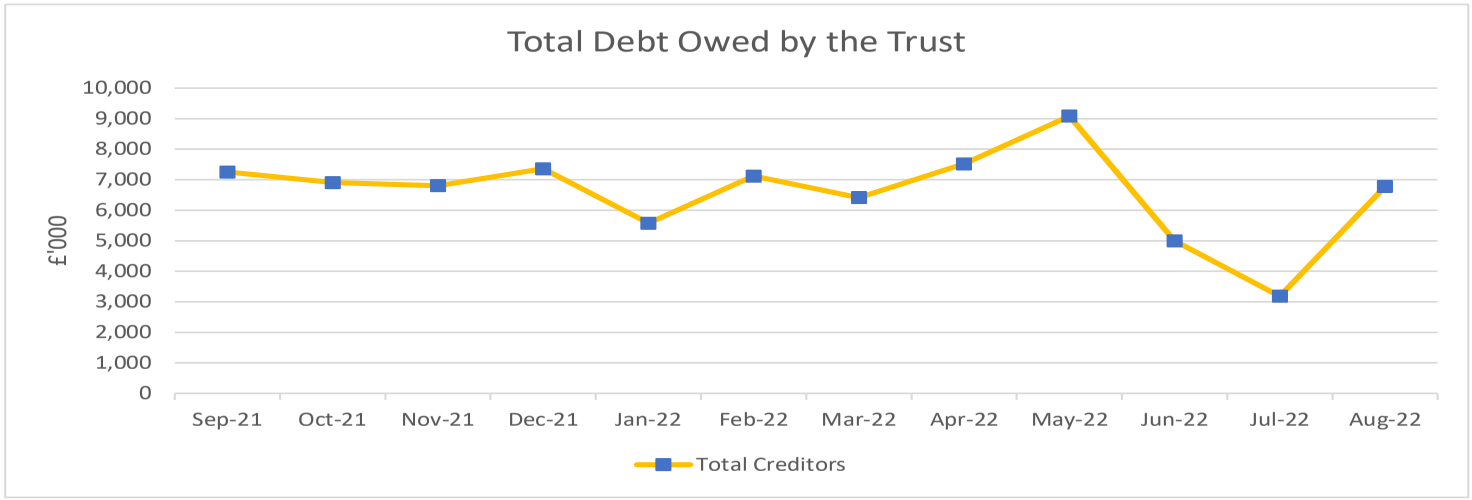
- Jun: 87.2 days
- Jul: 91.6 days
- Aug: 93.1 days



- November 2021 increase due to two large value invoices to Isle of Man and Health Education England raised in month.
- August 2022 increase due to WHSSC year end settlement invoice, Isle of Man M1-4 invoice and M4-6 Health Education England invoice that all fall in the 0-61 days outstanding position. These are expected to be settled in the coming month

Debt outstanding to Trust:

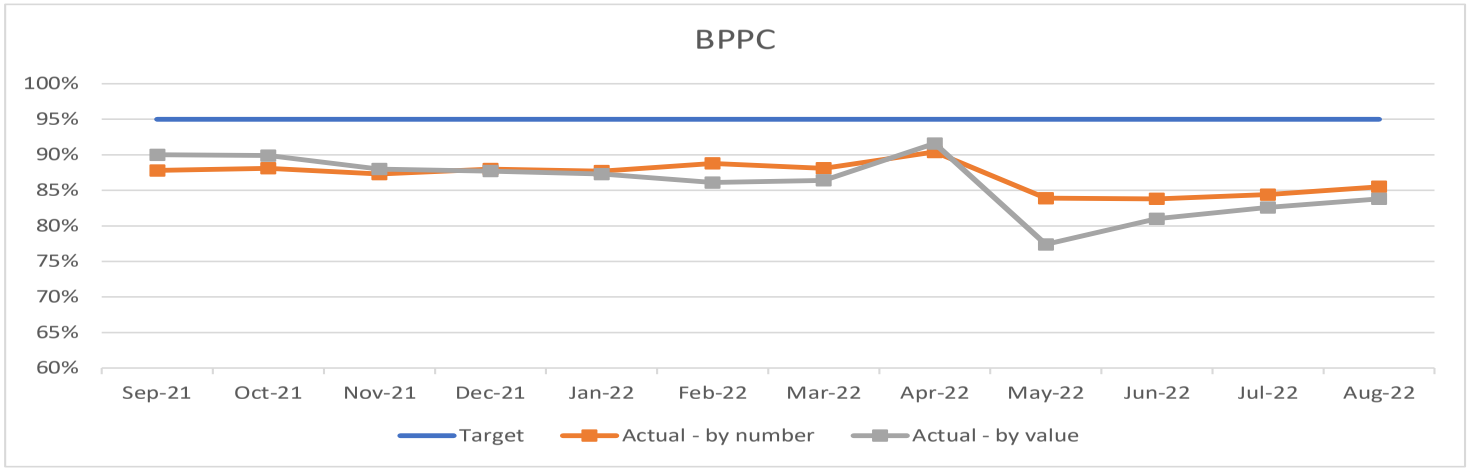
- Jun: £2,879k
- Jul: £4,174k
- Aug: £5,830k



Debt owed by the Trust:

Increase in M5 due to the level of outstanding LUHFT invoices awaiting payment that had been received in month.

- Jun: £4,497k
- Jul: £3,185k
- Aug: £6,777k



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

- The Trust BPPC percentage (by number of invoices paid) at the end of August is 85.5%. This has improved from 84.4% at the end of July.
- The Trust BPPC percentage (by value of invoices paid) at the end of August is 83.8%. This has improved from 82.6% at the end of July.
- Action plan now in place to improve BPPC performance.
- This involves collaborative working across the whole finance team, procurement, and the divisions to ensure that invoices are approved in a timely manner. and analysed prior to breaching the 30-day limit.

EXPENDITURE - NEUROLOGY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(428)	(358)	70	(2,232)	(2,006)	226	(5,500)	(4,689)	811
Allied health professionals	(480)	(506)	(26)	(2,438)	(2,372)	66	(5,845)	(5,780)	65
Other scientific, therapeutic and technical staff	(107)	(71)	36	(534)	(442)	92	(1,282)	(1,057)	225
Health care scientists	(61)	(59)	2	(303)	(295)	8	(727)	(706)	21
Support to nursing staff	(240)	(233)	7	(1,202)	(1,186)	16	(2,919)	(2,799)	120
Support to allied health professionals	(81)	(73)	8	(365)	(359)	6	(875)	(864)	11
Support to other clinical staff	11	0	(11)	(10)	(10)	0	(15)	(12)	3
Medical - Consultants	(800)	(783)	17	(3,964)	(3,792)	172	(9,482)	(9,332)	150
Medical - Junior	(236)	(250)	(14)	(1,184)	(1,136)	48	(2,839)	(2,773)	66
NHS infrastructure support	(200)	(193)	7	(940)	(878)	62	(2,262)	(2,114)	148
Bank/Agency	0	(195)	(195)	(336)	(884)	(548)	(336)	(2,277)	(1,941)
Total Pay Expenditure	**(2,622)**	**(2,721)**	**(99)**	**(13,508)**	**(13,360)**	**148**	**(32,082)**	**(32,403)**	**(321)**
Supplies and services – clinical (excluding drugs costs)	(677)	(800)	(123)	(3,387)	(3,686)	(299)	(8,130)	(8,854)	(724)
Supplies and services - general	(18)	(17)	1	(88)	(76)	12	(211)	(182)	29
Drugs costs	(1,742)	(2,042)	(300)	(8,679)	(9,767)	(1,088)	(20,830)	(23,442)	(2,612)
Establishment	(2)	(3)	(1)	(10)	(12)	(2)	(23)	(30)	(7)
Premises - other	(111)	(124)	(13)	(556)	(445)	111	(1,334)	(972)	362
Transport	(5)	(3)	2	(26)	(28)	(2)	(63)	(66)	(3)
Education and training - non-staff	(1)	(1)	0	(5)	(10)	(5)	(13)	(25)	(12)
Lease expenditure	(5)	6	11	(27)	(22)	5	(64)	(54)	10
Other	(5)	4	9	(23)	(39)	(16)	(55)	(94)	(39)
Total Non-pay Expenditure	**(2,560)**	**(2,979)**	**(419)**	**(12,801)**	**(14,085)**	**(1,284)**	**(30,723)**	**(33,719)**	**(2,996)**
Total Divisional Operating Expenditure	**(5,182)**	**(5,700)**	**(518)**	**(26,309)**	**(27,445)**	**(1,136)**	**(62,805)**	**(66,122)**	**(3,317)**

EXPENDITURE - NEUROSURGERY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(1,199)	(1,088)	111	(5,993)	(5,444)	549	(14,174)	(13,060)	1,114
Allied health professionals	(180)	(179)	1	(900)	(883)	17	(2,158)	(1,508)	650
Other scientific, therapeutic and technical staff	(51)	(47)	4	(255)	(253)	2	(612)	(1,215)	(603)
Health care scientists	(76)	(75)	1	(380)	(361)	19	(912)	(883)	29
Support to nursing staff	(262)	(278)	(16)	(1,493)	(1,303)	190	(3,295)	(3,260)	35
Support to allied health professionals	(12)	(12)	0	(59)	(59)	0	(142)	(141)	1
Support to other clinical staff	(2)	(2)	0	(2)	(2)	0	(13)	(13)	0
Medical - Consultants	(710)	(706)	4	(3,630)	(3,625)	5	(8,599)	(8,820)	(221)
Medical - Junior	(356)	(361)	(5)	(1,838)	(1,890)	(52)	(4,332)	(4,417)	(85)
NHS infrastructure support	(203)	(174)	29	(1,005)	(908)	97	(2,419)	(2,148)	271
Bank/Agency	0	(191)	(191)	(232)	(918)	(686)	(232)	(2,148)	(1,916)
Total Pay Expenditure	**(3,051)**	**(3,113)**	**(62)**	**(15,787)**	**(15,646)**	**141**	**(36,888)**	**(37,613)**	**(725)**
Supplies and services – clinical (excluding drugs costs)	(1,378)	(1,164)	214	(6,890)	(6,184)	706	(16,536)	(14,843)	1,693
Supplies and services - general	(21)	(28)	(7)	(107)	(118)	(11)	(258)	(284)	(26)
Drugs costs	(71)	(77)	(6)	(357)	(375)	(18)	(858)	(899)	(41)
Establishment	(9)	(8)	1	(45)	(52)	(7)	(109)	(124)	(15)
Premises - other	(50)	(35)	15	(248)	(179)	69	(595)	(431)	164
Transport	(2)	(5)	(3)	(11)	(24)	(13)	(27)	(59)	(32)
Education and training - non-staff	(5)	(4)	1	(23)	(15)	8	(54)	(38)	16
Lease expenditure	(6)	(7)	(1)	(29)	(34)	(5)	(69)	(83)	(14)
Other	(21)	(23)	(2)	(104)	(87)	17	(249)	(209)	40
Total Non-pay Expenditure	**(1,563)**	**(1,351)**	**212**	**(7,814)**	**(7,068)**	**746**	**(18,755)**	**(16,970)**	**1,785**
Total Divisional Operating Expenditure	**(4,614)**	**(4,464)**	**150**	**(23,601)**	**(22,714)**	**887**	**(55,643)**	**(54,583)**	**1,060**

EXPENDITURE - CORPORATE

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(101)	(93)	8	(507)	(460)	47	(1,216)	(1,228)	(12)
Other scientific, therapeutic and technical staff	0	0	0	0	(17)	(17)	0	(46)	(46)
Support to nursing staff	(1)	(1)	0	(4)	(4)	0	(10)	(11)	(1)
Medical - Consultants	(6)	(13)	(7)	(31)	(40)	(9)	(73)	(99)	(26)
NHS infrastructure support	(866)	(775)	91	(4,346)	(3,810)	536	(10,431)	(9,600)	831
Apprenticeship Levy	(24)	(24)	0	(120)	(123)	(3)	(287)	(291)	(4)
Bank/Agency	(13)	(17)	(4)	(64)	(125)	(61)	(153)	(231)	(78)
Total Pay Expenditure	**(1,011)**	**(923)**	**88**	**(5,072)**	**(4,579)**	**493**	**(12,170)**	**(11,506)**	**664**
Non-executive directors	(12)	(10)	2	(62)	(51)	11	(150)	(124)	26
Supplies and services – clinical (excluding drugs costs)	(45)	28	73	(225)	(146)	79	(541)	(390)	151
Supplies and services - general	(294)	(291)	3	(1,468)	(1,352)	116	(3,523)	(3,266)	257
Consultancy	(6)	0	6	(28)	(4)	24	(68)	(12)	56
Establishment	(84)	(92)	(8)	(419)	(434)	(15)	(1,005)	(963)	42
Premises - business rates payable to local authorities	(65)	(71)	(6)	(324)	(357)	(33)	(778)	(856)	(78)
Premises - other	(480)	80	560	(2,401)	(1,556)	845	(5,762)	(4,446)	1,316
Transport	(6)	(48)	(42)	(28)	(177)	(149)	(68)	(397)	(329)
Audit fees and other auditor remuneration	(12)	(8)	4	(59)	(39)	20	(141)	(94)	47
Clinical negligence	(475)	(475)	0	(2,377)	(2,377)	0	(5,704)	(5,704)	0
Education and training - non-staff	(16)	(68)	(52)	(82)	(126)	(44)	(197)	(214)	(17)
Lease expenditure	0	0	0	0	(1)	(1)	0	(1)	(1)
Other	(97)	(87)	10	(487)	(526)	(39)	(1,169)	(1,382)	(213)
Total Non-pay Expenditure	**(1,592)**	**(1,042)**	**550**	**(7,960)**	**(7,146)**	**814**	**(19,106)**	**(17,849)**	**1,257**
Total Divisional Operating Expenditure	**(2,603)**	**(1,965)**	**638**	**(13,032)**	**(11,725)**	**1,307**	**(31,276)**	**(29,355)**	**1,921**

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

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 28/09/22		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 27/09/22		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report (August 2022) • Digital Aspirant Monthly Update • Information Governance Bi-annual Report • People Substrategy (Draft) • Exit Interview Reviews • Business Continuity for Critical Staff – Industrial Action • Board Assurance Framework 2022/23 Q2 Report • Emergency Preparedness Resilience and Response Self-Assessment • Digital Aspirant Element Business Case (retrospective approval following Chair's Action • Key Issues Reports from 8 sub-committee meetings
2	**Alert**	• There is potential for industrial action related to the national pay settlement with some union ballots in process. The Committee received assurance that business continuity plans for critical staff have been prepared to mitigate impacts as far as possible for a range of scenarios.
3	**Assurance**	*Integrated Performance Report* • All cancer wait/treatment and diagnostic targets continue to be achieved. • Patient flow and outpatient transformation indicators remain strong, with the exception of Did Not Attends (DNAs) which remains challenging. There is a strong correlation of DNAs with indices of deprivation and this insight is being explored to seek ways to engage patients differently. • With regards to activity recovery – 104-week waiters have now been eradicated and 78-week long waiters are reducing. Focus will be on reducing the 52 weeks but the Trust has until March 2025 to do this. High levels of day case and outpatients were achieved in August but elective activity remains below target although is steadily improving. • A step change increase of 40% in the waiting list for new outpatients over recent months relates to taking on the spinal service. • Sickness remains high but latest data indicates a fall since mid-August after being held at 7% for several months. Appraisal completion and mandatory training compliance remain below target. The Committee will review further progress from the improvement plan in November 2022.

		• Turnover and vacancies in back-office roles remain high (but not in medical and nursing) but assurance was given that vacancies are being filled. • The reported Income and Expenditure outcome was £109k better than plan in August and £135k YTD, partly because all trusts were asked for reporting purposes to assume Elective Recovery Funding was in line with plan which has led to an increase. Income remains behind plan but is more than offset by reduced spend. For the full year, £1m of the £4.1m cost improvement plan has yet to be identified. • Capital spend remains behind plan but is expected to pick up in Q3. • BPPC performance (paying creditors on time) remains behind target but is steadily improving. *Other matters* • Internal Audit substantial assurance has been gained for the twelfth consecutive year for the Data Security & Protection Toolkit. The target of 95% of staff up-to-date with e-learning security awareness is another notable achievement. • An Internal Audit report covering a review of the Exit Interview process has highlighted some improvement areas and has triggered further work to try and increase uptake, analyse themes and extend 'retention interviews'. • A rigorous Emergency Preparedness Resilience and Response (EPPR) self-assessment concluded partial compliance. An action plan is addressing the gaps. • BPC-related Business Assurance Framework risks were reviewed and the updates recommended to Board. • An action to provide assurance on succession planning for critical staff has been deferred.		
4.	**Advise**	• A draft people substrategy was reviewed. The extensive content was commended but an alternative approach/format was suggested which it was felt would give better clarity (of this and all other substrategies). • A business case relating to part of the Digital Aspirant project had been approved by Chair's action in August 2022 (between meetings). • 8 Key Issues Reports from sub-groups were received and noted.		
5.	**Risks Identified**	None		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 06/10/22		**Report of:** **Quality Committee**
Date of last meeting: 15/09/22		**Membership Numbers:16** **Quorate**
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Quality or Risks for escalation to Quality Committee • Integrated Performance Report/Divisional KPI Reports • Quality Presentation by the Epilepsy Service • Board Assurance Framework • Quarterly Trust Risk Register • Quality Strategy 2019-2024 final review and closure • Quality Impact Assessments – Bed Repurposing • Visibility & Walkabout Report • Pathology Quality & Performance Review • Pharmacy Quarterly KPI Report • External Visits regarding Quality • Clinical Audit Joint Divisional Report • Sub-Committee Key Issues Reports to Quality Committee
2.	**Alert**	none
	Assurance	**Patient Story** • The patient joined the Quality Committee via MS teams and provided a detailed account of his journey following a sub-arachnoid haemorrhage. The patient was previously very fit and healthy, so being in a hospital environment was extremely alien to him. The patient noted and appreciated the time the specialist nurses spent with both him and his wife to fully explain the processes and recovery expectations. It was noted that the care provided on Chavasse Ward was excellent and the patient also gave some feedback of where improvements could be made, for example, with regards to noise at night. The patient felt safe returning to the Trust for a further procedure as the same team were there to support him. In addition, the patient reported that the Road to Recovery course was also very helpful as he felt able to return and thank those who helped to save his life. **Integrated Performance Report** • It was noted that there have been no hospital acquired infections on Lipton Ward since April 2022 and no pressure ulcers on Lipton for 280 days and on Chavasse Ward for 156 days.

		• It was also noted that ITU had no incidents of E. Coli since March 2022 and of MSSA since April 2022. The work undertaken on ITU to achieve infection reductions is to be mirrored on the wards. **Quality Presentation on behalf of Epilepsy Specialist Nurse Team** • The presentation demonstrated how the team provide a quality service to patients with epilepsy. Dr Janine Winterbottom continues to lead the original 1999 Delphi Study which is a multi-stakeholder study with regards to pre-conception care for women with epilepsy. The Quality Committee commended Dr Winterbottom for her work undertaken on behalf of the Trust and noted that she is recognised nationally for her continued work and research projects with regards to epilepsy. This work includes NICE Guidance advisor, NCEPOD support and expert panel member with regards to seizures within care homes. The team support and train new specialist nurses with a team member currently establishing the first nurse led Epidiolex clinic in the country. It was noted that the specialist nurse team have greatly supported the epilepsy service at a time of increased workload for consultants and difficulties arising from consultant vacancies. **Board Assurance Framework** • The Board Assurance Framework detailing the two risks pertaining to Quality Committee were discussed and ratified by the Committee. **Visibility & Walkabout Report** • It was noted that NED walkabouts recommenced over the summer. Significant positive feedback was received from patients, noting that staff are caring. Staff feedback was also positive and highlighted the value of openness within the Trust and the ability for staff to speak up. Staff felt more positive working at WCFT than at other Trusts. Any improvements identified during walkabouts were managed well and in a timely manner. **Clinical Audit – Joint Divisional Report** • It was noted that considerable work has been undertaken to compile the joint report which details clinical audit activity for quarter one of 2022. It was recognised that non-completion of some audits is being considered. The inclusion of a priority scale within the report was noted as a positive addition. Significant progress has been made to reduce the number of outstanding assessments and projects and will continue to be managed via the divisions. The Committee agreed to presentation of the clinical audit report on a quarterly basis at Quality Committee **Pathology Quality & Performance Report** • The department continues to perform well with low staff turnover, no serious incidents or RIDDORs. Staff appraisal is currently compliant. The vacancy for a consultant neuropathologist is on the risk register. • Assurances were provided with regards to the slightly below target histopathology turnaround times. Small numbers can skew percentages and each case is discussed with neurosurgeons accordingly. • Attention was drawn to the exceptional work being undertaken with regards to the Biobank (which was not part of the report). It is anticipated that the biobank

		will be accredited next year and further updates will be provided to the Quality Committee **External Visit to Trust** • With regards to pseudomonas cases identified in a number of areas, the UK Health Security Agency (UKHSA) were invited to the Trust to provide any further advice. The UKHSA team noted how welcome the WCFT made them feel The team also reported that the trust had consistently gone above and beyond the necessary steps in efforts to eliminate pseudomonas. Apart from some minor actions, the UKHSA had no further suggestions to make. It is anticipated that a possible cause of infection arose from the washer/disinfector in theatres which has been decommissioned. Monitoring and testing is on-going. **Quality Impact Assessments – Bed Repurposing** • The report noted the quality impact assessments which highlighted an overall positive impact on quality. Weekly meetings continue to monitor and track progress and allow key members to highlight concerns or risk. Conclusion of the bed repurposing works has been changed to the end of October.		
	Advise	**Quality Strategy 2019 - 2024** • The Divisional Directors for Operations provided the final updates and achievements during the past 12 months in line with the 6 workstreams of the current Quality Strategy, which was noted to be very positive. The Quality Committee approved the closure of the current Quality Strategy. The Divisions are now focussed on identifying a new Quality Strategy for 2023 in line with the new Trust Strategy. **Integrated Performance Report** • The report noted that a review of falls across both divisions is underway and investigations with regards to the slight drop in Friends & Family tests completion within neurology, has been commenced. • There was one serious incident in neurology which is currently under investigation. • Staffing within the Neurology Division was discussed in detail and focussed on CRU and Lipton wards. It was noted that whilst additional staffing was obtained for the two wards due to increases in patient acuity, this was a short-term solution and it was recognised that a staffing and patient acuity / dependency review was underway which would be shared with the executive team. It was noted CRU, at times, has not been at full capacity due to the increase in the complexity of patients to ensure care was safe. Safe Care data will be included in the October IPR which will note the patient acuity on the wards • Within Neurosurgery, there were 3 device related pressure ulcers reported. A new nasogastric fixation device is being trialled to prevent pressure damage • There were 3 catheter associated urinary tract infections which remains a focus for all staff working in collaboration with the infection control team		
2.	Risks Identified	• None identified		
3.	Report compiled	Karen Heslop	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
06/10/2022

Report Title	Health Inequalities Update
Executive Lead	Jan Ross – Chief Executive
Author (s)	Mark Foy – Head of Information & Business Intelligence
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Initial analysis undertaken on health inequalities to measure outcomes
- Steps taken to understand the workforce in relation to inequality

Next Steps

- Understand barriers for accessing care
- Improve collection of key demographic items

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

Strategic Risks

006 Prevention & Inequalities	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Health Inequalities Update

Executive Summary

1. The presentation is an overview of the work undertaken by the Trust to gain greater insight into health inequalities for patients and to understand inequality in the workforce.

2. Access to care, waiting times and outcomes were analysed for patients, while for workforce deprivation and Agenda for Change (AfC) Band were compared.

Conclusion

3. This work has highlighted the next areas for the Trust to focus on which is understanding and removing barriers to accessing healthcare and to improve collection of key demographic information to further increase understanding.

Recommendation

To note the presentation and its conclusions.

Author: Mark Foy – Head of Information & Business Intelligence
Date: 29/09/2022

Appendix 1 – Presentation

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Health Inequalities

Mark Foy
Head of Information & Business Intelligence

www.thewaltoncentre.nhs.uk

Baseline October 2020

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Area	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	BAME	White
Liverpool	4.30%	2.86%	2.89%	1.97%	**12.02%**	87.98%
Merseyside	2.33%	1.16%	1.78%	0.81%	**6.08%**	93.92%
Cheshire & Merseyside	2.06%	0.80%	1.53%	0.56%	**4.94%**	95.06%
North West	6.70%	1.53%	1.90%	0.70%	**10.82%**	89.18%
England & Wales	7.96%	3.56%	2.63%	1.07%	**15.22%**	84.78%

Referrals	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	BAME	White
%	0.73%	0.38%	0.71%	0.88%	**2.71%**	97.29%

Inpatients	Asian or Asian British	Black or Black British	Mixed	Other Ethnic Groups	BAME	White
% Daycase	0.71%	0.35%	0.55%	0.43%	**2.03%**	97.97%
% Elective	0.53%	0.31%	0.56%	0.62%	**2.02%**	97.98%
% Non Elective	0.49%	0.53%	0.53%	0.91%	**2.46%**	97.54%
% Overall	0.65%	0.36%	0.55%	0.52%	**2.08%**	97.92%

Baseline

The Walton Centre NHS Foundation Trust

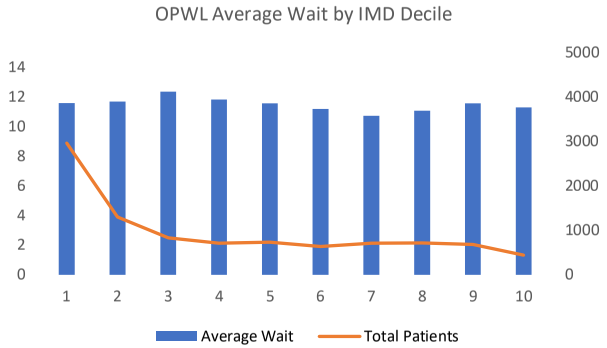
Excellence in Neuroscience

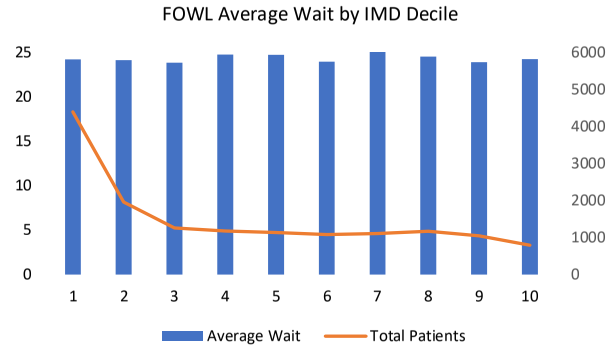
Deprivation (1 Most, 10 Least)	BAME %	Not Known %	White %	Overall %
1	37.70%	27.40%	25.94%	**26.30%**
2	13.32%	11.41%	12.52%	**12.48%**
3	9.26%	7.01%	8.27%	**8.22%**
4	6.32%	7.19%	7.18%	**7.16%**
5	5.87%	7.55%	7.96%	**7.89%**
6	6.09%	7.01%	7.54%	**7.48%**
7	5.42%	8.18%	8.12%	**8.06%**
8	7.22%	8.72%	8.96%	**8.90%**
9	3.84%	9.25%	7.93%	**7.92%**
10	4.97%	6.29%	5.58%	**5.61%**
Total	**2.34%**	**5.87%**	**91.79%**	

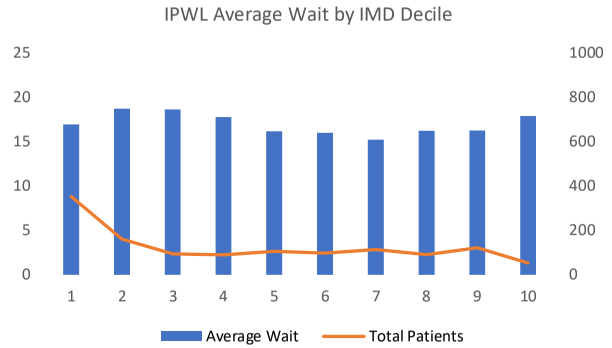
Waiting Lists

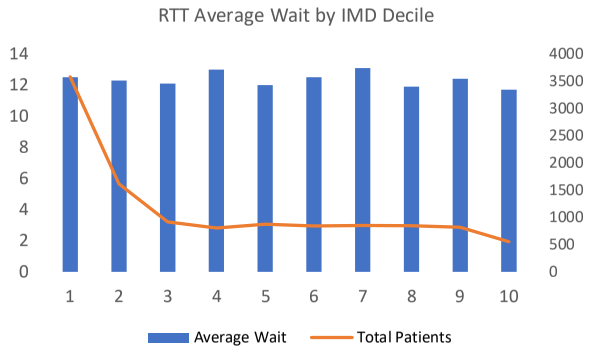
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience





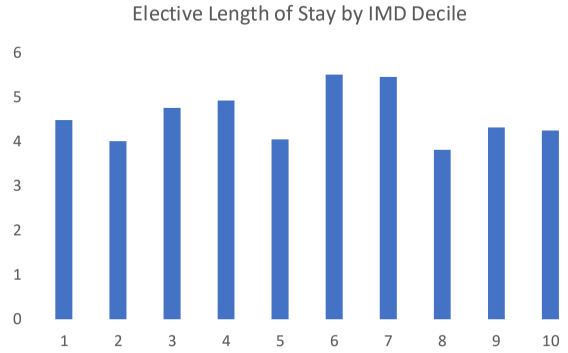


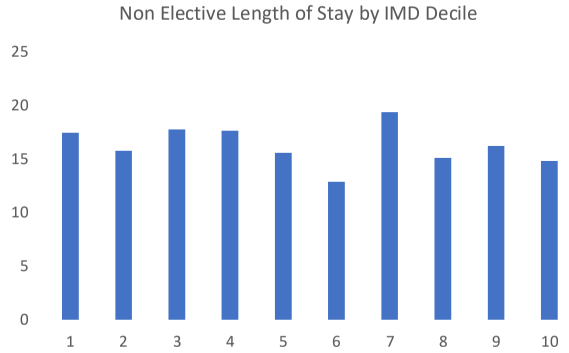


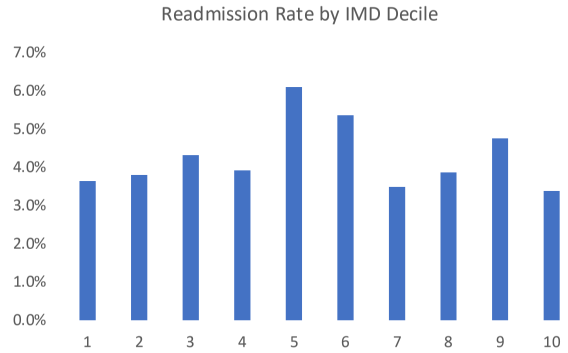
Outcomes

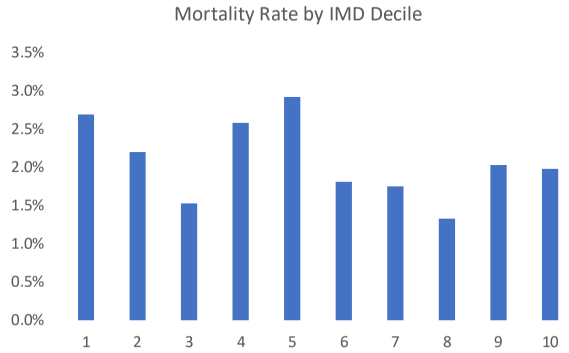
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience





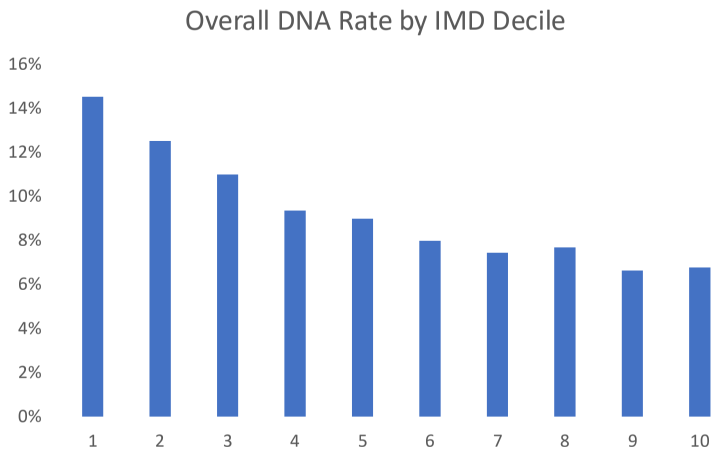


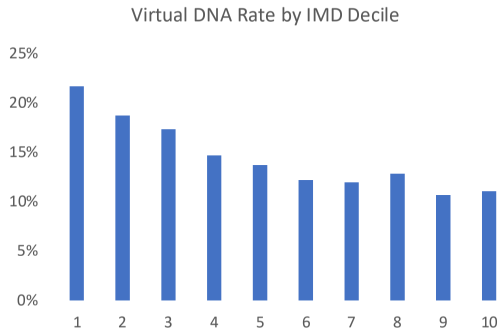


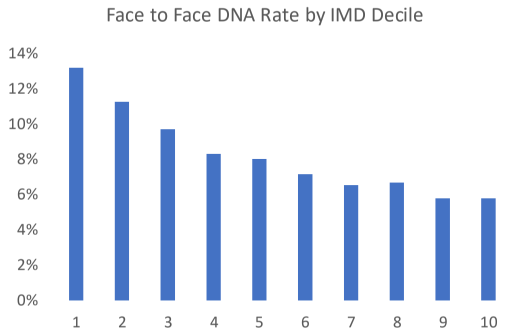
Did Not Attend Rate

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience





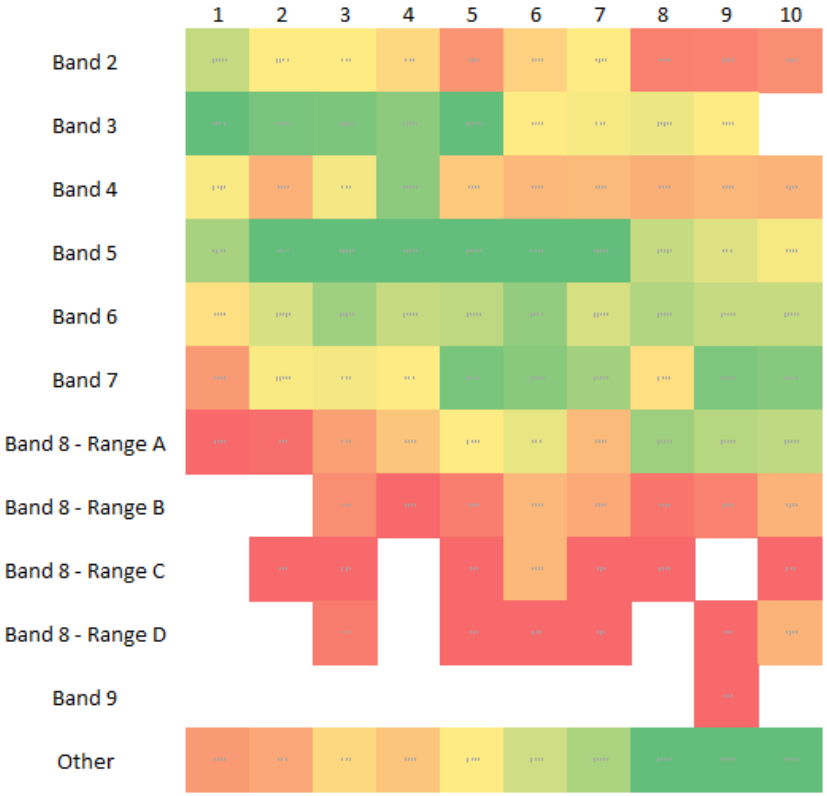


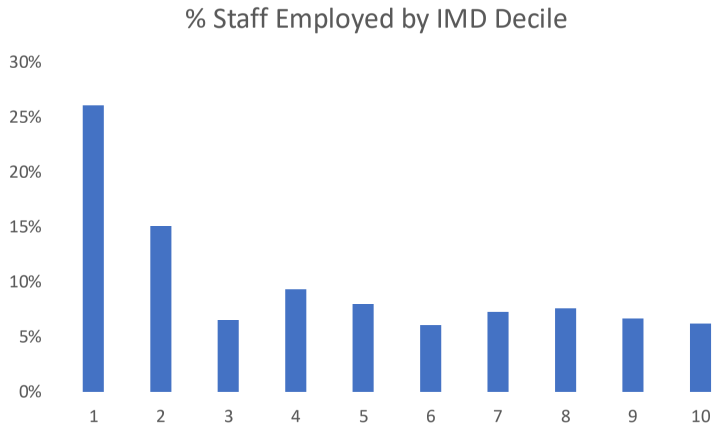
Initial Findings - Staff

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Staff AfC Band by IMD Heatmap





Any questions?

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

Report to Trust Board
6th October 2022

Report Title	CQC National Adult Inpatient Survey Results 2021
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Lisa Judge, Head of Patient & Family Experience
Action Required	To note

Level of Assurance Provided

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

Key Messages

- The CQC rated the Walton Centre as **Better than Expected** for 2021 Inpatient Survey
- The Walton Centre Trust scored **Much better than average** in one of the 10 sections and **Better than average** in 5 sections
- Out of the 62 questions asked, the Trust was the same as other trusts for 24 questions and worse than most Trusts average for one question which related to waiting times for admission.

Next Steps

- An action plan has been produced to address any areas where improvement have been identified and progress will be managed at Quality Committee.

Related Trust Strategic Ambitions and Themes	**Impact**		
Choose an item	Not Applicable	Not Applicable	Not Applicable

Strategic Risks

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

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

CQC National Adult Inpatient Survey Results 2021

Executive Summary

1. The Trust is required to participate in the CQC National Inpatient Survey annually to allow benchmarking of the patients' experience with other NHS providers. The survey is recognised as being a key indicator of overall care for the organisation and regulators, including the CQC and commissioners. CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's monitoring tools, which provide inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections.

   The CQC report they received responses from 62,235 patients, with an overall average response rate for all trusts of 39.5%.

2. The 2021 survey of adult inpatient's experiences involved 134 NHS acute trusts in England; at The Walton Centre (TWC), Picker were commissioned to undertake the survey and 72 other organisations.

3. Patients were eligible for the survey if they were aged 16 years or older and had spent at least one night in hospital during November 2021. Fieldwork for the survey (the time during which questionnaires were sent out and returned) took place between January and May 2022.

4. A total of 62 questions were asked, 45 of which can be positively scored, 41 of which can be historically compared.

5. CQC use the results from the survey in the regulation, monitoring and inspection of NHS trusts in England. Survey data will be used in CQC's monitoring tools, which provide inspectors with an assessment of performance in areas of care within an NHS trust that need to be followed up. Survey data will also be used to support CQC inspections.

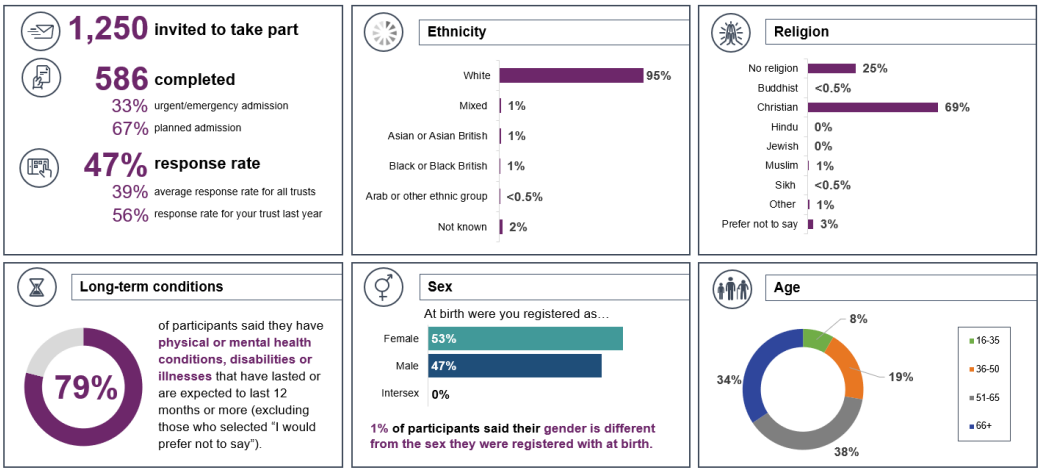
6. Picker have published that The Walton Centre have ranked 8th for overall positive patient scores in the league table from the 73 Trusts, which is the same position as in 2020. The Trust were ranked 11th out of 134 Trusts nationally.

7. Overall, the CQC rated the Trust as **Better than expected.**

Background and Analysis

Respondents and Response Rate

8. 586 patients (33% urgent/emergency. 67% planned admissions) responded to the survey with a response rate of 47.37% (56% in 2020) compared to a 39% response rate for similar.



Making Fair Comparisons Between Trusts

9. People's characteristics, such as age and sex can influence their experience of care and the way they respond to the questions asked. For example, males tend to be more positive than females. The CQC recognise that since trusts have different profiles of people who use their services, this could potentially affect their results and make trust comparisons different. To account for this, the CQC, standardise the data, in that they apply a weight to individual responses to account for differences in demographic profile between trusts. This is to ensure that no Trust appears better or worse than another because of the respondent profile.

Scoring

10. For each question that can be scored, responses were converted into a score on the scale of 1-10, 10 being the most positive. The higher the score the better the results.

11. The Survey is split into the following sections:
    - Admission to Hospital
    - The Hospital and Ward
    - Doctors
    - Nurses
    - Your Care and Treatment
    - Operations and Procedures
    - Leaving Hospital
    - Feedback on care
    - Dignity & Respect
    - Overall

Results

12. The CQC benchmark methodology is to provide Trusts with more detailed results. The scores have been categorised into the following bandings:

    - **Much Better** than most Trusts for 2 questions
    - **Better** than most trusts for 14 questions
    - **Somewhat better** for 6 questions
    - **Same** – about the same as most Trusts for 24 questions
    - **Much worse** than most Trusts for 0 questions
    - **Worse** than most trusts for 1 question
    - **Somewhat** worse for 0 questions

13. **Top 5 Scores (compared with trust average across England)**
    - ✓ Q7 Provided with reasons for changing wards at night

- ✓ Q3 Length of time waiting for a bed after arrival on the ward
- ✓ Q43 Informed who to contact if worried after leaving hospital
- ✓ Q49 Asked to provide views on the quality of care
- ✓ Q13 Got help from staff when eating meals

14. **Bottom 5 score (compared with trust average across England)**

- ↓ Length of time on the waiting list before admission
- ↓ Staff discussed the need for additional equipment following discharge
- ↓ Enough support provided by health and social care following discharge
- ↓ Given enough privacy when being examined/treated
- ↓ Enough information regarding medicines taking home

Table 1: Admission to hospital

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q2. How did you feel about the length of time you were on the waiting list before your admission to hospital?	382	6.7	Worse	7.4	↓
Q3. How long do you feel you had to wait to get to a bed on a ward after you arrived at the hospital?	554	8.9	Much better	9.1	

Table 2: The hospital and ward

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q4. Did you get help from staff to keep in touch with your family and friends?	348	8.3			
Q5.1. Were you ever prevented from sleeping at night by noise from other patients?	536	6.2		6.1	
Q5.2. Were you ever prevented from sleeping at night by noise from staff?	536	8.2		8.3	
Q5.4. Were you ever prevented from sleeping at night by hospital lighting?	536	8.7	Better	8.9	
Q7. Did the hospital staff explain the reasons for changing wards during the night in a way you could understand?	42	9.1	Much better	7.4	↑
Q8. How clean was the hospital room or ward that you were in?	574	9.4		9.7	↓
Q9. Did you get enough help from staff to wash or keep yourself clean?	388	8.8	Better	9.2	
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?	410	8.5		8.3	
Q11. Were you offered food that met any dietary needs or requirements you had?	313	8.6			
Q12. How would you rate the hospital food?	576	7.8	Better		
Q13. Did you get enough help from staff to eat your meals?	153	8.4	Better	8.1	

Table 2: The hospital and ward *(continued)*

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q14. Were you able to get hospital food outside of set meal times?	266	6.5			
Q15. During your time in hospital, did you get enough to drink?	567	9.7	Better	9.8	

Table 3: Doctors

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q16. When you asked doctors questions, did you get answers you could understand?	557	8.9		9.1	
Q17. Did you have confidence and trust in the doctors treating you?	579	9.6	Better	9.6	
Q18. When doctors spoke about your care in front of you, were you included in the conversation?	575	9.0	Somewhat better	8.8	

Table 4: Nurses

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q19. When you asked nurses questions, did you get answers you could understand?	554	9.1		9.3	
Q20. Did you have confidence and trust in the nurses treating you?	580	9.2		9.5	↓
Q21. When nurses spoke about your care in front of you, were you included in the conversation?	578	9.1	Somewhat better	9.0	
Q22. In your opinion, were there enough nurses on duty to care for you in hospital?	578	7.5		8.4	↓

Table 5: Your care and treatment

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q23. Thinking about your care and treatment, were you told something by a member of staff that was different to what you had been told by another member of staff?	512	8.3		8.5	
Q24. To what extent did staff looking after you involve you in decisions about your care and treatment?	548	7.8	Better	7.9	
Q25. How much information about your condition or treatment was given to you?	559	9.3	Better	9.4	
Q26. Did you feel able to talk to members of hospital staff about your worries and fears?	487	8.3	Somewhat better	8.3	
Q27. Were you able to discuss your condition or treatment with hospital staff without being overheard?	514	6.7			
Q28. Were you given enough privacy when being examined or treated?	565	9.5		9.7	↓
Q29. Do you think the hospital staff did everything they could to help control your pain?	516	9.0		9.3	↓
Q30. Were you able to get a member of staff to help you when you needed attention?	522	8.6		9.0	↓

Table 6: Operations and procedures

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q32. Beforehand, how well did hospital staff answer your questions about the operations or procedures?	464	9.2		9.3	
Q33. Beforehand, how well did hospital staff explain how you might feel after you had the operations or procedures?	485	8.0	Somewhat better	7.7	
Q34. After the operations or procedures, how well did hospital staff explain how the operation or procedure had gone?	496	8.1		8.4	

Table 7: Leaving hospital

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q35. To what extent did staff involve you in decisions about you leaving hospital?	567	7.5	Somewhat better	7.9	
Q36. To what extent did hospital staff take your family or home situation into account when planning for you to leave hospital?	457	8.0	Better	8.3	
Q37. Did hospital staff discuss with you whether you would need any additional equipment in your home, or any changes to your home, after leaving the hospital?	239	8.2		8.6	
Q38. Were you given enough notice about when you were going to leave hospital?	577	7.8	Better	8.1	
Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?	559	8.8	Better	8.2	↑
Q40. To what extent did you understand the information you were given about what you should or should not do after leaving hospital?	479	9.2	Somewhat better		
Q41. Thinking about any medicine you were to take at home, were you given any of the following?	390	4.7		5.0	

Table 7: Leaving hospital *(continued)*

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q42. Before you left hospital, did you know what would happen next with your care?	562	6.8		7.1	
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?	546	9.0	Better	8.9	
Q44. Did hospital staff discuss with you whether you may need any further health or social care services after leaving hospital?	328	8.5		8.4	
Q46. After leaving hospital, did you get enough support from health or social care services to help you recover or manage your condition?	320	6.3		6.9	

Table 8: Feedback on care

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?	468	2.4	Better	2.2	

Table 9: Respect and dignity

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q47. Overall, did you feel you were treated with respect and dignity while you were in the hospital?	578	9.4		9.6	

Table 10: Overall experience

Question	Respondents	2021 Score	2021 Band	2020 Score	2020 Change
Q48. Overall, how was your experience while you were in the hospital?	579	8.7	Better	9.0	↓

Table 11: Section Scores

Section	2021 Score	Band
Section 1. Admission to hospital	7.8	
Section 2. The hospital and ward	8.3	Much better
Section 3. Doctors	9.2	Better
Section 4. Nurses	8.7	
Section 5. Care and treatment	8.4	Better
Section 6. Operations and procedures	8.4	
Section 7. Leaving hospital	7.7	Better
Section 8. Feedback on care	2.4	Better
Section 9. Respect and dignity	9.4	
Section 10. Overall experience	8.7	Better

15. Scores with no band above means the Trust remained about the same.

Feedback – was there anything good in particular about your hospital care?

16. 387 patient provided positive additional comments a snapshot is below.

✓ **The Walton Centre is a fabulous hospital I have been in a few hospitals on Merseyside, and I rate you as by far the best for treatment diagnosis and after care. i I can't thank them enough for their ongoing care and support when other hospitals have given me a sheet with exercises on and sent me on my way no wonder my nerve was badly decompressed thank you.**

- ✓ **My care was exceptional - All of my experience was brilliant. Thank you.**
- ✓ **All staff where very good at their job nothing was to much trouble. They were short staffed on many occasions maybe due to covid, but they tried their best.**
- ✓ **Being kept in touch about my operation. Lovely staff (nurses and auxiliary and doctors) were very approachable and helpful at all times. Nothing was too much trouble.**
- ✓ **Certain members of staff had fantastic beside manner's & were very empathetic, but they were a very limited few. The majority of staff had very little patience or would forget about you.**
- ✓ **Excellent care, respect, thoughtfulness, friendliness we're always given. Nothing was too much trouble for the efficient & very rushed, busy team that looked after the patients. I was encouraged & impressed by the professional, confident care given. In an ideal world the night staff would not be so few in numbers.**
- ✓ **Throughout the time of my stay on how helpful and approachable all medical, nursing and support staff were. This made a difference at a time when visitors were not allowed in hospital. Staff went out of their way for me although they were very busy.**
- ✓ **I have been under the care of the Walton Centre for the last 37yrs I have Never had any bad experience at the Walton Centre Ever! The Dr's Nurses, All Staff are some of the nicest people you could ever want to meet**
- ✓ **My experience of The Walton Centre was excellent, my consultant was very thorough and understanding, as were the nurses and general staff, my stay in Chavasse ward, was, considering my situation was brilliant and I could not praise the hospital enough Happy Patient**
- ✓ **The domestic staff providing drinks & meals were very friendly & attentive.**
- ✓ **Walton provided excellent care. The surgical and medical team were exceptional. The spinal specialist nurses and even medical secretary provided great care and communication. The ward nurses are caring and competent on the whole and incredibly committed and hard working. They create good ward morale for patients. Very important too when there is no visiting allowed.**
- ✓ **The Walton Centre is FANTASTIC!!!!!! I have nothing but the highest praise for ALL the staff that work there. I cannot thank you enough for looking after me.**

Highlights and Improvements Noted

17. Where patient experience **is best**
    - ✓ Changing wards during the night: staff explaining the reasons for this
    - ✓ Waiting for a bed: patients feeling they waited the right amount of time to get a bed on a ward after they arrived at the hospital
    - ✓ Contact: patients being given information about who to contact if they were worried about their condition or treatment after leaving hospital
    - ✓ Feedback on care: patients being asked to give their views on the quality of care
    - ✓ Help with eating: patients being given enough help from staff to eat meals if needed

18. Where patient experience **could improve**
    - ➢ Waiting to be admitted; patients feel that they waited the right amount of time on the waiting list before being admitted to hospital

- Equipment and adaptations in the home, hospital staff discussing if any equipment or home adaptions were needed before leaving hospital
- Support from health or social care; patients being given enough support to manage their condition
- Privacy for examinations; patients given enough privacy when being examined or treated
- Information about medicines to take home: patients being given enough information about medicines they take home

19. In addition to the above, patients were asked to leave comments, if there was there anything that could be improved?

20. There were <300 comments, many of which were positive stating *No, or there is nothing that can be improved*. The following trends were identified are included in our improvement plan:

    - Noise at night – from other patients / staff
    - Aftercare / Discharge Planning & More information on discharge with regards to next steps, not informed who to contact after leaving hospital if worried
    - More nurses on wards

Conclusion

21. This report summarises the outcome from the CQC inpatient survey of our patient's experiences, care, and treatment. The results are very good for the second year running considering it was the second most difficult year for the NHS; however, we recognise that there is room for improvement to the care we delivery to every patient.

22. The vision in the Trust is 'Excellence in Neuroscience' and this will only be achieved by truly placing the quality, safety and experience of patients and families at the heart of the Trust's work. The improvements required will form part of the Patient & Family Centred Care agenda as this approach to care recognises each patient as part of a wider group, including families, friends and carers.

23. During 2022/23 and beyond the Trust will continue to build on this work to ensure it is working together with patients and their families as equal partners in care, in line with The Walton Way.

Recommendation

The Trust Board is asked to:

- Receive the report noting the results and improvements required
- Be assured that the Trust actively engage with patients, families and carers
- Be assured that the Trust continues to learn from feedback to improve care delivery

Author: Lisa Judge
Date: 29th September 2022

Appendix 1 – Action Plan

CQC National Inpatient Survey 2021 – Action Plan
to be implemented from October 2022

KEY CODE	Not Achieved	To Commence	Partially Achieved

Areas for Improvement	Actions	Lead	Progress/Evidence	Completion Date
Carried forward from Previous 2022 action plan **Patients able to administer own medication when need to**	Self-administration of Medicine to be reviewed and re-launched by each division. In progress, safe storage ordered and policy to be developed & implemented with the support of pharmacy. New education programme be developed and implemented to support the role out of the policy for nursing, medical and pharmacy staff.	Divisional Nurse Directors/ Practice Educator Lead		January 2023
Admission to Hospital **Length of time waiting for admission**	By continuing to work towards the Trust's recovery plan in line with the roadmap will improve waiting times for patients. Continually monitored at Board Level.	Chief Operating Officer		November 2022
Hospital & Ward **Noise at Night / Prevented from sleeping**	Awareness to be raised by Matrons & Ward Managers – this should be evidenced in ward newsletter & ward meeting minutes to provide assurance that this is embedded.	Divisional Heads of Nursing/Matrons/ Dept Chief Nurse		October 2022
	Adopt a – *Speak Quietly Space at Nursing Station* and outside bays	Matrons/Ward Managers		November 2022
	Ensure staff wear soft sole footwear at night	Ward Managers		November 2022
	Noise at night to be monitored via Ward Manager/Matrons' audits on Tendable, monitored at ward managers 1-1 and outcomes reported to Quality Committee	Matrons/Ward Managers		November 2022
	Adopt Night-time 'Shh' (Sleep helps healing) campaign focusing on lights out, and reducing noise at night	Communications/Ward Managers/PET		November 2022

Areas for Improvement	Actions	Lead	Progress/Evidence	Completion Date
<u>Hospital & Ward</u> Noise at Night / Prevented from sleeping cont.	Develop Noise at night Standard Operation Procedure/ posters regarding protected sleep time – Asking staff to raise concerns to ward manager, asking patients to reduce TV noise, use earphones / close doors quietly	Divisional Nurse Directors/Matrons/ Communications		November 2022
	Review feasibility on all wards to dim lights to aid comfort/sleep	Matrons/IT		November 2022
	Annual checks of all ward equipment to prevent squeaking trollies	Ward Managers		November 2022
	Soft Close Bins to be in all areas	Estates		November 2022
	Screen savers on wards to remind staff at 11pm to dim lights	IT		November 2022
	Patients receiving 1:1 or 2:1 care should be cared for in a side toom as much as possible	Matrons/Bed Managers		October 2022
	Earphone to be provided to patient to minimise noise from TVs – will be distributed by Patient Support Assistant along with Sleep well packs	Head of PET		October 2022
	Designate quiet time in which no routine checks are made unless medically necessary	Ward Managers		October 2023
	Re-stock supplies during early evening not night time when patients are trying to sleep	Housekeepers/Ward Managers		October 2023
	Handover/communications to take place away from bays/vicinity of patients	Ward Managers		October 2023
	Introduce night/small flashlights for when taking observations to prevent putting bay or overhead lights on	Deputy Divisional Nurses		November 2023
	Review if doors have door sweeps to help minimise noise	Deputy Divisional Nurses and Estates		November 2023
	Install – Sleeping - Do not Disturb notices for bays and side rooms	Comms/Ward Managers		October 2023
Care and Treatment Not given enough privacy when being examined or treated	Nursing staff to remind all health care professionals of the importance of privacy during ward rounds in their areas – to be added to Tendable to audit compliance.	Ward Managers /Outpatient Manager		November 2023

Areas for Improvement	Actions	Lead	Progress/Evidence	Completion Date
<u>Leaving Hospital</u> Improve Discharge Process / Provide patients with more information	Ward Managers/matron follow up calls to be made up to 72 hours after discharge to proactively seek feedback to prevent concerns	Matrons/Ward Managers		CRU already commenced, rest of clinical areas to have in place no later than November
	Specialist Nurses to call all specialty patients post-operatively and advise all patients of nurse advice line at time of discharge.	Dept Divisional Nurses/Specialist Nurses		November 2022
	Written discharge information to be provided at least 24 hours prior to discharge to give patients opportunity to review and ask questions	Dept Divisional Nurses/Matrons		November 2022
	Improve quality of discharge chat/process to provided more detailed information/signposting if required	Ward Managers		October 2022
	Awareness raised via Ward Manager Meetings/Learning & Sharing/ AP and CNS meeting	Dept Divisional Nurses/Matrons		November 2022
	Implement Teach back of TT0s – for patients to repeat back the information provided regarding their medications	Matrons/Ward Manager		December 2022
	Families to be involved at the earliest opportunity and informed of the likely date of discharge	Matrons/Ward Manager		December 2022
	Family to be invited to take part in discharge chat/TTO teach back	Matrons/Ward Manager		December 2022

The Walton Centre
NHS Foundation Trust

Report to Trust Board
6th October 2022

Report Title	Research & Development Annual Report 2021
Executive Lead	Mr Michael Gibney, Chief People Officer
Author (s)	Gemma Nanson, Head of Neuroscience Research Centre (NRC)
Action Required	To note

Level of Assurance Provided

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

Key Messages

- There were national challenges in research delivery and restarting the wider portfolio beyond COVID-19, which lessened the impact of the NRC's instability on the trust's reputation for research.
- There was a plateau in financial loss arising from research activity.
- The was ongoing work to restructure the NRC to make it more robust and viable for the future.

Next Steps

- Continue to embed new leadership structure within the NRC to make it more robust and viable for the future.
- Work more closely with Chief Investigators (Cis) / Principle Investigators (PIs) to establish a research active culture

Related Trust Strategic Ambitions and Themes	**Impact**		
Research	Compliance	Workforce	Finance

Strategic Risks		
009 Research & Development Ambition	Choose an item.	Choose an item.

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Research & Development Annual Report 2021

Executive Summary

1. The annual report for research captures the activity over the course of 2021. However, due to reporting requirements the data will be presented in the financial years – 2020/21 and 2021/22. The report will include data up to March 2022.

2. The ongoing COVID-19 pandemic coupled with instability in its own infrastructure, meant that the NRC's ability to deliver high-class research was still being impacted. However, these effects on the financial income had plateaued.

3. The ongoing instability in both the clinical and administrative structures of the NRC was acknowledged and addressed with significant investment into the research department from the trust.

4. Nationally, the focus was still very much on COVID-19 research and there were significant struggles restarting the wider portfolio. This will have limited the reputational damage to the trust from the instability within the NRC.

5. Looking forward to 2022/23 beyond, it is anticipated that with the newly appointed Head of NRC, the management structure of the NRC should be stronger which will increase participant recruitment and influence a creation of a research active culture.

6. Beyond the NRC, there was notable work by colleagues to consolidate key relationships internally and externally to drive the Trust's research agenda.

Background and Analysis

7. The findings from an independent review of the NRC undertaken by Caroline Murphy, Director of Operations at Clinical Trials Unit, King's College London were received in January 2021. This report was a significant driver in the need to acknowledge and address concerns with regards to the infrastructure of the NRC impacting on the ability to deliver high-class research.

8. The leadership of the NRC analysed the current infrastructure of the research department, trying to address the concerns of the reviews and of researchers at the trust, to develop the NRC into a viable business model. There have been two businesses cases made to and approved by the board in relation to the NRC. The first business case addressed the instability and capacity of the clinical and administrative structures of the NRC. The second was to appoint a service lead who was experienced in clinical trials.

9. Recruitment for the Trust has not returned to pre-pandemic levels. Even though there were capacity issues within the NRC team, nationally, there was unprecedented challenges to the delivery of research, due to the ongoing pandemic. The national focus continued to be towards COVID-19 research and there were difficulties in restarting the wider NHS portfolio. The impact of COVID-19 on national research, would have absorbed some of the reputational harm to the trust due to the NRC's instability,

10. The financial income from research was relatively stable between financial years, 2020/21 and 2021/22. There was generally less opportunity for the researchers to participate with non-COVID-19 research because the national focus continued to be on COVID-19 research. However, now that the effect of the pandemic has levelled out, some thought will be given to financial recovery for the NRC going forward.

Conclusion

11. The research landscape of 2021 was continued to be dominated by COVID-19. There had been some movement in restarting the wider portfolio but nationally there continued to be challenges with research delivery and less opportunity for non-COVID-19 research. For the NRC, 2021 continued to be a transitory period. The significant investment into the NRC by the Trust, aimed at addressing the capacity issues and providing a service leader who will be able to stabilise these structures.

12. Under the direction of the newly configured Research, Innovation and Medical Education (RIME) Committee, it anticipated that the stronger management structures within the NRC, should only help it stabilise the NRC but help it grow by creating a research active culture within the Trust, to serve the ambitions of our clinicians and their patients.

Recommendation

To Note

Author: Gemma Nanson, Head of NRC
Date: 27 September 2022

Appendix 1

Research & Development 2021 Annual Report

CONTENTS

FOREWORD

With a catchment area of around 3.5 million, the Walton Centre NHS Foundation Trust is the only specialist Trust dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services. Encouraging a research positive culture at the Trust is important to provide patients wider access to clinical research, improving patient care and treatment options overall. Evidence also shows clinically research active hospitals have better patient care outcomes.

The Neuroscience Research Centre (NRC) is imperative to achieving the Trust's objectives, and its working towards becoming a world-class, leading institution by securing a national/international reputation for excellence in neuroscience research. However, the NRC's ability to deliver this research was continued to be impacted by instability in its own infrastructure, along with the ongoing effects of the COVID-19 pandemic. Despite these pressures, 894 participants in 2020/21 and 501 patients in 2021/22 were recruited across the Trust. This included the recruitment of 142 patients into the urgent public health (UPH) portfolio, which was set-up in response to the COVID-19 pandemic.

It should be noted that the ability to support the delivery of research was facing unprecedented challenges across the UK, due to the ongoing pandemic. These widely accepted national challenges to the delivery of research, whilst undoubtedly hastened the exposure of the instability in the NRC, perhaps limited the damage and protected the Trust's reputation from significant harm had the instability occurred at different point in time.

By acknowledging and addressing the ongoing instability across both the clinical and administrative structures within the NRC with significant investment, has reinforced the Trust's commitment to providing the best neuroscience care and outcomes for its patients.

Mr Paul May
Non-Executive Director & Chair of the Research, Research Innovation & Medical Education Committee

Dr Rhys Davies
Clinical Director of

Mr Michael Gibney
Chief People Officer
Executive Lead for RIME

INTRODUCTION

The Research Annual Report captures activity over the course of 2021.

The Trust has a unique status as a specialist clinical neuroscience Trust, with an established reputation for delivering research and supporting innovation. This report illustrates our contribution to delivering the Trust's strategy whilst recognising the substantial challenges presented by the continued organisational change and the impact of / response to the ongoing COVID-19 pandemic.

It should be acknowledged that despite the difficulties, staff across the Trust are still committed to delivering high quality health research and have a genuine drive to improve the outcomes of patients through research.

OUR YEAR IN NUMBERS

The Research Annual Report covers the 2021 calendar year. However, reporting in this way is not suitable for income and expenditure purposes or the reporting of recruitment figures.

Therefore, for clarity, data on finance and recruitment will be reported on 2020/21 and 2021/22 financial years. This report will include data up to March 2022.

	2020/21	**2021/22**
Number of participants recruited into clinical research	894	501
Number of unique studies recruited	23	40
NIHR Funding	150,222	204,660
CRN funding	404,401	439,132
Research Capability Funding	102,702	45,449
Commercial Income	83,540	71,565
Income from Charities	96,703	64,398

FOCUS ON RESEARCH DEPARTMENT:

At the end of 2020, an independent review of the NRC was undertaken by Caroline Murphy, Director of Operations at Clinical Trials Unit, King's College London. The findings of which were presented to the RIME committee in March 2021. It was noted that she had an overall positive impression around the desire of the system to support the Trust's research ambition. However, the findings highlighted a considerable number of key recommendations to acquire sustainable growth and support the long-term viability of the NRC.

Whilst a plan was being developed to address the key recommendations of the review to take the research function forward, the NRC was still experiencing significant workforce pressures due to long term sickness and the ongoing COVID-19 pandemic. This resulted in staffing gaps across the team structure. This was a difficult and stressful period for the staff and morale was low. Despite this, the team successfully recruited 894 and 501 patients to studies in 2021/21 and 2021/22 respectively.

A business case was developed which aimed to implement sufficient research infrastructure to address the recommendations of the review and address concerns around staff member's well-being. It should be acknowledged that the process of mapping the existing structures of the NRC into a viable business model was more complex and took longer than expected. The business case was presented to the Trust's executive team on the 27th of October 2021, offering three options for consideration.

The board approved the financing of option 3 as presented by the business case, which was a full restructure of the department, including several additional posts to stabilise the clinical and administrative structure. However, this business case was modelled against a substantive, senior member of staff assuming the role of Lead Nurse for Research being uplifted to an 8a. Unfortunately, this internal arrangement did not provide the appropriate management support required for the team.

In 2022, an additional business case was submitted to and approved by the board to appoint a service lead who was experienced in clinical trials and a strong overview and appreciation of research governance who will guide the clinical trials staff to increase participant recruitment and influence the creation of a research active culture within the Trust.

FOCUS ON RESEARCH DELIVERY:

As a specialist neurosciences Trust our staff are committed to working in partnership to lead and undertake academic and commercial research in all aspects of neurological, neurosurgical and pain conditions to provide our patients with opportunities to participate in and benefit from research studies.

The Trust aims to excel at translating research findings into clinical practice to create new diagnostic investigations, treatments, and technologies for the benefit of our patients. However, the growth and activity of the NRC has continued to be hindered by its own structural instability and the impact of the ongoing COVID-19 pandemic.

Nationally, the NIHR continued to work with all their delivery partners to restore a diverse and balance portfolio of studies which were impacted due to the COVID-19 pandemic. The 'Managed Recovery' process was implemented in May 2021. However, this did not have the anticipated impact of restoring recruitment to pre-pandemic levels. The work to revitalise the NHS research portfolio continues through the Research Reset programme. The NIHR and NWCRN targets were still hold whilst the larger research portfolio, beyond the UPH portfolio was recovered.

Recruitment to Research Studies

In 2020/21 a total of 894 patients were recruited across 23 unique studies. In 2021/22, a total of 501 patients were recruited across 40 unique studies. The increased recruitment in 2020/21 was largely due to the Qualms Study, which recruited 235 patients by utilising questionnaires to investigate the impact on quality of life of having either an incidental meningioma or surgery to remove a meningioma.

The NRC continued to support recruitment into the UPH portfolio:

- ISARIC (International Severe Acute Respiratory and Emerging Infection Consortium) – Clinical Characterisation Protocol for Sever Emerging Infections: 146 patients successfully recruited (Late patient recruitment in September 2021)

Please see Appendix A and B for the monthly breakdown of recruitment across 2020/21 and 2021/22.

FOCUS ON RESEARCH BEYOND THE NRC

There was also notable work by colleagues beyond the NRC to consolidate key relationships internally and externally to drive the Trust's research agenda.

Medical innovations
Technology has the potential to revolutionise clinical trials and improve patient benefits. The potential for transformative change was explored within the Trust with the completion of both the ERNST and VERA pilot innovation studies. Further work is being completed with both projects to be research proven, including exploring further funding opportunities and IT integration.

Research Grant Applications
Accessing the skills and experience of the LHP SPARK grants application team, several Trust staff collaborated with local and national colleagues to produce high quality grant submissions.

Whilst several grant applications are still under review, Dr Andreas Goebel was a successful co-investigator with 'Fibromyalgia and refractory pain in rheumatic diseases' submitted for the MRC's – Mapping Complexity of pain with the Advanced Pain Discovery Platform call. The study was nominated in December 2021 by the Guardian as one of the top 10 science stories of the year.

Please see Appendix E for links to the Fibromyalgia study

Research Publications

The Trust strongly supports the promotion of research and dissemination of results to improve clinical practice. Data collated from Aintree Library showed that for the period of January – August 2021, 148 articles, revies, editorial or conference abstracts had been authored/co-authored by Trust staff members.

Please see Appendix C for list of publications

FOCUS ON RESEARCH FUNDING:

The level of total research income across 2020/21 and 2021/22 was relatively stable, £837, 568 and £825, 204 respectively. The level of commercial and charitable income was lower than in previous years; perhaps unsurprising in the context of the national push towards COVID-19 research. The shortfall across these funding streams was generally balanced out by several milestone payments received from the NIHR for the PREP study.

NIHR

The Trust received NIHR funding of £204,660 in 2021/22 in comparison to £150, 222 received in 2020/21.

- Radiation versus Observation following surgical resection of Atypical Meningioma: a randomised controlled trial (the ROAM trial); Chief Investigator: Mr Jenkinson. Study has now met its recruitment target despite reduced activity in the past year and is now moving into follow-up stages.

- Dr Janine Winterbottom's PREP study into women with Epilepsy

Research Capability Funding

The Trust attracts Research Capability Funding (RCF) in proportion to the amount of NIHR funding secured, in 2021 this was £45, 499 compared with £102,702 in 2020

Clinical Research Network: North West Coast Funding

In 2021/22 the Trust received service support funding of £ 439,132 (£404,401 2020/201) from the Clinical Research Network: North West Coast (CRN: NWC) to support the delivery of clinical research.

Professor Young is the Specialty Group Lead responsible for supporting the delivery of clinical research in dementias and neurodegeneration, and neurological disorders. Dr Sekhar is deputy lead for hyper acute stroke research centre for Cheshire & Merseyside. Dr Antonella Macerollo and Dr Saif Huda are enrolled on to cohort 2 and cohort 4 of the CRN NWC's Research Scholars programme, which is designed to develop 'research interested' individuals in the earlier phase of their clinical research careers.

Commercial Research Funding

The Trust received £71,565 from pharmaceutical and technology company sponsored projects in 2021/22 in conditions such as multiple sclerosis, migraine, cluster headache and backpain. The commercial income has continued to decline (£83,540 in 2020/21, £207,668 in 2019/20).

Funding from Charities

The Trust received £64,398 from charities in 2021/22. This is mainly to support research studies such as the Trajectories of Outcome in Neurological Conditions (TONiC) study. The TONiC study is a national study examining the factors that influence quality of life in patients with neurological conditions. It is one of the larges studies on quality of life in neurological conditions ever delivered in the UK and involves patients with multiple sclerosis, motor neurone disease and neuromuscular conditions.

WALTON CENTRE NHS FOUNDATION TRUST'S RESEARCH COLLABORATIONS AND PARTNERSHIPS:

WCFT Research, Innovation and Medical Education Committee – RIME
Research continued to report into Research, Innovation and Medical Education Committee to reinforce links between functions and consolidate Trust strategic aim to lead in research education and innovation

RD&I Sponsorship & Governance Oversight Committee
The RD&I Sponsorship & Governance Oversight Committee is constituted as a sub-group of the RIME committee will implement and oversee application of The UK Framework for Health and Social Care Research 2017 within The Walton Centre NHS Foundation Trust.

Liverpool Health Partners (LHP)
Liverpool Health Partners (LHP) brings together clinical and scientific expertise to develop world-leading research that draws on the strength from within each of the founding partner organisations. The Trust is a member of LHP which aims to create a strategic partnership for improving health and pursuing excellence in the delivery of health care research and education.

LHP's Single Point of Access to Research and Knowledge (SPARK) continued to support research activities around the development and set-up of studies within the Trust.

The LHP Neuroscience and Mental Health Programme aims build on the strengths and expertise of LHP's partners to translate neuroscience discoveries into better brain health and well-being for people to facilitate the integration of mental health and clinical neuroscience research for diagnosis, pathogenesis, and intervention across the life course. The Programme Manager was appointed at the beginning of 2021 and scoped potential collaborations across the region, including innovations with the use of immersive technology.

Clinical Research Network: North West Coast
The CRN: NWC supports the Government's Strategy for UK Life Sciences by improving the environment for commercial clinical research in the NHS. The CRN: NWC supports the Trust in undertaking academic and commercial neurosciences research to ensure the Trust sets up studies quickly, conducts studies efficiently and meets study recruitment targets.

The Trust is committed to increasing the opportunities for patients to participate in clinical research and recognises the important contribution patients make to our research success and supports NIHR's Patient Research Ambassadors initiative.

The Trust supports the CRN NWC's Building Research Partnerships Programme and participates in the annual NIHR Patient Research Survey.

Applied Research Collaboration: North West Coast
The Trust is a partner of the ARC: NWC which consists of health and social care providers, NHS commissioners, local authorities, universities, public advisers, the Innovation Agency (Academic Health Science Network), working together to learn more about these health inequalities, and overcome the barriers around translating these discoveries in health research into practice which improves lives.

The collaboration features research themes reflecting local needs. These are: 'Person-Centred Complex Care', 'Improving Population Health', 'Equitable Place-based Health and Care' and 'Health and Care across the Life-course'.

The Walton Centre Charity

The Walton Centre Charity offers funding to support several studies and projects in areas including Epilepsy, Huntington's Disease, MS, Motor Neurone Disease and Parkinson's Disease as well as other neurological and neurosurgical conditions. Dr Nisaharan Srikandarajah was the successful recipient of funding to support his work on the NERVES trials and Cauda Equina Syndrome study.

LOOKING AHEAD TO 2022 / 23

2021 continued to be a transitory period for the NRC. With the appointment of the NRC manager and continued senior leadership from SPARK and senior nursing leadership from the CRN NWC, we will endeavour to empower the research department to increase participant recruitment and influence the creation of a research active culture within the Trust, to serve the ambitions of our clinicians and their patients.

We will reinvigorate the Principal Investigators & Innovators forum to promote research community interaction, idea exchange, training opportunities, and needs assessment.

We will endeavour to work with the communications department to raise the profile of research within the Trust; including the promotion of our research to raise awareness of the range of research and innovative projects we undertake to encourage patients to participate in our studies in collaboration with the CRN: NWC and voluntary groups.

We will endeavour to establish a sustainable financial model that balances income stream, in particular the untapped commercial study capability.

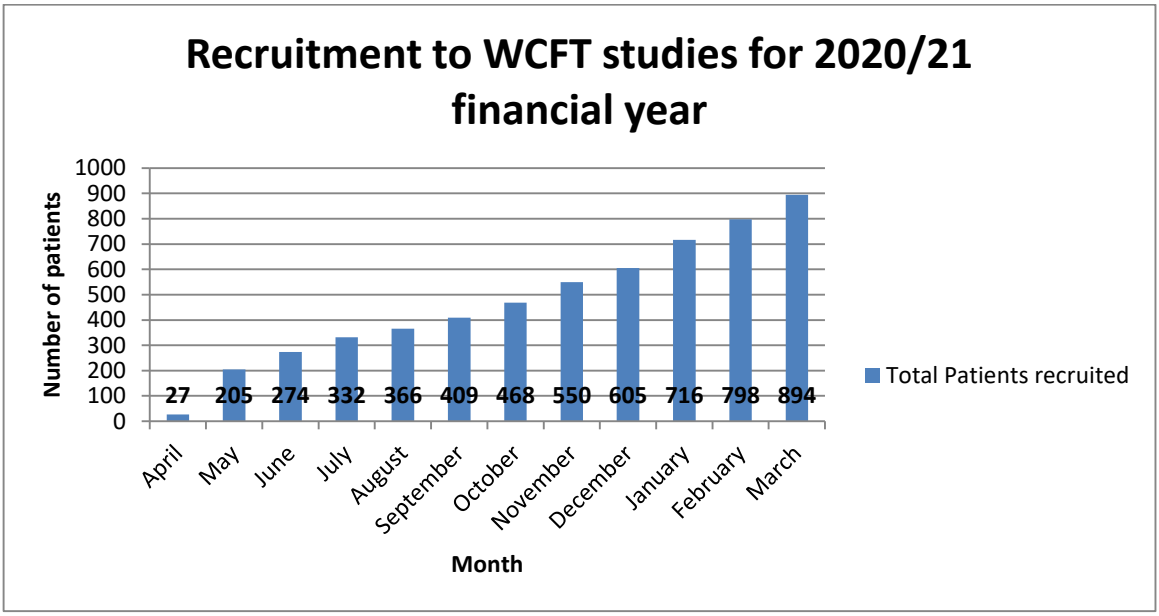
Although, the structures of LHP have been disbanded, the SPARK function will remain and be aligned with the CRN NWC. We will continue to take advantage of the unique expertise available through these professional networks to develop skill set of research staff regarding grant planning and application. As well as the integration of standard operating procedures to ensure more effective and robust set-up of studies.

We will continue to work with our partners across the region to create further research opportunities for patients and attract future collaborations with life science partners, such as the Stroke Research Consortium.

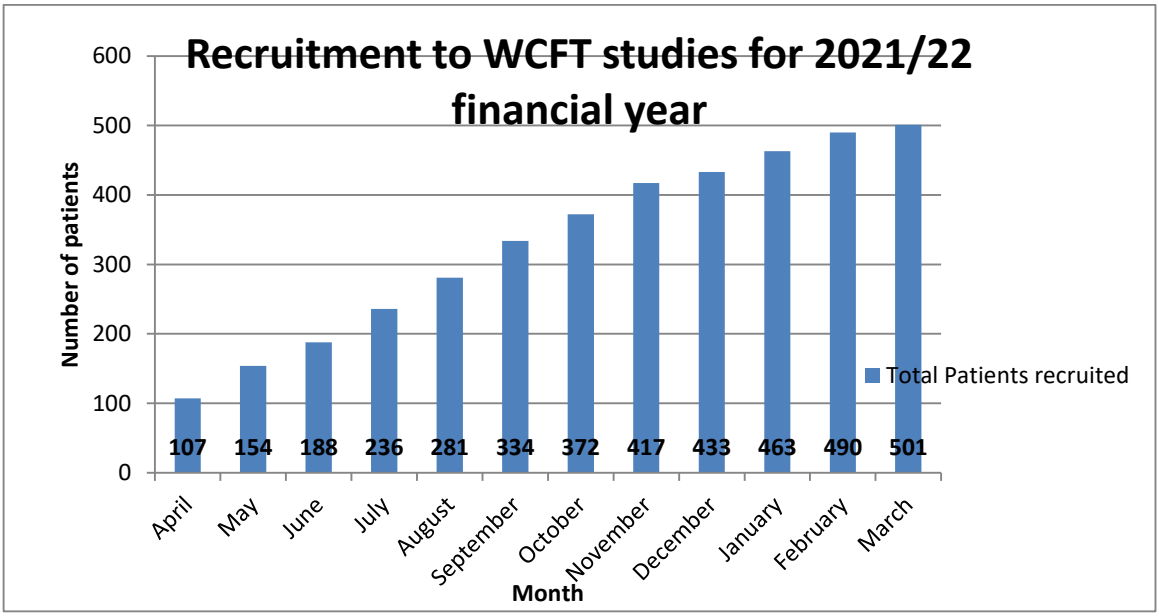
The significant investment into the NRC by the Trust, is a clear demonstration of the importance of research in the Trust's strategy. We will ensure there is clear alignment of research with the Trust's brand and ambitions. We will ensure the research portfolio is informed by and supports key Trust's and regional strategic priorities e.g., University Hospital Accreditation, Tessa Jowell Brain Cancer Mission Centre of Excellence

APPENDICES

Appendix A – 2020/21 Recruitment to WCFT studies



Appendix B – 2021/22 Recruitment to WCFT studies



Appendix C – Jan – August 2021 Publications

79b Walton Centre Research publications

Appendix D – TWC Grants Facilitated by SPARK

220923_Grant Facilated By SPARK.xls

Appendix E – Links to Fibromyalgia Study

- https://www.theguardian.com/science/2021/dec/19/the-years-top-10-science-stories-chosen-by-scientists
- https://www.kcl.ac.uk/news/new-study-shows-fibromyalgia-likely-the-result-of-autoimmune-problems

The Walton Centre NHS Foundation Trust

Report to Trust Board
Thursday 6 October 2022

Report Title	2021 Staff Survey Update and TEA Feedback
Executive Lead	Mike Gibney, Chief People Officer
Author	Jane Mullin, Deputy Chief People Officer
Action Required	To note

Level of Assurance Provided

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

Key Messages

- Review of the actions taken in response to the 2021 Annual National Staff Survey
- Feedback from TEA (Talk, Engage, Action) events

Next Steps

- Action Plan to be agreed following TEA events
- Communication Plan to be engaged
- TEA Rounds to continue with a focus on night staff and areas that did not have a presence at the in-person events

Related Trust Strategic Ambitions and Themes	**Impact**		
People	Workforce	Quality	Equality

Strategic Risks

004 Leadership Development	010 Innovative Culture	008 Medical Education Strategy

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Executive Summary

1. The Staff Survey is an annual survey that is distributed across the NHS from September to December each year, in 2021 600 Trust staff took part in the survey compared to 548 in 2020, a response rate of 41% and an increase of 2% from 2020.

2. The Survey is made up of nine themes:

    - We are compassionate and inclusive
    - We are recognised and rewarded
    - We each have a voice that counts
    - We are safe and healthy
    - We are always learning
    - We work flexibly
    - We are a team
    - Staff Engagement
    - Morale

3. Compared to the national average we scored better in five themes, the same in three and worse in one.

    Theme: We have a voice that counts

4. There were a number of key areas to be addressed under this theme and following a staff side/HR action planning session in March 2022 it was agreed we would hold a series of staff engagement events in response to the 2021 staff survey which became known as TEA events.

    TEA EVENTS

    PROCESS

5. Twelve events took place over four days during July and August 2022, 117 staff attended with a good cross section of disciplines.

6. The events were introduced by a member of the executive team and the following questions posed to staff in facilitated table discussions.

    - How would you describe the culture in the Trust now
    - How does it feel to work at the Trust compared to a year ago- what is better/worse
    - Why do you stay working at The Walton Centre
    - What are the best and worse parts of your role
    - What stops you being yourself at work

7. In addition to the above all staff were asked if they were the Chief Executive Officer what one thing would they do to make a difference.

8. A session was then held on 12th September with the Executive team to feedback from the day and agree key action to take forward.

    THEMES

9. The main themes from the sessions are summarised below:

    - IT infrastructure
    - Staff Facilities
    - Recognition & Reward

- Rationale for decisions made/ clarity of roles and responsibilities/cascading of information
- Cost of Living/Wellbeing Hub
- Celebrating success/sharing good news stories and initiatives across the Trust
- Cross team working

NEXT STEPS

- Action/Communication plan to be agreed with CEO
- TEA Rounds to continue with a focus on night staff and those unable to attend the events

ACTIONS OUTSIDE OF TEA EVENTS

Theme: We are safe and healthy

10. During Autumn 2021 the Trust ran a survey to find out what health and wellbeing issues affect staff and how we can best support their needs both in the workplace and in their home life, the results of the survey helped us developed a new focus with a vision to create a best practice staff wellbeing programme that engages the organisation, its leaders and staff in creating a vibrant, safe, healthy and resilient workforce.

11. As well as supporting day to day wellbeing we have offered the following new initiatives during 2022 in response to the surveys:

    - An identified space for a wellbeing hub
    - Health MOT's
    - Monthly newsletter focused on the five key strands of wellbeing, with tips, guidance and signposting to useful services
    - Wellbeing Wednesday once a month information stand
    - Support for current Mental Health First Aiders/Wellbeing Advocates
    - Further Mental Health First Aider Course

Theme: We are recognised and rewarded

12. The Trust have undertaken a review of all Health Care Assistants across the Trust to ensure staff are banded appropriately for the work they do, this resulted in a change of band for 70% of the Healthcare Assistant Workforce

Theme: We are safe and healthy

13. Staff Survey questions covering violence and aggression to staff have been a concern to the Trust for a number of years, actions taken during 2021 include:

    - Violence Prevention and Reduction Strategy developed and approved at Trust Board
    - Business case approved for a full-time band 6 Personal Safety Lead. Currently out to advert.
    - Personal Safety Lead role will include delivery of all training (conflict resolution, de-escalation and restraint).
    - Support for staff on the wards, including managing MDT meetings to ensure robust management plans/risk assessments in place for challenging patients

Theme: We are always learning

14. This was the only theme the trust scored lower compared to the national average. The key challenge was the complexity/duration/recording of the trust appraisal system at the time of the survey. We have implemented a new process for tracking completion rates at team and department level which is reported through the People Group. In addition a review of the paperwork is currently being undertaken. It is important for Board to note that the Messenger review singled out the burdensome nature of the current appraisal process within the NHS and is committing to develop one, simpler national version.

Conclusion

15. All of the People Promise theme and sub-theme scores for the 2021 NHS Staff Survey for The Trust are broadly in line with the sector scores of similar organisations. The Trust will continue to engage with staff to understand how we can best support them in the workplace.

Recommendation

Trust Board is asked to note the contents of this report

Author: Jane Mullin
Date: 16/09/22

The Walton Centre
NHS Foundation Trust

Report to Trust Board
Thursday 6 October 2022

Report Title	Responding to In Work Poverty
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Mike Gibney, Chief People Officer Jane Mullin, Deputy Chief People Officer
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- In work poverty is growing in severity and heightened by the current cost of living crisis.
- The Joseph Rowntree Foundation have identified four issues to prioritise in healthcare.
- The paper outlines the Trusts immediate response to this challenge based upon the guidance of the JRF.

Next Steps

- Identify/confirm leads in four key initiative and resource appropriately.
- Executive Team/Trust Board to proactively lead across the organisation.

Related Trust Strategic Ambitions and Themes	**Impact**		
People	Workforce	Quality	Equality

Strategic Risks

001 Quality Patient Care	004 Leadership Development	004 Operational Performance

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Responding to In Work Poverty

Executive Summary

1. In work poverty has been a growing challenge for all employers for decades. However, the bleakest economic climate in the UK for 40 years has exacerbated this and it is obvious that many of our staff are or will be impacted by this. It is important to note that nearly 40% of staff employed at the Walton Centre are from the three local areas with the highest indices of deprivation.

2. Rather than let a response emerge organically, the North West Staff Partnership Forum (NWSPF) has sought guidance and advice of the Joseph Rowntree Foundation. They have identified four areas for healthcare organisations to consider and the purpose of this update is to support the Board in establishing a shared understanding of the issues at this trust and explore appropriate responses. All four priorities have their own challenges, implementation issues and potential impact to performance and/or cost.

3. The overall response has been developed with our Staff Side partners in conjunction with the findings from the recent engagement sessions (TEA).

4. It is important for Board to note that although this report focuses upon the Joseph Rowntree Foundation guidance, there is a lot of ongoing support offered to staff on a daily basis. These can be very significant, such as pay/pension support or as small as providing free milk and toast to staff on wards.

Context

5. This year has seen the rapid emergence of a cost of living crisis in response to global events. This has become the top priority of trade union colleagues across Health & Social Care and virtually the only issue discussed at North West regional level. Many healthcare organisations have started to respond often with well intentioned but inconsistent initiatives such as access to washing machines, creating an internal foodbank, hardship funds etc. At the North West Staff Partnership Forum there was an aspiration to identify the key elements of an organisational response that would have the most benefit to staff struggling with in work poverty. Ultimately, the NWSPF would like to see a North West framework so that all NHS staff have access to a consistent menu of support.

6. The accepted experts in this field are the Joseph Rowntree Foundation and one of the policy advisors (Morgan Bestwick) was invited to present on the subject on 28 June 2022. The Joseph Rowntree Foundation is an independent social change organisation working to solve UK poverty. They work with private, public and voluntary sectors and people with lived experience of poverty to develop strategic responses and concrete recommendations. Both trade union and management requested that Morgan focus upon what data she had on Healthcare workers specifically and come up with a set of key issues (a framework) for healthcare organisation to focus their efforts.

7. It's interesting to note that because the issue is so emotive, having a subject matter expert (with some evidence) was universally welcomed to give the region a steer. The inconsistent response to the reintroduction of car parking charges was a strong example of how not to manage change.

8. The JRF came back to the following meeting on 26 July 2022 with a very clear briefing note that outlined the four key issues for healthcare employers to consider. See attached Appendix 1.

9. All courses of action have the potential to offend or upset some colleagues. This is a subject where people can feel shame or even be exposed to the judgement of others and even ridicule. All responses will need to be sensitive with a strong emphasis on anonymity.

10. The 4 key issues were discussed in detail by the Executive Team on 24 August 2022.

Response

11. The organisations response to in work poverty needs to align with the recommendations of the Joseph Rowntree Foundation. It builds upon the strong platform we have created through our long-standing commitment to Health & Wellbeing. The key issues to consider are as follows:

    - **Secure and predictable hours**
      The principle response to this issue is through the trust's commitment to achieving the Fair Employment Charter that has been promoted across the Liverpool City region and spearheaded by the Metro Mayor, Steve Rotheram. An overview of the Charter is attached in Appendix 2. The status of the Walton Centre's membership at the time of writing this report is 'Aspiring'.

      The Walton Centre was at the forefront of engaging with this initiative and promoted it to other trusts across the North West. The focus is on fair pay but also fair hours promoting a commitment to regular hours of work rather than using more stable contractual arrangements such as zero hours contracts etc.

      In addition, this is placed within the context of safe, healthy and inclusive workplace with demonstrable staff representation and engagement.

    - **Training and progression for lower paid workers**
      This is a deceptively simple recommendation that will require some concerted effort. Prior to the pandemic various initiatives were developed that targeted staff in the lower paid bands to broaden their skill set and enhance their prospects for promotion within the NHS. Therefore, there will be a review of the training opportunities for lower banded staff with a view to developing a dedicated training menu. Typically, the trust offers vocational skills training (specific to job role) but this is an opportunity to expand the offer into more general work place training that underpins career progression.

      IT are developing an IT literacy training offer that they want to deliver through the new Health & Wellbeing Hub. Other skills development could include assertiveness, presentation skills, CV writing etc. but this will need to be firmed up through a short engagement process with Staff Side colleagues.

      Clearly, this will run alongside the continuous development of the trusts model for flexible working but also could/should include specific initiatives. A good example would be the use of secondments, shadowing and reciprocal mentoring to enable colleagues to better understand the challenges of some roles and to make informed choices.

      In order for this campaign to be effective it will need to be supported by training and very clear messaging to front line managers across the organisation.

    - **Flexible working**
      The trust has a well-established flexible working policy and introduced its agile working policy rapidly at the beginning of the first lockdown. Its implementation was led by the trust's Transformation Team supported by Human Resources. We did conduct a satisfaction survey after four of five months to inform implementation but this is an opportunity to revisit that engagement process. Put simply, the greater the flexibility of working arrangements, hours, pay and shift patterns, the greater our capacity in enabling our employees to respond to in-work poverty.

Therefore, a comprehensive review of these Working Policies is required with a view to understanding what additional flexibilities could help staff in the current climate. Clearly, not everyone will get what they want as so much of our activity takes place on site but we should be able to optimise our offer to staff.

Building on the Trust's commitment to the Fair Employment Charter, the organisation will need to review its successful introduction of eRostering. This is to ensure that we enable/empower staff to work additional hours when they can to support them through the Cost of Living Crisis. This would build upon having secure hours by potentially offering additional shift opportunities that would help people keep their head above water financially.

- **Financial wellbeing support**

  In many ways financial wellbeing support is the most evolved of the four areas within the Walton Centre. There is a long-standing resource that has been developed in partnership with Vivup that is available to the trust staff. Many have already been assisted with consolidating loans into more manageable options with a much lower interest rate. Clearly this kind of service will become more challenging when and if interest rates rise.

  Further examples of the content are included in Appendix 3, Your Employee Benefits and Appendix 4, Help Combat Rising Living Costs with fee advice from Ask Bill. It is important to note that this resource is updated on a regular basis, and at the moment it is virtually weekly.

  In addition to these longer term measures the trust will need to strengthen its short term/immediate/emergency support where it can. This is likely to be through hardship funds etc that will enable front line managers to support staff who fall into crisis. Again, front line managers will need appropriate training and messaging to ensure implementation.

Conclusion

12. Responding to the JRF priorities will require some changes in the way we work and/or some new initiatives. The proposals outlined build upon our existing Health & Wellbeing work and are in line with the guidance of the Joseph Rowntree Foundation. This represents the beginning of the Trust's response and nobody is under the illusion that further challenges will not emerge if the crisis deepens.

Recommendation

13. The Trust Board to approve the additional measures in the paper.

Author: Mike Gibney, Chief People Officer
Date: 26/09/22

Appendix 1 – JRF Four Key Priorities

Four issues for NHS Employers to consider around the cost of living

Overall, we encourage employers to listen to the experiences of their staff and respond to their priorities in the workplace. As well as listening to their staff, employers can keep track of the broader impacts of cost of living pressures on people across the UK, to identify potential pressure points for staff - for example, JRF's recent research on the experiences of households on lower incomes outlines the scale of cost of living pressures people are currently experiencing, including many having to juggle the build-up of multiple forms of debt and arrears.

Key issues to consider

Hourly pay is absolutely key to supporting workers with the cost of living. But we acknowledge that this is part of a much broader context of public sector funding for the NHS, and we'd recommend also considering the following issues:

- **Secure and predictable hours**: employers can look beyond hourly pay to also provide workers with more secure hours and incomes where possible. We know that insecure work – for example, not knowing when or how often you'll be working – can cause real challenges for low paid workers. It has impacts on people's ability to budget, as well as plan their personal lives and other responsibilities.

  Employers can voluntarily act to make work more secure, through providing workers with more predictable working hours, giving workers good notice of when they'll be working wherever possible, and not cancelling shifts at short notice. The Living Hours standard from the Living Wage Foundation gives more details on different aspects of security which employers can consider.

- **Training and progression for lower paid workers:** helping employees on low pay to develop and progress, build their skills, and move onto higher pay if they want to. Employers can think about a few different elements to this:

  What training is available to staff – is it high quality, accessible, affordable, and genuinely useful to staff if they want to progress?

  What is the skills, training and progression offer specifically for staff on lower pay grades?

  How do pay progression structures enable progression? If there is lots of wage compression for example, this could disincentivise people from taking on lots more responsibility for little extra pay.

  How do progression and flexibility interact in your workplace? If people need flexible working, are they able to retain this while also moving onto higher pay and taking on more responsibility? If not, this can create blockers to progression for workers.

- **Flexible working:** flexible working can help work-life balance, enable people with caring responsibilities or health needs to enter and stay in the workplace, and allow people to work the hours they want to through better balancing work with other responsibilities.

Offering work which is flexible around staff's other responsibilities can support them to earn more by 'unlocking' more working hours for them. We know that underemployment – people not working as many hours as they would like to – is linked to in-work poverty.

Flexibility also links to progression, as outlined above. If flexible working is on offer as you move up pay levels within an organisation, this can enable people who need flexibility to progress and earn more. An important part of this is thinking about how to make a variety of forms of flexibility available in different jobs where possible. Work from Timewise shows that there are significant differences in the forms of flexibility available at different pay levels. If you can only access part-time work while on lower pay grades for example, this can act as a blocker to progression if you need to work part-time but would like to earn a higher hourly rate.

Employers can engage with good practice on how to provide more flexible working for workers in different job roles and at different pay grades. This could involve thinking about creative forms of flexibility for shift work, like self-scheduling. Consultancies like Timewise provide guidance for employers thinking about how to implement flexibility in different types of role.

- **Financial wellbeing support:** employers can also look at how the full benefits and support package available to workers helps them with living costs and supports them with financial pressures.

  JRF has produced an online resource hub for employers in partnership with the CIPD which provides guidance on different elements of in-work poverty for employers to consider, and suggests key areas for action. This includes taking action on financial wellbeing.

  Employers should aim to build a workplace culture in which employees feel able to discuss financial worries, in which the employer is signposting employees to specialist support whenever needed, and in which the broader benefits package offered to employees helps support them with costs and make their incomes go further wherever possible.

Appendix 2 – Fair Employment Charter: https://www.liverpoolcityregion-ca.gov.uk/fec/

Appendix 3 - Your Employee Benefits

Cost of Living Brochure.pdf

Appendix 4 - Help Combat Rising Living Costs with free advice from Ask Bill

Ask Bill Brochure.pdf

LIVERPOOL CITY REGION COMBINED AUTHORITY

METRO MAYOR LIVERPOOL CITY REGION

FAIR EMPLOYMENT CHARTER: CONSULTATION

Last year Steve Rotheram, Metro Mayor of Liverpool City Region, set out his ambition to improve the world of work in the Liverpool City Region.

This survey has now closed.

Many Thanks to those of you who responded to our consultation in Spring 2020 on developing Liverpool City Region's first ever Fair Employment Charter. Most responses were supportive of our suggested approach, and requirements and we look forward to these being reflected in the final Charter.

The COVID-19 Pandemic put into sharp focus the importance of many of the aims of the Charter, and it also meant that we were unable to hold as many stakeholder events as we had planned.

LIVERPOOL CITY REGION COMBINED AUTHORITY METRO MAYOR LIVERPOOL CITY REGION

encourages and recognises safe workplaces that support a healthy workforce.

With this in mind we are seeking further thoughts on these areas before publishing our final Charter early next year. Please fill in the survey here and thank you for supporting our drive for Fair Employment across Liverpool City Region.

HEALTHY	FAIR	INCLUSIVE	JUST
Safe workplaces supporting a healthy workforce	*Fair pay and fair hours*	*Inclusive workplaces that support staff to grow and develop*	*A voice for staff to help deliver justice in the workplace with opportunities available for young people*
A commitment to ensuring a safe and healthy working environment whether in the workplace, on the road or in the home	A defined set of hours available to each worker, with minimal use of unstable and temporary contracts.	A recognised Equality Policy representing all protected characteristics and proactive commitment to inclusivity and diversity in recruitment and retention.	An independent voice for staff in the workplace with trade union recognition and membership encouraged and valued.
Understanding the importance of mental and physical health to wellbeing and productivity. Flexible working available to support work-life balance and community or caring commitments	Fair pay, offering Real Living Wage or above and a commitment to supporting local partnership and co-operation in Liverpool City Region	The chance to access training so that staff can perform, develop, and be managed positively and effectively. Additionally there should be procedures to recognise and support performance that involve and are supported by staff.	Building a fair future through opportunities, apprenticeships and work experience for young people.

LIVERPOOL CITY REGION COMBINED AUTHORITY METRO MAYOR LIVERPOOL CITY REGION

As well as welcoming businesses at the start of their Fairness journey, we also want to recognise those who are going the extra mile themselves and who are supporting other businesses to meet the charter's requirements.

Ambassadors for our Fair Employment Charter will meet the requirements when they are confirmed following consultation. They will also display a commitment to be a leading voice and proponent of the objectives of the charter, seeking to support fellow LCR businesses, whilst also working to narrow the gaps and remove the barriers that continue to mean that our economy is not accessible or inclusive to some.

They could use their accredited status as a platform to:

- Provide support via case studies or similar to promote the scheme
- Demonstrate a commitment to recognising other Charter holders in procurement and spend – e.g. by supporting LCR-CA Community Wealth Building Approach
- Support other businesses in doing so – e.g. through mentoring and best practice sharing
- Display or develop best practice in training, inclusivity, and diversity, including by proactively working to "narrow the gaps"
- Recognise a Trade Union for collective bargaining purposes (whilst understanding that for some businesses formal recognition may not be the only way to demonstrate commitment)

In return, Liverpool City Region Combined Authority will celebrate and promote the achievements of those accredited members who have done the most to ensure that our Fair Employment Objectives are met, and spread across LCR

Our Fair Employment charter is a journey – so we'll invite all accredited members to tell us about their achievements in 12 months time, and ask those who have displayed best and innovative practice to become Ambassadors.

#LCRListens

LIVERPOOL CITY REGION COMBINED AUTHORITY

METRO MAYOR LIVERPOOL CITY REGION

Ambassadors – a structure for a Fair Employment Charter

We believe that the above Commitments represent what a Fair, Inclusive and Just employer could look like. But we also know that in order to make Liverpool City Region the best place to work in the country, then we need to build a movement that supports and recognises those businesses and employers who share our aim and who want to be part of this journey.

Employers who wish to play their part in becoming part of a fairer, more inclusive, and just City Region are invited to join the Fair Employment charter as ***Aspiring*** members

We think that ***Aspiring*** members could be required to;

- Give a public commitment to support the aims and values of the Fair Employment Charter – for example on a website or marketing materials
- Recognise the importance of secure working, staff voice, fair pay and training in the workplace
- Display their "Aspiring" commitment in the workplace for staff, partners and customers
- Start work to audit their practices, moving them on a pathway to accreditation
- Commit to meeting the membership requirements within an agreed timeframe

When employers are ready to progress we would then encourage them to become ***Accredited***. We will agree a framework of measures which employers will need to achieve to become accredited and we hope the support provided to Aspiring employers will help them on the journey to accreditation

Accreditation to the Liverpool City Region Fair Employment Charter is a welcome display of a commitment to delivering fair and positive working practices. However, our commitment to fairness, inclusivity and justice has never stood still, and there are many examples of how employers can and do go beyond the commitments outlined in the charter.

Ambassadors for a Fairer, more inclusive and just city

Your employee benefits

Here to help with the cost of living

vivup

Contents

vivup

Visit vivup.co.uk

Lifestyle Savings

Reduce your spending with offers and savings on the areas of life that matter most

Supermarkets

Utilities

Cars, Motoring & Commuting

Home, Garden & Pets

vivup

Savings or offers subject to change

Visit vivup.co.uk

Supermarkets

Save on the weekly shop with discounted eGift Cards from many of the UK's major supermarkets

Simply choose your retailer and amount, pay a discounted price and the eGift card will be emailed to your inbox to start using

vivup

ASDA

TESCO

Waitrose

Sainsbury's

M&S
EST. 1884

Morrisons
Since 1899

Iceland

and more...

Visit vivup.co.uk

Utilities

Lower your household bills with offers from mobile, broadband and utility providers

vivup

Reward Mobile

ParentShield
The Child-Safe Mobile Network

sky

plusnet

Three.co.uk

Switchd

CPR
CALL BLOCKER

O2

cuckoo

and many more...

Visit vivup.co.uk

Cars, Motoring & Commuting

From breakdown cover to insurance and car leasing, start saving with these discounts and exclusive offers

vivup

Europcar

RAC

Affinity Leasing
vehicle finance
0800 060 7070

halfords

TotalMotorbikeAssist

TotalVanAssist

TotalMotorAssist

Visit vivup.co.uk

Home, Garden & Pets

Whether you're looking to save on D.I.Y, an emergency appliance replacement or pet insurance, there are plenty of savings waiting to be discovered

vivup

HomeServe Heating & Plumbing Cover

Wickes Gift Card

wilko Gift card

beko

B&Q

Tails.com

anorak

The Big Yellow Self Storage Company

Argos

and many more...

Visit vivup.co.uk

Home and Electronics

Make essential items and emergency replacements more affordable by spreading the cost via manageable salary reductions

You can also choose from energy efficient white goods and smart home tech that can help you reduce your bills

vivup

* Ts and cs apply. Home and Electronics is provided via a salary sacrifice arrangement

Visit vivup.co.uk

Cycle to Work

Save on fuel costs, avoid parking charges and boost your wellbeing at the same time. Spread the cost of a brand new bike for your commute to and from work and benefit from up to 42%* savings

Our Partners

halfords

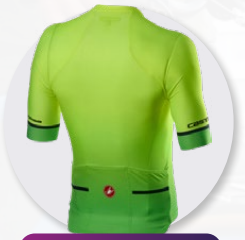
Cycle Solutions

EVANS CYCLES

vivup

Anything you need

Lighting



Hi-Vis

Locks

Helmets

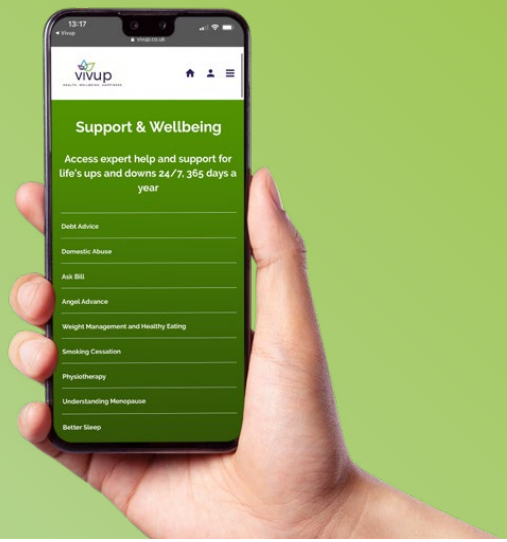
Bikes

*Excluding disposal fee (if applicable). Savings are realised through a salary sacrifice arrangement. Figures are a guide only and dependent on personal situation. Bikes available are subject to organisation scheme limit

Visit vivup.co.uk

Additional Support

It can be difficult to know where to start when you need financial advice and support but there are great resources available through your Support & Wellbeing benefits that can help in times of need



vivup

From water and energy to emergency support including fuel vouchers, Ask Bill is here to help you understand and access savings that can make a real difference to your daily life

Angel Advance
Supporting Financial Wellbeing

Dealing with debt can cause stress and worry, meaning you may find it difficult to concentrate on work and other responsibilities. Angel Advance provides online debt advice to get you back on track and make your finances more manageable

Visit vivup.co.uk

Start exploring your benefits and discover how they can help you with the **cost of living**

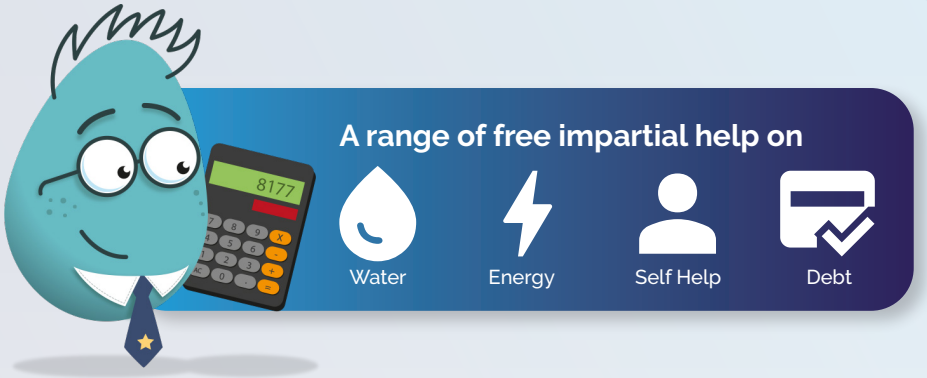
Register or login at vivup.co.uk

Visit vivup.co.uk

Help combat rising living costs with free advice from Ask Bill

During these challenging times, it's important to ensure that you are receiving the support you need to reduce financial stress and save for the future

You can access free and impartial money advice from Ask Bill - including tips on how to reduce utility bills, manage money and deal with debt issues



Ask Bill provides:

- Clear information on what to do when struggling with water or energy charges, and where to find further support
- Free online tools to self-assess and personalise advice
- In-depth and impartial debt advice over the phone or online
- A free Benefits Calculator to identify where extra financial support is available
- A free Budget Planner to help reduce household costs
- Fuel vouchers for those struggling to stay on top of their energy bills

vivup

Visit the Support & Wellbeing section at vivup.co.uk

In partnership with Ask Bill

The Walton Centre NHS Foundation Trust

Report to Trust Board
6 October 2022

Report Title	Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- To agree a collaborative approach and structure for decision making in the CMAST Provider Collaborative through a Joint Working Agreement and Terms of Reference for a Committee in Common

Next Steps

- All Trusts in CMAST are being asked to agree this at their Board through September and October

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

Strategic Risks

002 Collaborative Pathways	003 System Finance	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) Joint Working Agreement and Committee in Common

Executive Summary

1. Cheshire and Merseyside (C&M) acute and specialist providers have come together to collaborate on matters that can be best progressed and responded to, at scale, and through shared focus or action. Working together achieved real and tangible benefits during the pandemic, with much of CMAST's foundations emerging from these activities but also building upon, wider and existing, local collaborative strengths such as the Cancer Alliance.

2. In identifying, promoting and championing the benefits of collaboration NHS England have encouraged all providers to build on local successes through provider collaborative structures and, now, also require all providers to be part of a collaborative. Furthermore, such a policy imperative is seen as a way to ensure all providers adhere to the *'triple aim'* of the NHS as set out in the Health and Social Care Bill 2022, to assure the health and wellbeing of the population, quality of care and sustainable use of resources through:
   - Aligning priorities
   - Supporting establishment of the Cheshire & Merseyside Integrated Care System (ICS) with the capacity to support population-based decision-making
   - Directing resources to improve service provision.

Background and Analysis

3. C&M Trust leaders have been working together to explore collaborative potential, develop ways of working and defining priorities over the last year. This work has included working with Hill Dickinson and Mike Farrar and has involved both Chief Executives and Chairs.

4. In addition to the triple aim priorities CMAST has identified a number of complimentary, key functions, that the collaborative can and should perform:
   - Prioritising key programmes for delivery on behalf of the system
   - Creating an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision

5. Following the success of a number of CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB it has been proposed, by CMAST members, and is now advocated that CMAST's ways of working should be embedded through a Joint Working Agreement (Appendix 1). Such an approach provides a means to document the progress made, together within C&M, and provides an opportunity for Boards to demonstrate a shared commitment to the vision, priorities and programmes of work that they have identified and initiated, both internally and externally.

6. These documents do not change the statutory and constitutional rights of the Trust nor the Board's responsibility to deliver its constitutional standards. Nor does it impact the ability of the Trust to work in and deliver services to areas outside of Cheshire & Merseyside.

7. It is also proposed that CMAST more formally establish its governance to provide a route for shared and formalised decision making as and when required. This decision-making framework aims to underpin existing ways of working and provide a framework to build from, as necessary, to fulfil either the need, potential or ambition of CMAST Boards. Further summary details of both documents follow below.

8. **Joint Working Agreement (JWA) (Appendix 1)** - to be read in conjunction with Committees in Common (CiC) Terms of Reference (ToR):
    - Covers: vision; function; priorities and 2022/4 work programme
    - Establishes: rules of working; process of working together; stages of decision making and scale of involvement and decision making
    - Sets: exit plan approach; termination approach; dispute resolution approach; information sharing and competition law principles; conflicts of interest approach

9. **Committee in Common - Terms of Reference (CiC ToR) (Appendix 2)** - to be read in conjunction with JWA:
    - Sets out the C&M response, as proposed by Chairs and Chief Executives, to the Provider Leadership Board collaborative approach
    - Committees in Common: Staged levels of Committees in Common decision making; rules based approach; will underpin clear and consistent communication supporting Board awareness and assurance
    - Sets aims and objectives of CiC
    - Establishes membership and signals wider engagement including minimum frequency of Chairs' engagement
    - Confirms the quorum
    - Annex A establishes potential activities delegated to the CiC when in scope of the CiC work as set in the JWA
    - To note: NWAS is proposed as a participant of the meeting rather than as a Member

Conclusion

10. The documentation provides outputs that represent the culmination of a period of engagement and development with C&M Trust Board leadership and supporting officers. The approach represents the will and direction of this leadership steer and contribution and is put forward as representative of C&M's preferred way of operating.

11. The document delivers both a foundation and framework for CMAST development, decision making and supports its evolution. It focuses on approach and governance. Business and content scope will iterate and be defined by Boards as the scope and remit of CMAST develops and the ask of the system, for it, expand, vary or diminish. Examples of decision making have been developed to help Boards understand how the documents will work in practice.

12. The Trust has a duty to collaborate and to be part of one or more provider collaboratives. LHCH continues to work collaboratively through CMAST and also a range of well-established networks, in addition to a number of joint posts, services and mutual aid.

13. Trust approval of the Joint Working Agreement and Committee in Common Terms of Reference is an important step in formalising the governance arrangements to enable CMAST to operate effectively.

Recommendation

To approve:

- the CMAST Joint Working Agreement to be signed by the Chief Executive on behalf of the Board
- the establishment of a Committee in Common with Terms of Reference as proposed
- to adopt and sponsor the approaches to collaborative working and decision making, as described, recognising the anticipated evolution and development of these proposals

Author: K Dowson,
Date: September 2022

Appendix 1 - CMAST Joint Working Agreement
Appendix 2 - CMAST Leadership Board The Walton Centre Committee in Common Terms of Reference

HILL DICKINSON

Draft No:1 – 6
Date of Draft: 5 September 2022

Appendix 1

Dated 2022

CHESHIRE & MERSEYSIDE ACUTE AND SPECIALIST TRUSTS PROVIDER COLLABORATIVE (CMAST) JOINT WORKING AGREEMENT

Between

(1) **COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST**

(2) **LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

(3) **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

(4) **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST**

(5) **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST**

(6) **THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST**

(7) **LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST**

(8) **THE WALTON CENTRE NHS FOUNDATION TRUST**

(9) **LIVERPOOL WOMEN'S NHS FOUNDATION TRUST**

(10) **ALDER HEY CHILDREN'S HOSPITAL NHS FOUNDATION TRUST**

(11) **EAST CHESHIRE NHS TRUST**

(12) **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

(13) **MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST**

and

(14) **NORTH WEST AMBULANCE SERVICE NHS TRUST**

CONTENTS

CLAUSE **PAGE**

1 Introduction

1.1 In this Agreement, the following words bear the following meanings:

Agreement	this agreement signed by each of the Trusts in relation to their joint working and the operation of the CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly.
CMAST Leadership Board	the CMAST CiC's meeting in common.
Confidential Information	all information which is secret or otherwise not publicly available (in both cases in its entirety or in part) including commercial, financial, marketing or technical information, know-how, trade secrets or business methods, in all cases whether disclosed orally or in writing before or after the date of this Agreement;
Competition Sensitive Information	means Confidential Information which is owned, produced and marked as Competition Sensitive Information including information on costs by one of the Trusts and which that Trust properly considers is of such a nature that it cannot be exchanged with the other Trusts without a breach or potential breach of competition law;
Dispute	any dispute arising between two or more of the Trusts in connection with this Agreement or their respective rights and obligations under it;
Meeting Lead	the CMAST CiC Member nominated (from time to time) in accordance with paragraph 7.6 of the Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of a CMAST CiC in accordance with their Trust's Terms of Reference and "**Members**" shall be interpreted accordingly;
Terms of Reference	the terms of reference adopted by each Trust (in substantially the same form) more particularly set out in the Appendices 1-14 to this Agreement;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's Hospital NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust, Mid Cheshire

	Hospitals NHS FT and "**Trust**" shall be interpreted accordingly.

1.2 Each Trust is putting in place a governance structure which will enable it to work together with the other Trusts to implement change and develop CMAST as a provider collaborative.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a party to this Agreement as a participant in CMAST but is not forming a CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 The CMAST Trusts agree that, notwithstanding the good faith consideration that each Trust has afforded the terms set out in this agreement, this agreement shall not be legally binding. The CMAST Trusts enter into this agreement with the approval of their boards and intending to honour all their obligations to each other.

2 Background

Vision

2.1 CMAST has the immediate and short-term vision to ensure the coordination of an effective provider response to current system and NHS priorities including: ongoing pandemic response; NHS service restoration and elective recovery; support and mutual aid; sharing best practice, increasing standardisation and reducing variation. CMAST Trusts will work together to speak with one voice, enhancing our ability to lead on system wide programmes and workforce development, including harnessing clinical and professional leadership resources.

2.2 In the medium and longer term CMAST will develop an overview of existing services, locations and pathways to ensure they are patient-centred, productive, streamlined and of high quality. CMAST will work with the wider system and the ICB to ensure finances and organisational structures facilitate change and do not obstruct progress. The Trusts will work together, in places and with partners to ensure that those in greatest need have access to high quality services.

Key functions

2.3 The key functions of CMAST are to:

2.3.1 Deliver the CMAST vision;

2.3.2 Support the delivery of the ICS triple aim in Cheshire and Merseyside;

2.3.3 Align priorities across the member Trusts;

2.3.4 Support establishment of ICBs with the capacity to support population-based decision-making, and working with other collaboratives and partners to develop and support ICS maturity and encourage wider system working and collaboration

2.3.5 Direct operational resources across Trust members to improve service provision;

2.3.6 Prioritise key programmes for delivery on behalf of the Cheshire and Merseyside system; and

2.3.7 Create an environment of innovation, challenge and support in order to deliver improved performance and quality of service provision.

2.4 CMAST's stated priorities are to strengthen each of the Trusts by sharing collective expertise and knowledge to:

2.4.1 Reduce health inequalities;

2.4.2 Improve access to services and health outcomes;

2.4.3 Stabilise fragile services;

2.4.4 Improve pathways;

2.4.5 Support the wellbeing of staff and develop more robust workforce plans; and

2.4.6 Achieve financial sustainability.

2.5 The Trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision making structures; the CMAST CiCs acting through the CMAST Leadership Board.

2.6 More specifically the CMAST CiCs and the CMAST Leadership Board will facilitate the Trusts' work in the following key work programmes at this initial stage of CMAST development*:*

2.6.1 Delivery and coordination of the C&M Elective Recovery Programme;

2.6.2 Cancer Alliance delivery and enablement – subject to the request of the Alliance;

2.6.3 Delivery and coordination of the C&M Diagnostics Programme including system decision making on pathology optimisation following existing C&M case for change and OBC;

2.6.4 Initiation of proposals and case for change for clinical pathway redesign - subject to discrete decision making as may be appropriate;

2.6.5 Coordinating and enabling CMAST members contribution and response to collective system wide workforce needs, pressures and the People agenda;

2.6.6 Coordinating and enabling CMAST members contribution and response to system wide financial decision making, pressures and financial governance;

2.6.7 Responding to and coordinating CMAST action in response to any national, regional or ICB initiated priorities for example TIF, system or elective capital prioritisation, 104 week wait delivery; and

2.6.8 The CMAST Trusts are part of the C&M ICS. Regional and inter regional relationships should first and foremost be guided by the ICB. To support this CMAST will provide both intelligence to the ICB and respond to ICB calls for action. Where necessary and appropriate CMAST may seek to develop relationships with peers or for trusts, across other ICS's and ICB's (for example, related to specialised commissioning). This will be notified and communicated between the CMAST Trusts in accordance with the principle outlined in clause 4.6.

The areas within scope of this Agreement may be amended though variation, by Trust Board resolutions or agreement of the annual CMAST workplan.

2.7 The Trusts will remain as separate legal entities with their own accountabilities and responsibilities. The priorities for CMAST will be complementary to (and do not revise or replace) the existing statutory duties of the Trusts (such as the delivery of NHS Constitutional Standards or equivalent). For avoidance of doubt there is no intention that the governance structure outlined in this Agreement will lead to a statutory merger or acquisition under section 56 or section 56A of the National Health Service Act 2006 (as amended).

3 Rules of working

3.1 The Trusts have agreed to adopt this Agreement and agree to operate the CMAST CiCs as the **CMAST Leadership Board** in line with the terms of this Agreement, including the following rules (the "**Rules of Working**"):

3.1.1 Working together in good faith;

3.1.2 Putting patients interests first;

3.1.3 Having regard to staff and considering workforce in all that we do;

3.1.4 Consider the wider system impact and perspective and discuss proposals before any unilateral Trust action which may impact other Trusts;

3.1.5 Airing challenges to collective approach / direction within CMAST openly and proactively seeking solutions;

3.1.6 Support each other to deliver shared and system objectives;

3.1.7 Empower and expect our professional (executive) groups to think from a system perspective and to develop proposals with this in mind;

3.1.8 Recognising and respecting the collective view and keeping to any agreements made between the CMAST CiC's;

3.1.9 Maintain CMAST collective agreed position on shared decisions in all relevant communications;

3.1.10 Be accountable. Take on, manage and account to each other for performance of our respective roles and responsibilities; and

3.1.11 Appropriately engage with the ICB and with other partners on any material service change.

4 Process of working together

4.1 The CMAST CiCs shall meet together as the CMAST Leadership Board in accordance with and discuss the matters delegated to them in accordance with their Terms of References (attached here as Appendices 1-14).

4.1.1 Meetings of the CMAST Leadership Board will be categorised under three types of business, dependent on the agenda to be discussed and whether any formal decisions are required to be taken:

A. CMAST Leadership Board – Operational business - Informal CEO discussions and representing the standard regular meeting structure; [1]

B. CMAST Leadership Board – Decisions to be made under the CMAST CiC delegations - CiC CEOs;

C. CMAST Leadership Board –CiC CEOs and Chairs discussion (or NED designate)

4.2 The CMAST CiCs shall work collaboratively with each other as the CMAST Leadership Board in relation to the committees in common model.

4.3 Each CMAST CiC is a separate committee, with functions delegated to it from its respective Trust in accordance with its Terms of Reference and is responsible and accountable to its Trust. Acknowledging this and without fettering the decision-making power of any CMAST CiC or its duty to act in the best interests of its Trust, each CMAST CiC shall seek to reach agreement with the other CMAST CiCs in the CMAST Leadership Board and take decisions in consensus, in light of its aims and Rules of Working set out in clauses 2 and 3 above.

4.4 When the CMAST CiCs meet in common, as the CMAST Leadership Board, the Meeting Lead shall preside over and run the meeting. The intention is that the current lead arrangements for the Meeting Lead will continue until 1 April 2024 [and thereafter rotate between the Trusts on a biannual basis with each Meeting Lead remaining in place for a period of 24 months].

[1] Chairs will be invited to CMAST Leadership Board meetings, at least quarterly.

4.5 The Trusts agree that they will adopt a tiered approach to bringing decisions which come within the Terms of Reference to the CMAST Leadership Board which will reflect the principle of subsidiarity (that issues should be dealt with at the most immediate level that is consistent with their resolution**)** in the following approach:

Scale of involvement/impact	**Approach to decision**
Matter under discussion has no involvement or impact on other CMAST Trusts (e.g. local issue related to place)	Matter for the Trust involved and notified to the CMAST Leadership Board if appropriate.
Matter only involves or impacts a smaller group of CMAST Trusts and not all (e.g. specialised commissioning issue for specialist trusts)	The CMAST CiC's for the Trusts involved shall consider the required decision if it is within their delegation as set out in the Terms of Reference. Notify the CMAST Leadership Board.
Matter involves or impacts all CMAST Trusts and comes within the delegation under the CMAST CiCs (e.g. collaborative approach to non-clinical services or workforce)	Matter to be dealt with through the CMAST CiCs at the CMAST Leadership Board in accordance with this Agreement and the Terms of Reference.

4.6 Each CMAST Trust will report back to its own Board and the CMAST Leadership Board will be responsible for transparent information sharing in the form of common briefings and updates to each of the CMAST Trust Board meetings. The CMAST Trust chairs will (as well as their quarterly CMAST meetings - clause 4.1.1 above) meet regularly as a group to share information and for general discussions on CMAST on an informal basis. In addition, the CMAST Leadership Board will ensure that each CMAST programme should have a Chair sponsor appointed whose role will include updating the chairs meetings on the progress of the relevant programme.

4.7 When CMAST CiC meetings are intended to take decisions under the delegations made to those committees (in accordance with clause 4.1.1 B) then the meeting of CMAST (or if relevant, section of the meeting), will be held in public except where a resolution is agreed by the CMAST Leadership Board to exclude the public on the grounds that it is believed to not be in the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time. Papers and minutes of CMAST meetings held in public will be published.

5 Future Involvement and Addition of Parties

5.1 Subject to complying with all applicable law, and the Trusts' unanimous agreement, third parties may become parties to this Agreement on such terms as the Trusts shall unanimously agree.

5.2 Any Trust may propose to the other Trusts that a third party be added as a Party to this Agreement.

6 Exit Plan

6.1 Within three (3) months of the date of this Agreement the Trusts shall develop and agree an exit plan which shall deal with, for example, the impact on resourcing or financial consequences of:

6.1.1 termination of this Agreement;

6.1.2 a Trust exercising its rights under clause 7.1 below; or

6.1.3 the Meeting Lead and the CMAST CiC Chairs varying the Agreement under clause 10.6.2.

6.2 Once agreed by all of the Trusts, the exit plan shall be inserted into this Agreement at Appendix 15 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

7 Termination

7.1 If any Trust wishes to revoke the delegation of functions to the relevant CMAST CiC committee and exit this Agreement ("**Exiting Trust**"), then the Exiting Trust shall, prior to such revocation and exit:

7.1.1 send a written notice from the Chair of the Exiting Trust to the other Trusts' Chairs and the CMAST Leadership Board of their intention to do so; and

7.1.2 if required by any of the other Trusts (by sending a written notice within ten (10) business days of receipt of such notice) meet with the other Trusts' Chairs within ten (10) business days of the notice given under clause 7.1.1 to discuss the consequences of such revocation and exit.

7.2 If:

7.2.1 no other Trust sends a notice to the Exiting Trust within the time limit referred to in clause 7.1.2; or

7.2.2 following the meeting held under clause 7.1.2 the Exiting Trust still intends to exit the Agreement,

then the Exiting Trust may (subject to the terms of the exit plan at Appendix 15) exit this Agreement.

7.3 If following the steps and meeting (if any) pursuant to clause 7.1.2 above the Exiting Trust revokes its delegation to its CMAST CiC and exits this Agreement then the remaining Trusts shall meet and consider whether to:

7.3.1 Revoke their delegations and terminate this Agreement; or

7.3.2 Amend and replace this Agreement with a revised Agreement to be executed by the remaining Trusts and to make such revisions as may be appropriate in the circumstance.

8 Information Sharing and Competition Law

8.1 For the purposes of any applicable data protection legislation the Trusts shall be the data controller of any Personal Data (as defined in the UK General Data Protection Regulation (UK GDPR)) created in connection with the conduct or performance of the principles of this Agreement.

8.2 Where appropriate the CMAST Trusts agree to use all reasonable efforts to assist each other to comply with their respective responsibilities under any applicable data protection legislation. For the avoidance of doubt, this may include providing other Trusts with reasonable assistance in complying with subject access requests and consulting with other Trusts, as appropriate, prior to the disclosure of any Personal Data (as defined in the UK GDPR) created in connection with the conduct or performance of this Agreement in relation to such requests.

8.3 All Trusts will adhere to all applicable statutory requirements regarding data protection and confidentiality. The CMAST Trusts agree to co-operate with one another with respective statutory obligations under the Freedom of Information Act 2000 and Environmental Information Regulations 2004.

8.4 Subject to compliance with all applicable law (including without limitation competition law and obligations of confidentiality (contractual or otherwise)) the Trusts agree to share all information relevant to the operation of this Agreement in an honest, open and timely manner. The Trusts, shall not, (save as permitted by this Clause 8) either during or after the period of this Agreement divulge or permit to divulge to any person (including the other Trusts) any information acquired form other Trusts in connection with this Agreement which concerns:

8.4.1 any matter of commercial interest contained or referred to in this Agreement;

8.4.2 Trusts' manner of operations, staff or procedures;

8.4.3 the identity or address or medical condition or treatment of services received by any client or patient of any of the Trusts;

unless previously authorised by the Trusts concerned in writing, provided that these obligations will not extend to any information which is or shall become public information otherwise than by reason of a breach by a Trust of the provisions of this Agreement.

8.4.4 CMAST is committed to clear, consistent and transparent communication across the CMAST Trusts and with system partners' where appropriate. It is specifically recognised that CMAST Trusts are part of the ICS and members of Place Based Partnerships and will be working with their local partners and other collaboratives. Communication to and from Place Based Partnerships will be key for CMAST and the CMAST Trusts may be asked to represent both their own organisations and CMAST in such local place-based discussions.

8.5 For the avoidance of doubt, nothing in this Agreement shall be construed as preventing any rights or obligations that the Trusts may have under the Public Interest Disclosure Act (1998) and / or any obligations to raise concerns about any malpractice with regulatory or other appropriate statutory bodies pursuant to professional and ethical obligations including those obligations set out in the guidance issued by regulatory or other appropriate statutory bodies from time to time.

8.6 The Trusts acknowledge and agree that each may be required to disclose Confidential Information to others. For the purpose of this Agreement "Confidential Information" means all information provided in connection with this Agreement which is secret or otherwise not publicly available (in both cases in its entirely or in part) including commercial, financial, marketing or technical information, know-know or trade secrets, in all cases whether disclosed orally or in writing before or after the date of this Agreement.

8.7 The Trusts undertake for themselves and their respective Boards and employees that:

8.7.1 the disclosing Trust shall confirm whether information is to be regarded as confidential prior to its disclosure by clearly marking all such documents with 'Confidential';

8.7.2 they will use no lesser security measures and degree of care in relation to any Confidential Information received from the other Trusts than they apply to their own Confidential Information;

8.7.3 they will not disclose any Confidential Information of the other Trusts to any third party without the prior written consent of the disclosing Trust; and

8.7.4 on the termination of this Agreement, they will return any documents or other material in their possession that contains Confidential Information of the other Trusts.

8.8 The Trusts agree to provide in a timely manner and without restriction all information requested and required by the relevant designated CMAST Programme Support team (either internal team or external contractor where agreed) to carry out work including but not limited to relevant detailed financial, activity, workforce and estates related information pertaining to CMAST activities.

8.9 The Trusts will ensure they share information, and in particular Competition Sensitive Information, in such a way that is compliant with competition law to the extent applicable.

8.10 The Trusts will seek to agree a protocol to manage the sharing of information to facilitate the operation of CMAST across the Trusts as envisaged under this Agreement in accordance with competition law requirements, within three (3) months of the date of this Agreement. Once agreed by the Trusts (and their relevant information officers), this protocol shall be inserted into this Agreement at Appendix 16 and the Trusts shall review and, as appropriate, update the exit plan on each anniversary of the date of this Agreement.

9 Conflicts of Interest

9.1 Members of each of the CMAST CiCs shall make arrangements to manage any actual and potential conflicts of interest to ensure that decisions made by the CMAST Leadership Board will be taken and seen to be taken without being unduly influenced by external or private interest and do not, (and do not risk appearing to) affect the integrity of CMAST's decision-making processes.

9.2 The CMAST Leadership Board will agree policies and procedures for the identification and management of conflicts of interest which will be published on the CMAST website. It is proposed that

such policies will either be CMAST developed or CMAST will support the adoption and application of the policy of the CMAST Chair and/or Meeting Lead.

9.3 All CMAST Leadership Board, committee and sub-committee members, and employees acting on behalf of CMAST, will comply with the CMAST policy on conflicts of interest in line with their terms of office and/ or employment. This will include but not be limited to declaring all interests on a register that will be maintained by CMAST. Reuse / resubmission of host employer or home trust data, where applicable, will be supported

9.4 All delegation arrangements made by the Trusts will include a requirement for transparent identification and management of interests and any potential conflicts in accordance with suitable policies and procedures agreed by the CMAST Leadership Board.

9.5 Where an individual, including any individual directly involved with the business or decision-making of the CMAST Leadership Board and not otherwise covered by one of the categories above, has an interest, or becomes aware of an interest which could lead to a conflict of interests in the event of the CMAST Leadership Board considering an action or decision in relation to that interest, that must be considered as a potential conflict, and is subject to the provisions of this Agreement and any agreed CMAST Conflicts of interest Policy and Standards of Business Conduct Policy.

10 Dispute Resolution

10.1 The Trusts agree to adopt a systematic approach to problem resolution which recognises the Rules of Working set out in clause 3 above.

10.2 If a problem, issue, concern, or complaint comes to the attention of a Trust in relation to any matter in this Agreement, that Trust shall notify the other Trusts in writing and the Trusts each acknowledge and confirm that they shall then seek to resolve the issue by a process of discussion.

10.3 If any Trust considers an issue identified in accordance with clause 10.2 to amount to a Dispute requiring resolution and such issue has not been resolved under clause 10.2 within a reasonable period of time, the matter shall be escalated to the Meeting Lead who shall decide in conjunction with the CMAST CiCs at the CMAST Leadership Board the appropriate course of action to take.

10.4 If the Meeting Lead and the CMAST Leadership Board reach a decision that resolves, or otherwise concludes a Dispute, the Meeting Lead will advise the Trusts of the decision by written notice. Any decision of the Meeting Lead and the CMAST Leadership Board will be final and binding on the Trusts once it has been ratified by the Trusts' Boards (if applicable).

10.5 If the matter referred to in clause 10.3 above cannot be resolved by the Meeting Lead and the CMAST Leadership Board, within fifteen (15) Working Days, the Trusts agree that the Meeting Lead and the CMAST Leadership Board, may determine whatever action they believe necessary to resolve the Dispute which may include:

10.5.1 appointment of a panel of CMAST Leadership Board members who are not involved in the dispute to consider the issues and propose a resolution to the Dispute;

10.5.2 mediation arranged by C&M ICB for consideration and to propose a resolution to the Dispute; or

10.5.3 if considered appropriate selecting an independent facilitator and utilising the Centre for Effective Dispute Resolution (CEDR) Model Mediation Procedure. Unless otherwise agreed between the CMAST Trusts, the facilitator will be nominated by CEDR to assist with resolving the Dispute;

10.6 and who shall:

- be provided with any information they request about the Dispute;
- assist the Meeting Lead and CMAST Leadership Board to work towards a consensus decision in respect of the Dispute;

- regulate their procedure and, subject to the terms of this Agreement, the procedure of the Meeting Lead and CMAST Leadership Board at such discussions;
- determine the number of facilitated discussions, provided that there will be not less than three and not more than six facilitated discussions, which must take place within 20 Working Days of their appointment; and
- where appropriate have their costs and disbursements met by the Trusts in dispute equally.

10.7 If the independent facilitator proposed under clause 1.5 cannot resolve the Dispute, the Dispute must be considered afresh in accordance with this clause 10 and only if after such further consideration the Trusts again fail to resolve the Dispute, the Meeting Lead and CMAST Leadership Board may decide to recommend their Trust's Board of Directors to:

10.7.1 terminate the Agreement;

10.7.2 vary the Agreement (which may include re-drawing the member Trusts); or

10.7.3 agree that the Dispute need not be resolved.

11 Variation

No variation of this Agreement shall be effective unless it is in writing and signed by the Trusts (or their authorised representatives).

12 Counterparts

12.1 This Agreement may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Agreement, but all the counterparts shall together constitute the same agreement.

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

12.3 No counterpart shall be effective until each Trust has executed at least one counterpart.

13 Governing law and jurisdiction

This Agreement shall be governed by and construed in accordance with English law.

This Agreement is executed on the date stated above by

……
For and on behalf of **COUNTESS OF CHESTER HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL UNIVERSITY HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE CLATTERBRIDGE CANCER CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL HEART AND CHEST HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **THE WALTON CENTRE NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **LIVERPOOL WOMEN'S NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **ALDER HEY CHILDREN'S HOSPITAL NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **EAST CHESHIRE NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST**

This Agreement is executed on the date stated above by

……
For and on behalf of **MID CHESHIRE HOSPITALS NHS FT**

This Agreement is executed on the date stated above by

……
For and on behalf of **NORTH WEST AMBULANCE SERVICE NHS TRUST**

APPENDIX 1 – TERMS OF REFERENCE FOR THE COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Countess of Chester Hospital NHS Foundation Trust CiC]

APPENDIX 2 – TERMS OF REFERENCE FOR THE LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool University Hospitals NHS Foundation Trust CiC]

APPENDIX 3 – TERMS OF REFERENCE FOR THE SOUTHPORT AND ORMSKIRK HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Southport and Ormskirk Hospital NHS Foundation Trust CiC]

APPENDIX 4 – TERMS OF REFERENCE FOR WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for Warrington and Halton Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 5 – TERMS OF REFERENCE FOR THE WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Wirral University Teaching Hospital NHS Foundation Trust CiC]

APPENDIX 6 – TERMS OF REFERENCE FOR THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Clatterbridge Cancer Centre NHS Foundation Trust CiC]

APPENDIX 7 – TERMS OF REFERENCE FOR THE LIVERPOOL HEART AND CHEST HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Heart and Chest Hospitals NHS Foundation Trust CiC]

APPENDIX 8 – TERMS OF REFERENCE FOR THE WALTON CENTRE NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for The Walton Centre NHS Foundation Trust CiC]

APPENDIX 9 – TERMS OF REFERENCE FOR THE LIVERPOOL WOMEN'S NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Liverpool Women's NHS Foundation Trust CiC]

APPENDIX 10 – TERMS OF REFERENCE FOR THE ALDER HEY CHILDREN'T HOSPITAL NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the Alder Hey Children's Hospital NHS Foundation Trust CiC]

APPENDIX 11 – TERMS OF REFERENCE FOR THE EAST CHESHIRE NHS TRUST CIC

[Insert Terms of Reference for the East Cheshire NHS Trust CiC]

APPENDIX 12 – TERMS OF REFERENCE FOR THE ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS FOUNDATION TRUST CIC

[Insert Terms of Reference for the St Helens and Knowsley Teaching Hospitals NHS Foundation Trust CiC]

APPENDIX 13 – TERMS OF REFERENCE FOR THE MID CHESHIRE HOSPITALS NHS TRUST CIC

[Insert Terms of Reference for the Mid Cheshire Hospitals NHS Trust CiC]

APPENDIX 14 – TERMS OF REFERENCE FOR THE NORTH WEST AMBULANCE SERVICE NHS TRUST CIC

[Not applicable]

APPENDIX 15 - EXIT PLAN

1 In the event of termination of this Agreement by all parties, the Trusts agree that:

1.1 each Trust will be responsible for its own costs and expenses incurred because of the termination of the Agreement up to the date of termination UNLESS it is agreed between the Trusts that the costs and expenses are to be borne equally between the Trusts;

1.2 upon reasonable written notice, each Trust will be liable for one thirteenth of any professional advisers' fees incurred by and on behalf of CMAST in relation to the termination of this Agreement (if any) up to and including the date of termination of this Agreement;

1.3 each Trust will revoke its delegation to its CMAST Committee in Common (CiC) on termination of this Agreement;

1.4 termination of this Agreement shall not affect any rights, obligations or liabilities that the Trusts have accrued under this Agreement prior to the termination of this Agreement; and

1.5 there are no join assets and resources but should these be identified in the future, Trusts will need to confirm agreement at termination of this Agreement how any joint assets or resources will need to be dealt with on termination of the Agreement.

2 In the event of an Exiting Trust leaving this Agreement in accordance with clause 7, the Trusts agree that:

2.1 a minimum of six months' notice will be given by the Exiting Trust and they shall pay to the other Trusts all reasonable costs and expenses incurred by the other Trusts as a consequence of the Exiting Trust's exit from CMAST and this Agreement up to and including the Exiting Trust's date of exit from this Agreement. Notwithstanding this, the Exiting Trust's total aggregate liability, in respect of such reasonable costs and the expenses, shall be capped at the value of their annual contribution of resources that are agreed to remain for the financial year or term of any agreement being overseen by the CMAST CiC;

2.2 upon reasonable written notice from the other Trusts, the Exiting Trust shall be liable to pay [one thirteenth of] any professional advisers' fees incurrent by and on behalf of CMAST as a consequence of the Exiting Trust's exit from the Working Together Partnership and this Agreement up to and including the date of exit of the Exiting Trust from this Agreement;

2.3 the Exiting Trusts will revoke its delegation to its CMAST CiC on its exit from this Agreement;

2.4 the remaining Trusts shall use reasonable endeavours to procure that the Agreement is amended or replaced as appropriate in accordance with clause 7.3.2;

2.5 subject to any variation to or replacement of this Agreement in accordance with paragraph 2.4 above, and clause 7.3.2, this Agreement shall remain in full force and effect following the exit of the Exiting Trust from this Agreement

APPENDIX 16 - INFORMATION SHARING PROTOCOL

[to be inserted once agreed]

Appendix 2

V 5-2 September 2022

THE WALTON CENTRE NHS FOUNDATION TRUST

CMAST LEADERSHIP BOARD TERMS OF REFERENCE FOR A COMMITTEE OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER CMAST TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In these terms of reference, the following words bear the following meanings:

Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative or CMAST	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the NHS Cheshire & Merseyside Integrated Care System.
CMAST Agreement	the joint working agreement signed by each of the Trusts in relation to their provider collaborative working and the operation of the Walton Centre NHS Foundation Trust CiC together with the other CMAST CiCs;
CMAST CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**CMAST CiC**" shall be interpreted accordingly;
CMAST Programme Steering Group	the Group, to provide programme support and oversight of the delivery of agreed collaborative activities;
CMAST Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to CMAST;
CMAST Programme Support	Administrative infrastructure supporting CMAST;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.5 of these Terms of Reference, to preside over and run the CMAST CiC meetings when they meet in common;
Member	a person nominated as a member of an CMAST CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;
NHS Cheshire & Merseyside Integrated Care System or "C&M ICS"	the Integrated Care System (ICS) for Cheshire and Merseyside bringing together NHS organisations, councils, and wider partners in a defined geographical area to deliver more joined up care for the population.

The Walton Centre NHS Foundation Trust	The Walton Centre NHS Foundation Trust of Lower Lane, Liverpool, L9 7LJ;
The Walton Centre NHS Foundation Trust CiC	the committee established by Walton Centre NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other CMAST CiCs in accordance with these Terms of Reference;
Trusts	the Countess Of Chester Hospital NHS FT, Liverpool University Hospitals NHS FT, Southport And Ormskirk Hospital NHS Trust, Warrington And Halton Teaching Hospitals NHS FT, Wirral University Teaching Hospital NHS FT, The Clatterbridge Cancer Centre NHS FT, Liverpool Heart And Chest Hospital NHS FT, The Walton Centre NHS FT, Liverpool Women's NHS FT, Alder Hey Children's NHS FT, East Cheshire NHS Trust, St Helens And Knowsley Teaching Hospitals NHS Trust and Mid Cheshire Hospitals NHS FT and "**Trust**" shall be interpreted accordingly;
Working Day	a day other than a Saturday, Sunday or public holiday in England;

1.2 The Walton Centre NHS Foundation Trust is putting in place a governance structure, which will enable it to work together with the other Trusts in CMAST to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other CMAST CiCs, but which will each take its decisions independently on behalf of its own Trust. North West Ambulance Service NHS Trust is a participant in CMAST but is not forming its own CMAST CiC and will be in attendance at meetings of the CMAST CiC's but not a member Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each CMAST CiC will be different.

1.5 Each Trust has entered into the CMAST Agreement on **[DATE]** and agrees to operate its CMAST CiC in accordance with the CMAST Agreement.

2 Aims and Objectives of the Walton Centre NHS Foundation Trust CiC

2.1 The aims and objectives of the Walton Centre NHS Foundation Trust CiC are to work with the other CMAST CiCs on system work or matters of significance as delegated to the Walton Centre NHS Foundation Trust CiC under Appendix A to these Terms of Reference to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of CMAST and its workstreams;

2.1.2 set the strategic goals for CMAST, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Clinical Networks or other collaborative forums, by working in partnership with the ICB, have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Professional (reference) Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the NHS Cheshire and Merseyside Integrated Care Board;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts of CMAST;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the CMAST Agreement and Terms of Reference for CMAST CiCs on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The Walton Centre NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the Walton

Centre NHS Foundation Trust CiC. These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Walton Centre NHS Foundation Trust CiC.

3.2 The Walton Centre NHS Foundation Trust CiC shall work cooperatively with the other CMAST CiCs and in accordance with the terms of the CMAST Agreement.

3.3 The Walton Centre NHS Foundation Trust CiC is a committee of Walton Centre NHS Foundation Trust's board of directors and therefore can only make decisions binding the Walton Centre NHS Foundation Trust. None of the Trusts other than the Walton Centre NHS Foundation Trust can be bound by a decision taken by the Walton Centre NHS Foundation Trust CiC.

3.4 The Walton Centre NHS Foundation Trust CiC will form part of a governance structure to support collaborative leadership and relationships with system partners and follow good governance in decision making (as set out in the updated Code of Governance for NHS Provider Trusts). The Walton Centre NHS Foundation Trust CiC will have regard in their decision-making to the triple aim duty of better health and wellbeing for everyone, better quality of health services for all individuals and sustainable use of NHS resources.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in the Walton Centre NHS Foundation Trust's Constitution.

4.2 The Walton Centre NHS Foundation Trust CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the Walton Centre NHS Foundation Trust CiC in paragraph 4 of these Terms of Reference shall be retained by the Walton Centre NHS Foundation Trust's Board or Council of Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of the Walton Centre NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the Walton Centre NHS Foundation Trust CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to the Walton Centre NHS Foundation Trust's Board for inclusion on the private agenda of the Walton Centre NHS Foundation Trust's next Board meeting in order that the Walton Centre NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The Walton Centre NHS Foundation Trust CiC shall send the minutes of the Walton Centre NHS Foundation Trust CiC meetings to the Walton Centre NHS Foundation Trust's Board, on a monthly basis, for inclusion on the agenda of the Walton Centre NHS Foundation Trust's Board meeting.

6.3 The Walton Centre NHS Foundation Trust CiC shall provide such reports and communications briefings as requested by the Walton Centre NHS Foundation Trust's Board for inclusion on the agenda of the Walton Centre NHS Foundation Trust's Board meeting.

7 Membership

7.1 The Walton Centre NHS Foundation Trust CiC shall be constituted of directors of NHS Foundation Trust. Namely the Walton Centre NHS Foundation Trust's Chief Executive who shall be referred to as a "Member".

7.2 Each Walton Centre NHS Foundation Trust CiC Member shall nominate a deputy to attend the Walton Centre NHS Foundation Trust CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for the Walton Centre NHS Foundation Trust's Chief Executive shall be an Executive Director of the Walton Centre NHS Foundation Trust.

7.4 In the absence of the Walton Centre NHS Foundation Trust CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 Attend the Walton Centre NHS Foundation Trust CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of the Walton Centre NHS Foundation Trust CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending the Walton Centre NHS Foundation Trust CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 When the CMAST CiCs meet in common, one person nominated from the Members of the CMAST CiCs shall be designated the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other CMAST CiCs and the chief executive (or designated deputy) of the North West Ambulance Service NHS Trust shall have the right to attend the meetings of the Walton Centre NHS Foundation Trust CiC. The Walton Centre NHS Foundation Trust's Chair shall be invited to meetings of the CMAST CiCs on at least a quarterly basis (or where the CiC feels it is appropriate – as set out in the CMAST Agreement under clause 4) as a non-voting attendee.

8.2 The Meeting Lead's Trust Corporate Secretary shall have the right to attend the meetings of the Walton Centre NHS Foundation Trust CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the CMAST CiCs.

8.3 The CMAST Programme Lead shall have the right to attend the meetings of the Walton Centre NHS Foundation Trust CiC.

8.4 Without prejudice to paragraphs 8.1 to 8.3**Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the CMAST CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the CMAST CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of the Walton Centre NHS Foundation Trust CiC.

9 Meetings

9.1 Subject to paragraph 9.3 below, the Walton Centre NHS Foundation Trust CiC meetings shall take place monthly.

9.2 The Walton Centre NHS Foundation Trust CiC shall meet with the other CMAST CiCs as the CMAST Leadership Board in accordance with the CMAST Agreement (as set out in clause 4 of the CMAST Agreement) and discuss the matters delegated to them in accordance with their respective Terms of References.

9.3 Any Trust CiC Member may request an extraordinary meeting of the CMAST CiCs (working in common) on the basis of urgency etc. by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the CMAST Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.4 Meetings of the Walton Centre NHS Foundation Trust CiC shall generally be held in public save where items are agreed to be private and confidential and otherwise in accordance with clause 4.6 of the CMAST Agreement.

9.5 Matters not discussed in public in accordance with paragraph 9.4 above and dealt with at the meetings of the Walton Centre NHS Foundation Trust CiC shall be confidential to the Walton Centre NHS Foundation Trust CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of the Walton Centre NHS Foundation Trust's Board.

10 Quorum and Voting

10.1 Members of the Walton Centre NHS Foundation Trust CiC have a responsibility for the operation of the Walton Centre NHS Foundation Trust CiC. They will participate in

discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the Walton Centre NHS Foundation Trust CiC shall have one vote. The Walton Centre NHS Foundation Trust CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be one (1) Member.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the Walton Centre NHS Foundation Trust CiC shall comply with the provisions on conflicts of interest contained in the Walton Centre NHS Foundation Trust Constitution/Standing Orders, the CMAST Agreement and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in the Walton Centre NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the Walton Centre NHS Foundation Trust CiC.

11.2 All Members of the Walton Centre NHS Foundation Trust CiC shall declare any new interest at the beginning of any Walton Centre NHS Foundation Trust CiC meeting and at any point during a Walton Centre NHS Foundation Trust CiC meeting if relevant.

12 Attendance at meetings

12.1 The Walton Centre NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, the Walton Centre NHS Foundation Trust CiC Members (or their Nominated Deputy) shall attend the Walton Centre NHS Foundation Trust CiC meetings (in person) and fully participate in all the Walton Centre NHS Foundation Trust CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the Walton Centre NHS Foundation Trust CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the Walton Centre NHS Foundation Trust CiC will be provided by CMAST Programme Support (or such other route as the Trusts may agree in writing). The CMAST Programme Support will:

13.1.1 draw up an annual schedule of CMAST CiC meeting dates and circulate it to the CMAST CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to CMAST CiC meetings; and

13.1.3 take minutes of each Walton Centre NHS Foundation Trust CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant Walton Centre NHS Foundation Trust CiC meeting.

13.2 The agenda for the Walton Centre NHS Foundation Trust CiC meetings shall be determined by the CMAST Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the CMAST Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE WALTON CENTRE NHS FOUNDATION TRUST CIC

The Board of each Trust within CMAST remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to the Walton Centre NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the Walton Centre NHS Foundation Trust CiC to decide are set out in the table below.

If it is intended that the CMAST CiCs are to discuss a proposal or matter which is outside the decisions delegated to the Walton Centre NHS Foundation Trust CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the Walton Centre NHS Foundation Trust CiC meeting with a view to the Walton Centre NHS Foundation Trust CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by the Walton Centre NHS Foundation Trust's Board). Any proposals discussed at the Walton Centre NHS Foundation Trust CiC meeting outside of these parameters would come back before the Walton Centre NHS Foundation Trust's Board.

References in the table below to the "Services" refer to the services that form part of the CMAST Agreement for joint working between the Trusts (as set out in Clause 2.6 of the CMAST Agreement and which may be supplemented or further defined by an annual CMAST Work Programme) and may include both back office and clinical services.

	Decisions delegated to the Walton Centre NHS Foundation Trust CiC
1.	Providing overall strategic oversight and direction to the development of the CMAST programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the key Rules of Working;
3.	Seeking to determine or resolve any matter within the remit of the Walton Centre NHS Foundation Trust CiC referred to it by the CMAST Programme Steering Group or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the benefits and risks associated in terms of the impact to CMAST Programmes and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of CMAST Programmes;

	Decisions delegated to the Walton Centre NHS Foundation Trust CiC
6.	In relation to services preparing business cases to support or describe delivery of agreed CMAST priorities or programmes (including as required by any agreed CMAST annual work programme);
7.	Provision of staffing and support and sharing of staffing information in relation to Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises;

	Decisions delegated to the Walton Centre NHS Foundation Trust CiC
	f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;
12.	Reviewing the Terms of Reference and CMAST Joint Working Agreement on an annual basis.

APPROVED BY THE BOARD OF DIRECTORS: [DATE] 2022

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 14/09/22		**Report of:** Research, Innovation and Medical Education Committee
Date of last meeting: 07/09/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Effectiveness Review of RIME Committee Report • Board Assurance Framework – Q2 2022/23 • Strategic Partnerships Update • Government Motor Neurone Disease Research Fund Update Report • GMC National Training Survey 2022 Report • Research and Development Finance and Performance Report • Subgroup Chair's Reports for two subgroup meetings
2.	**Alert**	**Research and Development Finance and Performance Report** Committee was updated on the Trust's Research and Development funding position for the income, planned and actual expenditure and variance as of month 4 of the 2022/23 financial year. Overall, there was £100k deficit with an annual forecast of £300k deficit by the end of the financial year. Year-to-date, 146 patients had been recruited the majority of which were attributed to the TONiC studies. It was proposed for Finance and the Neuroscience Research Centre to develop a realistic model for a financial recovery plan. Discussions had been held with regard to this but there was also a need to have a clearer understanding of the money that the Trust was able to recover as well as generate. Committee was informed that there were current limitations due to the existing nursing staff within the Neuroscience Research Centre being funded by the Clinical Research Network (CRN) and therefore only able to work on portfolio research. However, there was funding identified within the research budget for a Band 6 nursing post which would be able to focus on commercial/non-portfolio studies. There was also recognition that there was further work required to ensure that the centre was in a position to be able to deliver on commercial contracts e.g. governance and quality assurance, as this would otherwise pose a significant reputational risk to the organisation. The work would be led by the Head of Neuroscience Research Centre and the Research Delivery and Quality Manager. A full review of the research portfolio was also in the process of being undertaken.

3.	**Assurance**	**RIME Committee Membership** Ms Gemma Nanson was welcomed to the Committee. Ms Nanson had recently been appointed as the Head of the Neuroscience Research Centre and was a fantastic asset to the service. She had previously worked for the CRN. **Effectiveness Review of RIME Committee Report** Following the completion of phase one of the review which focused on the subgroup structure of the RIME Committee, a second phase was undertaken to review the Committee's terms of reference, membership and cycle of business. The outcome of the review was to maintain the purpose of the RIME Committee which was to provide the Board of Directors assurance and oversight of the research, medical education and innovation agendas with a more strategic as opposed to operational focus. This was reflected in the revised cycle of business and terms of reference. It was noted that no amendments had been made to the duties of the Committee however, changes had been proposed to the membership to enable the duties to be undertaken more effectively. It was also proposed that with the Committee's function being more streamlined and strategically focused, the frequency of Committee meetings be reduced from bi-monthly to quarterly. The timing of the meeting was also under review in line with the revised membership. It was noted that any current members of the Committee that it was proposed would not be included in the revised membership would be included in one of the Committee's subgroups (Medical Education Group, Research Governance Group and Innovation Group) as appropriate. There was agreement for any research clinicians who had previously been a Committee member but had not been included within the revised membership, to automatically be included in the Research Governance Group whilst the renewed terms of reference were being agreed. This was in line with the effectiveness review implementation completion date of March 2023. **Board Assurance Framework – Q2 2022/23** The Q2 Board Assurance Framework (BAF) report for the three strategic risks that are assigned to the Committee (Medical Education Strategy - 008, Research and Development - 009 and Innovative Culture - 010) was reviewed. It was noted that a number of actions had been identified for each of the risks to address the gaps in controls or assurance. In line with the new strategic ambitions outlined in the new Trust strategy, there was a variation in the risk appetite assigned to each of the risks e.g. Medical Education and Research and Development were noted as 'open' but Innovation Culture was 'adventurous'. Work continued to progress to link operational risks that aligned to the strategic risks with the work to be completed by Q3. The Committee approved the report and the three strategic risks in alignment with the new Trust strategic ambitions.
4.	**Advise**	**GMC National Training Survey 2022 Report**

		The annual GMC National Training Survey collects feedback from doctors in training as well as consultants within their trainer roles. It is a comprehensive assessment and provides a high-level evaluation of experiences. There had been a high response rate to this year's survey with almost all trainees and 59% of trainers responding. Key areas of note were: • Overall, no areas of concern had been highlighted by the trainees • Fewer positive outcomes for higher training this year which was attributed to the significant changes for the Neurology trainees as a result of the 24/7 thrombectomy service. Given the context, the Neurology Educational Leads had accepted the results from the Neurology registrar survey as a relatively positive outcome • One negative outlier for radiology teaching which was due to the availability of the regional teaching provision to attend • Year-on-year feedback had improved from the core surgery trainees which was largely attributed to Mr Carleton-Bland as the Surgical College Tutor. Mr Carleton-Bland had since step down from the post and Mr Olubajo had been appointed as his successor. To have received satisfaction feedback from this cohort was noted as a remarkable achievement as had historically been an area of difficulty and all who were involved were congratulated • Areas of focus for the coming year were induction and additional support for educational trainers which would be provided through the recent appointments to the Medical Education Faculty of; Deputy Director of Medical Education - Mr Carleton-Bland, Appraisal Lead - Dr Pomeroy, and Project Lead to improve the use of MTI international medical trainees' initiative – Dr Mahalingam. There had been engagement in the programme from the Trust in the areas of neuro-anaesthesia and critical care but looking to expand on this. **National Student Feedback Survey Summary - Local Trusts' Report** The Trust had been referenced in this year's National Student Feedback Survey summary of local trusts with one of the students commenting that their Neuro teaching was of particular high standard and was the best rotation that they had. This was illustrative of the education provision and encouragement received from neuroscience clinicians from the Trust. It was noted that The Walton Centre was the only trust that had been specifically referenced.		
5.	**Risks Identified**	• No new risks identified		
6.	**Report Compiled by**	Professor Paul May, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors
6 October 2022

Report Title	Research, Innovation and Medical Education (RIME) Committee Effectiveness Review and Terms of Reference
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To decide

Level of Assurance Provided

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

Key Messages

- Proposed changed of Terms of Reference incorporating refreshed membership, meeting timings and cycle of business following working group review of Committee

Next Steps

- Implement the changes to RIME with immediate effect and set up a new meeting schedule
- Review in six months as part of the annual committee effectiveness cycle

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

Strategic Risks

009 Research & Development Ambition	010 Innovative Culture	008 Medical Education Strategy

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
RIME	6 July 2022	K Dowson, Corporate Secretary	Review of subgroups (Phase 1) agreed.
RIME Working Group	25 August 2022	K Dowson, Corporate Secretary	Development of proposal for changes to RIME Terms of Reference
RIME	7 September 2022	K Dowson, Corporate Secretary	Recommendations of working group accepted and Terms of Reference agreed

Terms of Reference - RIME Committee

Executive Summary

1. The Terms of Reference (ToR) for the Research, Innovation and Medical Education (RIME) Committee have been reviewed as part of the working group review of RIME which took place between May and September 2022. The new ToR do not change the focus and duties of the Committee significantly, but there are proposed changes to the membership and cycle of business that have been agreed by RIME and need to be approved by the Board.

Background and Purpose of Review

2. Following the annual effectiveness review of RIME and critical feedback of the operation and impact of the Committee in May 2022 it was agreed that a full review of the Committee's effectiveness would be undertaken.

3. A working group was established consisting of:
    - Rhys Davies, Clinical Director of Research, Innovation Medical Education
    - Katharine Dowson, Company Secretary
    - Mike Gibney, Chief People Officer
    - Andy Nicolson, Medical Director (lead executive for RIME)
    - Rachel Saunderson, Innovation Coordinator

4. The working group agreed the following areas required review:
    - Membership (currently 26 members)
        - Clinical
        - External
        - Board Members
        - Neuroscience Research Centre (NRC) Staff
    - Purpose of Committee
    - Governance/ Reporting Structure (Phase 1)
        - Division of responsibilities across these
        - Reviewing ToR of groups to bring less operational items to RIME
        - Role of subgroup chairs in bringing assurance to RIME
    - Meeting Structure:
        - Agenda setting – too many verbal items for information sharing – not decision-making
        - Balance of agenda
        - Timing of Meeting
        - Virtual/ Face to Face
    - Timing of committee reporting to Board/ BAF etc

5. Particular areas to be built on were identified:
    - Partnership involvement - updates from external stakeholders were of value
    - Bringing Medical Education, Research and Innovation together in one forum has been of benefit and should be maintained.
    - Maintaining clinical engagement
    - Avoiding duplication of membership, business and papers between subgroups and RIME

Approach

6. A two-stage approach was agreed with initial (Phase 1) focus on the subgroups of RIME, in order to ensure that the subgroups could manage operational issues, with RIME refocused on strategic issues and direction. The phase 1 changes to subgroups names, cycle of business, membership and focus was agreed at RIME in July 2022 and initiated at the subgroups from September meetings.

7. In September RIME agreed to the second phase which was to the membership and cycle of business of RIME and confirmation of a new ToR.

RIME Terms of Reference (ToR)

1. The draft ToR are attached at Appendix 1. No changes have been proposed to the purpose or duties of RIME through the review. The changes now proposed will allow RIME to focus on these key duties more effectively.

2. There had been significant duplication of membership across RIME and the subgroups which was not an effective use of staff/ clinician's time and created duplication of discussions across two meetings. As the subgroups are where 'business is done', this is where clinical input is considered to of greatest value. Assurance of subgroup business will now be provided to RIME through the attendance of the Chair of each subgroup who will remain a non-voting member of the Committee. A Chair's report from each subgroup will provide assurance about the business being discussed at the subgroups.

3. This enables the formal membership of RIME to be streamlined to just the Board Members (RIME is a Board Committee and powers can only be delegated to Committee's that are exclusively composed of Board Members). However, the benefits of partner engagement are recognised and it is proposed that representatives of strategic external partners remain as non-voting members. Some existing clinical members will therefore still attend but as representatives of strategic partners.

4. The quorum of members has been changed from three members to two to match the other Board Committees and the format of the ToR has been refreshed to bring it into line with other Board committees. As the Chief People Officer is now a fully voting member of the Board they have taken on the Executive Lead role for RIME and therefore it was agreed at RIME in May that the Chief Nurse was no longer required to be a member. This is in line with other Board Committees where there are two Executive members and two Non-Executive members. The Medical Director remains a member of the Committee.

5. A number of key staff will be expected to attend on a regular basis to deliver reports. These are:
    - Medical Education Manager
    - Research and Development Manager
    - Innovation Coordinator
    - Research, Development & Innovation Management Accountant
    - Corporate Secretary

6. In addition, at the RIME meeting in September the following were added to the staff expected to attend on a regular basis. These are highlighted in purple in paragraph 9 and are:
    - Head of Neuroscience Research Centre

- Head of SPARK (Single Point of Access to Research and Knowledge) for Liverpool Health Partners
- Neuroscience Programme Manager for Liverpool Health Partners.

7. Other staff would be invited to attend for the presentation of papers to the Committee as and when required.

8. It is now proposed that RIME should meet quarterly rather than six times per year. This will enable progress to be shown against the substrategies and keep the focus on strategic issues. If required, an extra ordinary meeting can be called. Meeting timings are under review to ensure that RIME can report into the Board appropriately through the Chair's assurance report. The next meeting of RIME is anticipated to be in December 2022.

Next Steps

9. If agreed, it is proposed to review the arrangements at the end of the year (March 2023) to ensure that the changes made have had a positive impact and review whether further changes are required.

Recommendation

To approve the ToR for RIME incorporating a streamlined membership, quoracy and schedule of meetings

Author: K Dowson
Date: September 2022

Appendix 1 – Revised ToR for RIME

Appendix 1

RESEARCH, INNOVATION AND MEDICAL EDUCATION (RIME) COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

10. The Research, Innovation and Medical Education (RIME) (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

11. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

12. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

13. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

14. The Committee is authorised to create operational sub-groups, forum, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

15. The purpose of the Committee is to provide the Board of Directors with assurance that the Trust has a strategic direction and there is a comprehensive and integrated approach to research, innovation and medical education. Also, that risks to patient safety and the Trust's reputation have been identified and mitigated.

Membership

16. The Committee shall be comprised of the following voting members:
    - Two Non-Executive Directors, one of whom will be the Committee Chair
    - Medical Director
    - ~~Chief Nurse~~
    - Chief People Officer

17. The following are required to attend in a non-voting capacity:

- ~~Director of Workforce and Innovation~~
- Clinical Director for Research, Medical Education and Innovation
- Chair of Innovation Group
- ~~Public Governor~~
- ~~Head of Commercial Engagement and Marketing~~
- ~~Consultant Neurosurgeon x2~~
- ~~Consultant Neurologist x2~~
- ~~Consultant in Pain Medicine~~
- ~~Consultant Neuropsychologist~~
- ~~Consultant Neuroradiologist~~
- ~~Radiology Directorate Manager/AHP Lead~~
- ~~Clinical Lead for Neurorehabilitation~~
- ~~Allied Health Professional (AHP)~~
- University of Liverpool Representative (Research)
- Clinical Research Network NWC Representative
- ~~Internal Clinical Research Network NWC Lead for Neurosurgery~~
- ~~Internal Clinical Research Network NWC Lead for Neurology~~
- ~~Liverpool Health Partners Representative~~
- Applied Research Collaborative NWC Representative
- ~~Research Doctor~~
- ~~Lead Research Nurse~~
- ~~Research Management and Governance Lead~~
- ~~Research Lead for Pain Management Programme~~

18. The following will attend as required by the meeting agenda:
    - Innovation Coordinator
    - Medical Education Manager
    - Research and Development Manager
    - Research, Development & Innovation Management Accountant
    - Corporate Secretary
    - Head of Neuroscience Research Centre
    - Head of SPARK (Single Point of Access to Research and Knowledge) for Liverpool Health Partners
    - Neuroscience Programme Manager for Liverpool Health Partners.

19. The Committee will be deemed quorate when two voting members are present, including at least one Executive and one Non-Executive Director.

20. In the event that the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

21. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

22. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

23. An open invitation exists for all members of the Board of Directors to attend the Committee.

Requirements of Membership

24. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

25. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

26. In order to fulfil its role and obtain the necessary assurance, the Committee will:
    - Inform the development and provide assurance against the following strategies, associated policies, sub-strategies, implementation plans and annual reports:
        - People Substrategy (Innovation and Medical Education elements)
        - Research and Development Substrategy

27. Ensure that governance and assurance systems operate effectively and underpin programme delivery to include the areas associated with the above strategies and annual reports.

28. Identify and support the synergies between innovation, research partnerships and medical education to ensure they are strategically aligned and sustainable

29. The Committee's general duties in the above areas will be to:

    - Provide assurance to the Board on compliance with associated legislation, national reporting and regulatory requirements and best practice

    - Monitor the efficient and safe delivery of work and projects to meet national and Trust objectives and seek assurance on the quality of research and innovation projects and the medical educational provision in order to enhance the reputation of the Trust as a centre of excellence

    - Consider emerging national and international initiatives that may provide opportunities for research or innovative working

    - Consider and review relevant metrics, support the development of appropriate performance measures such as key performance indicators (KPIs), and

associated analysis, reporting and escalation frameworks to inform the organisation to support continual improvement

- Oversee the delivery of any corrective action plans in areas where acceptable assurance is not yet in place

- To review and ratify all sponsorship decisions made by the Research Governance Group including:
  - Sponsorship for non-interventional studies
  - Clinical Trials of Investigational Medical Product (CTIMP) studies
  - Withdrawals of sponsorship or studies that have been rejected

- To monitor research and innovation finances including grant income

- Facilitate collaborative partnerships and receive presentations and reports from partners including Liverpool Health Partners (LHP), Innovation Agency North West Coast, Applied Research Collaborative (ARC) North West Coast, Clinical Research Network: North West Coast and University of Liverpool (Research and Medical Education).

30. The Committee will also keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed

Data Privacy

31. The Committee is committed to protecting and respecting data privacy. The RIME Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

32. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

33. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

34. Reports including regular assurance reports will be received from the following sub-groups which have been established by the Committee to support it in fulfilling its

duties. The Committee will approve the terms of reference for each of these groups during the year:

- Medical Education Group
- Innovation Group
- Research Governance Group
- ~~Medical Innovation Group~~
- Research Capability Fund Panel
- ~~Sponsorship and Governance Oversight Committee~~
- ~~Workforce Innovation Group~~

Administration of Meetings

35. Meetings shall be held quarterly ~~every other month~~ with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of four ~~six~~ meetings per year.

36. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

37. Agendas and papers will be circulated at least four working days in advance of the meeting.

38. Minutes will be circulated to members for comment as soon as is reasonably practicable.

39. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

40. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

41. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved by Board of Directors: October 2022
Review Date: March 2023

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 06/10/22		**Report of:** Remuneration Committee (RemCom)		
Date of last meeting: 01/09/22		**Membership Numbers:** Quorate		
1	**Agenda**	The Committee considered an agenda which included the following: • Annual Appraisal of Effectiveness • Terms of Reference • Pension Contribution alternative Reward Scheme Policy (Pension Recycling Policy)		
2	**Alert**	• None		
3	**Assurance**	• Annual review was positive with improvements in year noted • Terms of Reference have been refreshed with minor changes ready for Board approval • Pension Contribution Alternative Reward Scheme Policy approved by Committee		
4.	**Advise**	• Achievements in year highlighted included adoption of a Very Senior Manager (VSM) pay policy following external pay review and establishment of a set cycle of appraisal and remuneration review for VSM		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	Max Steinberg, Chair	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Trust Board
6 October 2022

Report Title	Remuneration Committee Terms of Reference
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- Terms of Reference (ToR) have been refreshed with minimal changes

Next Steps

N/A

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

Strategic Risks

Not Applicable	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Remuneration Committee	1 September 2022	Katharine Dowson, Corporate Secretary	Draft ToR agreed by Committee

Terms of Reference (ToR) Remuneration Committee

Background and Analysis

1. A review of the ToR has taken place at Remuneration Committee and has been agreed. There have been no significant changes made.

2. The format has been refreshed in line with other Board Committees.

3. The duties of the Committee have been refreshed to reflect the discussions held at Remuneration Committee throughout the year regarding the Committee's role in Executive Director nominations and recruitment. Some of the specific responsibilities regarding identifying candidates for Executive Director roles (not including the Chief Executive) have been removed in agreement with the Committee as these are the responsibility of the Chief Executive. This followed a review of Executive Director appointments in May.

4. The Committee still retains the responsibility for agreed a job description, remuneration package and making the final appointed for any Executive Director appointments.

5. Quoracy of the Committee has been kept at four, which is higher than other Board Committees, given the sensitive and significant nature of some of the decisions to be made.

Conclusion

6. The ToR have been updated to ensure they remain fit for purpose and reflect the requirements for the Committee as set out in the Trust Constitution.

Recommendation

To approve

Author: Katharine Dowson
Date: 2 September 2022

Appendix 1 – Terms of Reference

Appendix 1

REMUNERATION COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Remuneration Committee (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust.

2. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Committee has the authority to oversee and take decisions relating to the organisation's activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group. Any of these groups will report directly to the Committee who will oversee their work.

Purpose

6. The purpose of the Committee is to provide the Board of Directors with assurance that the appointment and remuneration of Executive Directors is conducted in line with statutory and regulatory requirements in order to make the most appropriate appointments to the senior leadership of the Trust. The Committee will determine the approach to be taken to appoint Executive Directors and approve any such appointments, taking into account the skills gaps within the Board of Directors. The Committee will also have oversight of any policies or processes that impact on the terms and conditions of remuneration of Very Senior Managers (VSM) who are not subject to agenda for changes terms and conditions.

Membership

7. The Committee shall be comprised of the following voting members:
   - Trust Chair
   - All other Non-Executive Directors

8. The Corporate Secretary, Chief Executive and Chief People Office may be required to attend regularly, according to the agenda.

9. The Committee will be deemed quorate when four members are present.

10. In the event that the Chair of the Committee is unable to attend a meeting, the Deputy Chair shall be the Chair for that meeting. In their absence the members shall appoint one of their number to be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

11. There is no provision for deputies to represent members at meetings of the Committee.

12. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

Requirements of Membership

13. Members should attend at least 75% of all meetings each financial year and should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

14. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

15. Review the leadership needs of the Trust at Executive Director level, to ensure the continued ability of the Trust to operate effectively in the local and regional health economy, taking into consideration the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board of Directors. To include using outputs from any Board evaluation process as appropriate and make recommendations to the Board of Directors with regard to any changes.

16. Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed on the Board in the future.

17. Oversee the appointment process for Executive Directors by approving the appointment process, agreeing the job description and skills mix required by the Board of Directors, and agreeing the advertised remuneration package. Making the final approval decision on appointment (excluding Chief Executive).

18. Ensure that proposed candidates are a 'fit and proper person' in accordance with the Trust's Fit and Proper Persons Policy and that any significant commitments are considered before appointment.

19. Establish and keep under review a remuneration policy in respect of VSM.

20. Consult the Chief Executive about proposals relating to the remuneration of VSM.

21. In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of VSM including:
    - salary, including any performance-related pay or bonus or earn-back arrangements (none currently in place)
    - provisions for other benefits, including pensions and cars
    - allowances
    - payable expenses
    - compensation payments

22. Establish levels of remuneration which are sufficient to attract, retain and motivate high-quality Executive Directors with the skills and experience required to lead the Trust successfully, without paying more than is necessary for this purpose, and at a level which is affordable for the Trust.

23. Use national guidance and market benchmarking analysis in the review of Executive Director remuneration (and any senior managers on locally-determined pay), whilst ensuring that increases are not applied where either Trust or individual performance do not justify them, and be sensitive to pay and employment conditions elsewhere in the Trust.

24. Review and assess the output of evaluation of the performance of individual Executive Directors and consider this output when reviewing remuneration levels.

25. Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments, to avoid rewarding poor performance.

26. Consider and approve matters regarding extraordinary and additional payments to staff employed by the Trust in relation to Mutually Agreed Resignation Schemes and/or Voluntary/Compulsory Redundancy programmes.

Data Privacy

27. The Committee is committed to protecting and respecting data privacy. The Quality Committee will have regard to the EU General Data Protection Regulation (Regulation (EU) 2016/679) (GDPR) and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 1998 (DPA).

Equality, Diversity & Inclusion

28. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service users, including those who have protected characteristics and vulnerable members of our community.

Reporting

29. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

Administration of Meetings

30. Meetings shall be held as required with a minimum of one per year, with additional meetings held as required at the request of the Chair or any three voting members of the Committee.

31. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include, agenda setting, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

32. Agendas and papers will be circulated at least four working days in advance of the meeting.

33. Minutes will be circulated to members for comment as soon as is reasonably practicable.

Review

34. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

35. The Committee will undertake an annual review of its performance against its work plan and the Trust's Annual Plan in order to evaluate the achievement of its duties.

Approved: October 2022
Review Date: October 2023

The Walton Centre NHS Foundation Trust

Report to Trust Board
6th October 2022

Report Title	Health Education England 2022 WCFT Self-Assessment of Education & Training Report
Executive Lead	Mike Gibney, Chief People Officer Lisa Salter, Chief Nurse
Author (s)	Liz Doherty, Medical Education Development Manager Paula Price, Practice Education Facilitator Zoe Kershaw, Senior Education Manager
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- Trust self-evaluation of multi-professional education and training against Health Education England (HEE) Quality Standards
- Areas of achievement are the investment in simulation – NeuroVR simulator - and development of interprofessional learning programmes.
- Areas of challenge are managing the demands of external strategic change at a local level i.e. the implementation of national NHS workforce strategy, e.g. The People Plan, and the filtering down of national training programme reviews e.g. Royal College of Physicians Shape of Training.

Next Steps

- Following Board approval, to be submitted to HEE on 14.10.2022

Related Trust Strategic Ambitions and Themes	**Impact**		
Education, Teaching & Learning	Workforce	Compliance	Finance

Strategic Risks		
008 Medical Education Strategy	Not Applicable	Not Applicable

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

CONSENT AGENDA - HEE EducationTraining Self Assessment Report

Health Education England
2022 WCFT Self Assessment of Education & Training Report

Executive Summary

1. The HEE Self-Assessment Report (Appendix 1) is an evaluation of multi-professional education and training provided by the Trust as a health education placement provider.

2. The report asks for examples of achievement and of challenge. It is then sectioned into the domains of the HEE Quality Framework, against which the Trust has completed the self-assessment.

3. Areas of achievement include the investment in simulation and the opportunities this presents in terms of growing the educational offer in Neuroscience training. Areas of challenge identified arise from the impact an evolving, changing workforce might have upon the maintenance of a high quality learning environment.

Background and Analysis

4. All healthcare learners are considered in this evaluation. Medical education and nursing education information was readily available due to there being dedicated leads appointed to manage the learner groups (i.e. Medical Education Development Manager and Practice Education Facilitator). The PEF coordinated input from the leads of other learner groups (AHPs), which highlighted that information gathering from the various disciplines could be more streamlined.

5. The Trust meets all the standards of the framework however some areas are less strong i.e. the evidence available to draw upon was not as defined. This was particularly true with how the Trust uses differential attainment and Equality, Diversity and Inclusion (ED&I) outcomes as a measure to develop education and training management and delivery at the Trust. It should be noted however at the time of completion of the SA Report, the Trust ED&I post had / has remained vacant for a period.

6. The Trust may need to review how differential attainment and ED&I data related to learners is collected and used to inform the delivery and design of education and training.

7. Notwithstanding, there is plenty of evidence based on student feedback and placement evaluation to assure the learning environment is conducive for Trust learners from diverse backgrounds, and that their distinct academic objectives are achievable and of a very high standard.

Conclusion

8. In summary the HEE Self-Assessment report has provided a comprehensive review of multi professional education and training at Walton and shone a light on the areas for reinforcing as noted above.

9. The board approved Self-Assessment report will be submitted to HEE on 14th October 2022.

Recommendation

To approve

Author: Liz Doherty, Medical Education Development Manager
Date: 27/09/2022

Appendix 1 HEE Education Training Self-Assessment

HEE Self-Assessment Tool

HEE Self-Assessment - Introduction
The HEE Self-Assessment (SA) is a process by which providers carry out their own quality evaluation against a set of standards. It is based on the philosophy of continuous quality improvement, the identification of quality improvement potential, the development of action plans, implementation, and subsequent evaluation.

Providers are asked to complete this online form indicating where they have or have not met the standards as set out in the SA. There is the opportunity under most of the questions for providers to provide comments to support their answer, this is optional and not mandatory.

Completing the SA
Some questions within the SA will ask you to provide some further information based on your responses.

Where standards have not been met: In these instances, you will be given the opportunity to provide some information detailing why the standard has not been met and any work that is underway to ensure it will be met in future.

Where standards have been met: Where you have met the standards, some questions may give you the opportunity to add comments to support your answer.

Responses by Professional Group: For some questions we have asked you to provide a response per professional group. Throughout the SA we have arranged these groups by their regulators. For example, some questions will ask for you to respond for GMC or NMC associated learners or educators. There is an N/A option should these learner groups not be relevant for your organisation.

Further Questions
If you have any queries regarding the completion of the HEE SA, please review the FAQ document. If you still require further information, you can contact your regional HEE Quality Team.

Contents

HEE Provider Self-Assessment – 2022

Section 1 - Provider

(100-word limit on each response).

1. HEE Region: Health Education England Northwest.
Placement Provider: The Walton Centre NHS Foundation Trust

2. Please provide details of 3 challenges within education and training that you would like to share with HEE

1. With increasing learners in all clinical placements, the trust will need to manage the challenge to capacity and logistics of accommodating more students on site whilst not compromising the quality of education and training provision. Placements will need to be developed through collaborative working between Trust departments and professional groups, sensitively to competing education and clinical service demands.

2. A challenge faced is responding to the external priorities of the People Plan and strategic objectives for the NHS workforce. The drive to re-align workforce development systems to better serve population health needs has instigated fundamental change to multi-professional health education and training. The challenge for the Trust is ensuring it adapts to the new ways of training to protect current and future learners while mitigating impact on service delivery locally. The introduction of Internal Medicine Training and consequences for Neurology training demonstrated the broader effect this can have at trust level, both for service and developing future Neurologists.

3. Responding to Covid and managing the post pandemic training recovery across all disciplines: ensuring learners are supported and receive the same level of pre-covid quality learning experience, whilst balancing significant backlogs caused by the pandemic, continuing to manage elevated staff sickness levels and general staff fatigue. HEE recovery funding has been beneficial in assisting to support the workforce, but it is a challenge in itself to execute spending plans during a period of reduced staff levels and limited external opportunities.

Internally, differing learner preferences in relation to F2F vs virtual learning and increased demand on educational facilities adding further complication.

3. Please provide details of up to 3 key achievements within education and training that you would like to share with HEE.

1. The medical education faculty has been extended. We have appointed an appraisal lead who will provide enhanced support for educational appraisal and trust educators in their development. There is greater resilience across the faculty with a new deputy DME and there are two WTE education fellows whose remit is undergraduate education. The impact of the fellows has been huge as evidenced by the outstanding student feedback received for 2021/22 year.

2. The Trust hosted an interprofessional learning day February 22, focusing on the patient pathway and teams encountered to enable understanding and appreciation of team working / interdependencies. The study day was open to a range of students from all disciplines and designed, coordinated and delivered by a range of multidisciplinary educational leads across the Trust. The IPL day evaluated highly, and further dates are planned for the coming year.

3. The trust is fostering an environment which enables technology enhanced learning. Neurology doctors have developed Neuropod cases, an online resource of common neurological conditions, capturing expert discussion by specialists in their field. This has been accessed worldwide and topics have been extended to include Neurosurgery.
The Trust has also acquired a £100k NEUROVR simulator – first of its kind in the UK and was featured on national news in late 2021. It will be used strategically in Junior doctor training and assessment and will facilitate the development of Trust simulation education offerings to learners.

4. Please cross the box below to confirm that your Self-Assessment response has been signed off at board level before submission back to HEE.

☐

5. Please confirm the date that board level sign off was received:

06/10/2022

Section 2 - Contracting

6. **Do you have board level engagement for education and training?**

Yes [x] **No** [ ]

If yes, please provide their name and job title; if no, please provide further detail.

Michael Gibney Chief People Officer, Executive Lead for Workforce
Lisa Salter Chief Nurse, Executive Lead for Clinical Education

7. Can the provider confirm that the funding provided via the education contract to support and deliver education and training is used for explicitly this purpose?

Yes, [x] No [ ]

If 'yes', please add optional comments to support your answer; if 'no' please provide further detail:

Yes – Active and consistent engagement between education management and finance supports appropriate access to and allocation of education contract funding.

If 'yes' please list any available evidence, if 'no' please provide further detail:

Education Centre - clinical skills room, simulation suite, study / IT facilities. Ringfenced SPA funds to support UGME teaching & supervision. Administrative staff employed to enable delivery of education and training.

8. Is an activity in the Education Contract being delivered through a third-party provider?

Yes [X] No [ ]

If yes, please detail who with:

Yes – SLA with LUHFT for provision of library services

9. Has the provider reported any breaches in relation to the requirements of the NHS Education Contract for any sub-contractor?

Yes, [ ] No [x]

If 'yes', please add **optional comments to support your answer; if 'no' please provide further detail:**

10. Is the provider able to give assurance that they are compliant with all HEE education and training data requests?

Yes, [x] No [ ]

If 'yes' please add optional comments to support your answer, if 'no' please provide further detail:

11. Have there been any health and safety breaches that involve a trainee or learner?

Yes [ ] **No** [x]

If yes, please provide detail:

12. Does the provider engage with the ICS for system learning?

Yes [x] **No** [ ]

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Yes – System learning is completed on the ICS footprint. The trust is leading on a proposed project to develop medical education staff across the ICS footprint. That project ultimately will be reported back to the Chief Executives within the ICS.

Section 3a - Quality

(50-word limit on each response)

13. Is the provider aware of the requirements and process for a HEE Quality Intervention, including who is required to attend and how to escalate issues with HEE?

Yes [x] **No** [ ]

The trust has specific leads for each strand of health education who are responsible for leading quality interventions and responding to HEE requests for information pertaining to their remit.

If no, please provide detail:

14. Have any conditions been imposed on the provider from regulators?

	Yes	No	N/A
GDC			x
GMC		x	
GPhC			x
HCPC		x	
NMC		x	
GOsC			x
Other Learner Group		x	

If yes, please provide further detail:

15. Has the provider actively promoted the National Education and Training survey (NETS) to learners?

Yes [x] **No** [ ]

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The NETS survey was widely, and frequently, circulated to learners from both the PEF and Medical Education teams.

16. Has the provider reviewed and where appropriate taken action on the basis of the results of the National Education and Training Survey (NETS)

Yes [x] **No** [ ]

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The Nov 21 NETS survey was discussed at the Medical Education Committee in March 2022. Useful information was limited due to the very low numbers reporting. PG trainees provided the most detailed feedback, and this was reviewed with the DME. No further action was deemed necessary as issues raised had already been actioned.

17. Does the provider have a Freedom to Speak Up Guardian and do they actively promote the process for raising concerns through them to your learners?

Yes x No

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

FTSU Guardian does regular Trust walkabouts and there is the development of FTSU ambassadors. FTSU Guardian attends monthly trust and learner induction. The FTSU also attends Junior Doctors Forum with GOSW and attends Ward Managers meetings to promote speaking up.

18. Does the provider have a Guardian of Safe Working, and do they actively promote the process for raising concerns through them to their learners?

Yes [x] **No** [ ]

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

GoSW has a slot on the Junior Dr induction and contact details are advertised via posters in the education centre. The monthly JDF is promoted widely as a means for trainees to report concerns. Medical staffing informs trainees of exception reporting on rotation to the trust.

19. Please confirm whether you have an Equality, Diversity and Inclusion Lead (or equivalent):

Yes [x] **No** [ ]

If 'yes' please add comments to support your answer; if 'no' please provide further detail:

The trust has a well-established ED&I lead role. The post is currently being recruited to, due to the previous post holder retired in July 2022.

20. Please confirm that the provider liaises with their Equality, Diversity and Inclusion Lead (or equivalent) to:

	Yes	No
Ensure reporting mechanisms and data collection take learners into account?	x	
Implement reasonable adjustments for disabled learners?	x	
Ensure policies and procedures do not negatively impact learners who may share protected characteristics?	x	
Analyse and promote awareness of outcome data (such as exam results, assessments, ARCP outcomes) by protected characteristic?	x	
Ensure International Medical Graduates (IMGs) receive a specific induction in your organisation?	x	
Ensure policies and processes are in place to manage with discriminatory behaviour from patients?	x	

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The trust is creating an education lead (consultant) who will have pastoral/professional responsibility for MTI doctors. With relatively low PG training numbers, programme leads can monitor outcome data on an individual basis including consideration of protected characteristics.

21. Patient Safety and the promotion of a Patient Safety culture is integral to the HEE Quality Framework. Can you confirm as a provider that you have the following:

	Yes	No
A named Board representative for Patient Safety	x	
A named Patient Safety Specialist/s	x	

A process to ensure that all staff are made aware of and can access the NHS Patient Safety Syllabus Level 1 training on the e-Learning for Healthcare platform	**x**	

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Daily Safety Huddles (open to all staff to attend) discuss patient safety as well as any other urgent Trust issues. On a strategic level, the Patient Safety Group reports to Trust Board. The national e-learning training will form part of the National Patient Safety Strategy implementation plan for Trust.

22. Has the provider developed and implemented a service improvement plan to ensure progression through the Quality and Improvement Outcomes Framework for NHS Funded Knowledge and Library Services?

Yes [x] **No** [ ]

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The trust has an SLA with an external provider (LUHFT) to provide library and knowledge services (LKS). Following the 2021 LKS QIOF self-assessment the trust and LKS provider have worked together to produce action plan to address gaps in provision. This will enable and assure alignment of the service to the quality standards.

23. Has the provider been actively promoting, to all learners, use of the national clinical decision support tool funded by HEE?

Yes [x] **No** [ ]

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

This has been widely shared with learners across the trust and is publicised as a resource by the LKS.

Section 3b - HEE Quality Framework Domain 1 - Learning environment and culture

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

24. The learning environment is one in which education and training is valued and championed.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

There is an award in the annual trust awards recognising excellence in education. There is a named departmental education liaison person for every discipline, who promote learning. UG student feedback from 21/22 commended junior doctors' engagement in ad hoc ward teaching as excellent.

25. The learning environment is inclusive and supportive for learners of all backgrounds and from all professional groups.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Trust & NTN trainees have equitable access to education/training, study leave and named educational supervisor. There is a practice of near peer education in all professions.

26. The organisational culture is one in which all staff, including learners, are treated fairly, with equity, consistency, dignity and respect.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The trust has IIP Gold accreditation, which highlights its positive staff engagement processes. Learners have equal access to the trusts staff development, health and wellbeing and other organisational support offerings.

27. There is a culture of continuous learning, where giving and receiving constructive feedback is encouraged and routine.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The trust actively seeks feedback and new ideas from staff – it holds regular 'Listening Weeks', drives by service improvement and executive led engagement events such as TEA (Talking Engagement Action - staff feedback sessions)

28. Learners are in an environment that delivers safe, effective, compassionate care and prioritises a positive experience for patients and service users.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The trust frequently receives positive feedback from its patients for the standard of clinical care and treatment received, this is shared via the trust internal communications. The CQC at the last visit in 2019 awarded the trust outstanding overall with an outstanding in the area of Caring.

29. The environment is one that ensures the safety of all staff, including learners on placement.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

All learners complete an appropriate site induction in addition to a local induction. We have assurance of consistency with a departmental local induction checklist.

30. All staff, including learners, are able to speak up if they have any concerns, without fear of negative consequences.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		

GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Learners are made aware of the variety of people that they can speak to about any concerns i.e., supervisors, assessor/educator, placement manager/Medical Education manager/ PEF, Freedom to Speak Up Guardian, Safeguarding team. Induction signposts learners to Datix and how to report incidents.

31. The environment is sensitive to both the diversity of learners and the population the organisation serves.

	Yes	**No**	**N/A**
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

All staff are required to complete E&D training as part of mandatory training. The trust has Navajo accreditation as well as Investors in People Gold. There is an ED&I steering group, learners are able to join

32. There are opportunities for learners to take an active role in quality improvement initiatives, including participation in improving evidence led practice activities and research and innovation.

	Yes	**No**	**N/A**
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		

GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Staff are supported to take an active role in identifying and participating in quality improvement initiatives. E.g., the Rehabilitation team staff map projects to strategic objective and national policy/guidelines, and measure impacts on staff, patients and service to communicate results and support evidence led practice.

33. There are opportunities to learn constructively from the experience and outcomes of patients and service users, whether positive or negative.

	Yes	**No**	**N/A**
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Clinical learners have debrief/ reflection with mentors and through liaison with PEF. Positive comments from patients are shared on the Trust daily huddle. Feedback is provided via regular supervision sessions, reflective practice pieces, assessment findings. Pre covid Schwartz Rounds enabled direct patient experience feedback.

34. The learning environment provides suitable educational facilities for both learners and supervisors, including space and IT facilities, and access to library and knowledge services and specialists.

	Yes	**No**	**N/A**
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail for each facility:

A comprehensive LKS is subcontracted via LUHFT, including access to all library services, online and physical resources as well as knowledge management specialists. Onsite to WCFT there are IT and study areas for learners to access

35. The learning environment promotes multi-professional learning opportunities.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Via the multiprofessional group, IPL is facilitated through workshops and other teaching events. The IPL events focus on the patient pathway and teams encountered to enable understanding & appreciation of team working / interdependencies. Neurosurgical medics have led the development of an ANP educational programme taught by both medical and nursing leads.

36. The learning environment encourages learners to be proactive and take a lead in accessing learning opportunities and take responsibility for their own learning.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

AHP/nursing learners are always encouraged to take responsibility for their own development, where appropriate they would be included in team development. Med students – to inform ward staff posters display clinical competencies each undergraduate year group can carry out, so they can perform with independence (w/pt consent)

Section 3c - HEE Quality Framework Domain 2 - Educational governance and commitment to quality

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

37. There is clear, visible and inclusive senior educational leadership, with responsibility for all relevant learner groups, which is joined up and promotes team-working and both a multi-professional and, where appropriate, inter-professional approach to education and training.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

All learner groups have identifiable senior education lead. Medical and clinical education are connected through the multiprofessional practice group which has representation from all healthcare learner leads.

38. There is active engagement and ownership of equality, diversity and inclusion in education and training at a senior level.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The ED&I Lead (post vacant since Summer 22) worked closely with educational leads to ensure ED&I was considered in all training / teaching initiatives.

39. The governance arrangements promote fairness in education and training and challenge discrimination.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Appointments to education lead roles are made following Trust recruitment processes to mitigate against any bias or discrimination and panels feature external representation where appropriate.

40. Education and training issues are fed into, considered and represented at the most senior level of decision making.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Education quality assurance reports e.g., the SAR, GMC, NTS are routinely presented to a non-executive director chaired committee, which reports directly to Board. Issues, successes and matters of importance are escalated to Trust executive committee via this structure.

41. The provider can demonstrate how educational resources (including financial) are allocated and used.

	Yes	No	N/A
GDC Learners			x

GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Education funding supports a dedicated education centre including simulation suite, clinical skills room and study area. The trust has an SLA for library services. Education service is administrated by a team of staff and there is a dedicated medical education clinical faculty with job planned SPA time for education work.

42. Educational governance arrangements enable organisational self-assessment of performance against the quality standards, an active response when standards are not being met, as well as continuous quality improvement of education and training.

	Yes	No	N/A
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The Trust includes GMC NTS and undergraduate MBChB feedback within the annual reporting cycle. This ensures a regular review of performance against the quality standards and assures accountability of a response where standards are not being met. PEF led placement audit provides self-assessment of learning environment

43. There is proactive and collaborative working with other partner and stakeholder organisations to support effective delivery of healthcare education and training and spread good practice.

	Yes	No	N/A
GDC Learners			**x**
GMC Learners	**x**		

GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

In response to changes to PG training, and to sustain access to Neuroscience training, innovative 'hybrid' training posts have been developed with neighbouring trusts.

44. Consideration is given to the potential impact on education and training of services changes (i.e. service re-design / service reconfiguration), taking into account the views of learners, supervisors and key stakeholders (including HEE and Education Providers).

	Yes	**No**	**N/A**
GDC Learners			**X**
GMC Learners	**x**		
GPhC Learners			**X**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**X**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Introduction of a 24/7 clinical service had a potential negative impact on trainee experience. Change managed carefully by Education leads, trainees and service managers to ensure impact was minimized. Actions appear successful as 2022 GMC survey did not reveal any negative outliers for the specialty concerned.

Section 3d - HEE Quality Framework Domain 3 - Developing and supporting learners

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

45. There is parity of access to learning opportunities for all learners, with providers making reasonable adjustments where required.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Students encouraged to discuss any reasonable adjustments and the placements. Leads work with the students and equality, diversity, and inclusion team. Medical student TOI are acted upon, and RA made where required after discussion with the student and relevant supervisors. Similar process for Lead Employer trainees.

46. The potential for differences in educational attainment is recognised and learners are supported to ensure that any differences do not relate to protected characteristics.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Learners e.g., Nurse Associate and apprenticeships without entry level credentials such as GCSE English, Maths are able to sit qualification to enable progression in their fields.

47. Supervision arrangements enable learners in difficulty to be identified and supported at the earliest opportunity.

	Yes	No	N/A
GDC Learners			**X**
GMC Learners	**x**		
GPhC Learners			**X**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**X**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

All medical learners meet their named educational supervisor regularly through placement. Specialty education leads have educational and clinical oversight and are privy to both educational/clinical environment. Non-medical students have mid-placement assessment with learning outcomes monitored to identify difficulties. Action plans are created to support students' attainment.

48. Learners receive clinical supervision appropriate to their level of experience, competence and confidence, and according to their scope of practice.

	Yes	No	N/A
GDC Learners			**X**
GMC Learners	**x**		
GPhC Learners			**X**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**X**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Student nurses are supervised as per NMC guidance i.e., supervision provided to students reflects stages of learning. Student AHPs also supervised appropriate to their level of need and competence. Consultants provide clinical supervision as befits the activity taking place but always enabling the learner to practice within scope of their competence

49. Learners receive the educational supervision and support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Students allocated to specific assessors/educators but communicated in nursing (as per NMC) that student supervision is a team approach.
All medical learners are allocated a named educational supervisor.

50. Learners are supported to complete appropriate summative and/or formative assessments to evidence that they are meeting their curriculum, professional and regulatory standards, and learning outcomes.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Undergraduate medical education timetables are mapped to enable portfolio outcomes. Junior doctor work schedules are coordinated to provide adequate opportunity to fulfil portfolio outcomes. The Trust's education leads closely monitor trainee progression and facilitate additional training opportunities, including assessment such as professional exams. Nursing student documentation facilitates this at student assessment points.

51. Learners are valued members of the healthcare teams within which they are placed and enabled to contribute to the work of those teams.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Nursing students are rostered into the teams (although supernumerary - except apprentices) and shadow the qualified professionals. Once they are competent in skills they can contribute to the workload of the team. PGME trainees are fully integrated into the clinical teams at the trust and key team members.

52. Learners receive an appropriate, effective and timely induction and introduction into the clinical learning environment.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The trust has a blended medical induction of e learning and face to face. Non-attendance is monitored and escalated. Induction also includes introduction to key staff and a hospital tour. Student nurses have an induction with the PEF and a local departmental induction. All other students are inducted by their educator.

53. Learners understand their role and the context of their placement in relation to care pathways, journeys and expected outcomes of patients and service users.

	Yes	No	N/A

GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

We are a specialist Trust, so the nature of the Trust is discussed with students on induction. The IPL day gives learners an overview of the system from a patient journey. The UGME placement covers all aspects of neuroscience management so provides comprehensive understanding of the context in which the trust operates.

54. Learners are supported, and developed, to undertake supervision responsibilities with more junior staff as appropriate.

	Yes	**No**	**N/A**
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Registrars are expected to provide supervision as befits the responsibility of a senior doctor in training to that of a junior colleague. Doctors in training at ST 5+ may be a named UG ES. Clinical students are supported to demonstrate leadership and delegation qualities within their learning outcomes.

Section 3e - HEE Quality Framework Domain 4 - Developing and supporting supervisors

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

55. Formally recognised supervisors are appropriately supported, with allocated time in job plans/ job descriptions, to undertake their roles.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

UG Educational Supervisors have job planned SPA time for supervision. All consultants have a standard 0.25 SPA for education activity including Postgraduate supervision. The NMC states "...have supported time and resources to enable them to fulfil their roles in addition to their other professional responsibilities". This is emphasized to placements.

56. Those undertaking formal supervision roles are appropriately trained as defined by the relevant regulator and/or professional body and in line with any other standards and expectations of partner organisations (e.g. Education Provider, HEE).

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Consultants are GMC recognized trainers. Educational CPD is part of their annual appraisal. Nursing supervisor/assessor update training sessions are available, nurses recommended to attend. Formal mentorship qualifications not mandatory but nurses assessed to supervise. Minimum expectation for qualified nurses/nursing associates is to be a supervisor and contribute to student learning.

57. Clinical Supervisors understand the scope of practice and expected competence of those they are supervising.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Undergraduate learning objectives are shared with supervisors, PGME updates are made as and when curriculum changes are implemented. Practitioners are on the same part of the qualification register so understand the curriculum and learning outcomes

58. Educational Supervisors are familiar with, understand and are up to date with the curricula of the learners they are supporting. They also understand their role in the context of leaners' programmes and career pathways, enhancing their ability to support learners' progression.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

UG curricula / portfolio changes are communicated annually to UG supervisors.

59. Clinical supervisors are supported to understand the education, training and any other support needs of their learners.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Regular communication is shared by the Sub Dean and DME to consultants to ensure awareness of UG/PG learning needs for those providing clinical supervision. For example, making sure ward round is seen as a learning opportunity and is inclusive of students and junior doctors.

60. Supervisor performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for continued professional development and role progression and/or when they may be experiencing difficulties and challenges.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

There is a named consultant lead for medical education appraisal. All PGME trainers are required to provide CPD as an educator annually to renew trainer recognition with the GMC.

Section 3f - HEE Quality Framework Domain 5 - Delivering programmes and curricula

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

61. Practice placements must enable the delivery of relevant parts of curricula and contribute as expected to training programmes.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

UGME placement programmes are reviewed annually, and changes implemented to ensure content continues to meet requirements.

62. Placement providers work in partnership with programme leads in planning and delivery of curricula and assessments.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Trust PEF is part of the C&M PEF network that provides representation on curriculum boards and feedback information to the network, who then feeds back to own Trust.

Trust consultants have key leadership roles at HEE and HEIs and inform bi-lateral discussion regarding Neuroscience content and delivery.

63. Placement providers collaborate with professional bodies, curriculum/ programme leads and key stakeholders to help to shape curricula, assessments and programmes to ensure their content is responsive to changes in treatments, technologies and care delivery models, as well as a focus on health promotion and disease prevention.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

The Trust is a key partner in regional population health programmes and its consultants are active in education development at a national level, engaging with and contributing to Specialty Advisory Committees and other strategic groups. This supports the alignment between shaping of education and responding to health outcomes

64. Placement providers proactively seek to develop new and innovative methods of education delivery, including multi-professional approaches.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' (optional) please add comments to support your answer; if 'no' please provide further detail:

The Trust has an Innovation Lead, who is engaging with the education leads to identify and develop opportunities to innovate education delivery.

65. The involvement of patients and service users, and also learners, in the development of education delivery is encouraged.

	Yes	No	N/A
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Student exit surveys informs the delivery of education. Patients feedback at the patient experience group where themes are identified that could be addressed with a change in education.

66. Timetables, rotas and workload enable learners to attend planned/ timetabled education sessions needed to meet curriculum requirements.

	Yes	No	N/A
GDC Learners			**x**
GMC Learners	**x**		
GPhC Learners			**x**
HCPC Learners	**x**		
NMC Learners	**x**		
GOsC Learners			**x**
Other Learner Group	**x**		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

UG and PG medical learners have prescribed timetables with protected teaching time. All students (except apprentices) are supernumerary, and their rotas and workloads are managed within their capabilities.

Section 3g - HEE Quality Framework Domain 6 - Developing a sustainable workforce

For each learner group, please confirm whether the provider meets the following standards from the HEE Quality Framework:

67. Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Work with HEIs to communicate learner needs and action plans put into place. PG Education Leads liaise with regional TPDs to provide cross organisational trainee support.

68. Does the provider provide opportunities for learners to receive appropriate careers advice from colleagues

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

All staff newly appointed from training are allocated a named mentor who will offer support and advice regarding progression of their role and career trajectory.

69. The provider engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Nurse recruitment events target pre graduate learners to fulfil Trust workforce needs with reference to the specialism of the Trust.

70. Transition from a healthcare education programme to employment and/or, where appropriate, career progression, is underpinned by a clear process of support developed and delivered in partnership with the learner.

	Yes	No	N/A
GDC Learners			x
GMC Learners	x		
GPhC Learners			x
HCPC Learners	x		
NMC Learners	x		
GOsC Learners			x
Other Learner Group	x		

If 'yes' please add optional comments to support your answer; if 'no' please provide further detail:

Final Submission

Before completing your final submission please ensure you have completed the following:

1. Completed all questions within the Self-Assessment (including the free text sections)

2. You have confirmed that you have received Board level sign off for your submission (Section 1 - Provider)

71. Confirm Final Submission to HEE *

Complete submission: ☐

Trust Board
6th October 2022

Report Title	Emergency Planning Resilience & Response (EPRR) self-assessment against NHS England Core Standards
Executive Lead	Lindsey Vlasman – Chief Operating Officer
Author (s)	Sally Butler-Rice – Health, Safety and EPRR Manager
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- Overview of compliance against EPRR self-assessment core standards. The deadline for external submission is 28th October 2022.
- The Trust is fully complaint with 45 out of 56 applicable standards for specialist Trusts. Resulting in a compliance score of 80%, Partially Compliant.

Next Steps

- Submission of standards to NHS Cheshire & Merseyside Integrated Care Board and Local Health Resilience Partnership (LHRP) which in turn reports to NHS England.

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

Strategic Risks

	Choose an item.	Choose an item.

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
BPC	27/09/22	Lindsey Vlasman	Approved at BPC. A review of all core standards including non and partial compliant standards.

CONSENT AGENDA - EPRR Core Standards Self Assessment

Emergency Planning Resilience & Response (EPRR) self-assessment against NHS England Core Standards

Executive Summary

1. Provider organisations are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness.

2. The total number of EPRR Core standards for 2022 is 68. However, only 56 standards are applicable to Specialist Trusts, this is an increase from 38 in 2021.

3. Based on the assessment, the Trust is fully compliant with 45 of the 56 applicable standards, partially compliant with 10 and non-compliant with 1. Therefore, the Trust will be submitting a score of 80% compliance, this equates to a rating of partially compliant. See appendix 1, dashboard of compliance against each standard.

Background and Analysis

Compliant standards

4. The Trust is fully compliant with 45 of the 56 applicable standards.

Non-compliant standards

5. The Trust is non-compliant with 1 of the 56 applicable. Details were shared with BPC on 27th September 2022.

Partially compliant standards

6. The Trust is partially compliant with 10 of the 56 applicable standards. Details were shared with BPC on 27th September 2022.

Deep dive

7. As part of the self-assessment, there is a deep dive on evacuation and shelter. This does not form part of the annual declaration. The Trust is partially compliant with evacuation and shelter.

Statement of compliance

8. Organisations are required to complete a Statement of Compliance and report this via the relevant group/committee to a public Board meeting.

9. The statement of compliance (appendix 2) has been signed by Lindsey Vlasman, the organisation's Accountable Emergency Officer. This was presented and approved by the BPC on 27th September 2022. It will also be presented to the Resilience Planning Group (RPG) on the 24th October 2022.

10. This report, along with the Core Standards assurance ratings are submitted to NHS Cheshire & Merseyside Integrated Care Board and Local Health Resilience Partnership (LHRP) which in turn reports to NHS England.

Conclusion

11. The annual assurance self-assessment has highlighted one area of non-compliance. This is because there are no sufficiently trained loggists within the Trust.

12. Areas of partial compliance are predominantly due to an absence of training and exercising throughout the Trust, partly due to a gap in provision of an EPRR lead. A new Trust lead for EPRR was appointed on 1st August 2022.

13. It should be noted that this year's self-assessment is more stringent than previous years with a requirement to implement Chemical, Biological, Radiological and Nuclear (CBRN) measures for self-presenters.

14. A training and exercise programme is being developed and will be implemented over the next 12 months. This will enable lessons to be learnt and corrective actions to be applied where required.

15. A work plan is required to address the aforementioned area of non and partial compliance, which will be overseen by the RPG.

Recommendation

- To approve

Author: Sally Butler-Rice

Date: 29th September 2022

Appendix 1 – Dashboard of compliance

Please choose your organisation type: Specialist Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	9	2	0	0
Command and control	2	2	0	0	0
Training and exercising	4	3	1	0	0
Response	6	5	0	1	1
Warning and informing	4	4	0	0	0
Cooperation	4	3	1	0	3
Business continuity	10	6	4	0	1
CBRN	7	5	2	0	7
Total	**56**	**45**	**10**	**1**	**12**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	3	10	0	0
Total	**13**	**3**	**10**	**0**	**0**

Percentage Compliance	80%
Overall Assessment	Partially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY compliant standards

Notes
Please do not delete rows or columns from any sheet as this will stop the calculations
Please ensure you have the correct Organisation Type selected
The Overall Assessment excludes the Deep Dive questions
Please do not copy and paste into the Self Assessment Column (*Column T*)

Appendix 2 – Statement of Compliance

The Walton Centre NHS Foundation Trust Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2022-2023

STATEMENT OF COMPLIANCE

The Walton Centre NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0
Where areas require further action, The Walton Centre NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.
Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____Lindsey Vlasman _____

Signed by the organisation's Accountable Emergency Officer

16/09/2022

Date signed

Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Report to Trust Board
6 October 2022

Report Title	Cheshire & Merseyside NHS Prevention Pledge
Executive Lead	Andrew Nicolson Deputy Chief Executive
Author (s)	Deputy Directors
Action Required	To note

Level of Assurance Provided

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

Key Messages

- To update the Board on the Trust progress with the NHS Prevention Pledge.

Next Steps

- To continue to work towards the commitments within the pledge.
- To share final version with:
  - Staff Side Partnership Committee on 06/12/22
  - Local Negotiation Committee on 14/12/22

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

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

Equality Impact Assessment Completed		
Strategy ☐	Policy ☐	Service Change ☐

Report Development

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

Cheshire & Merseyside NHS Prevention Pledge

Executive Summary

1. The Prevention Pledge consists of a set of commitments whereby NHS organisations pledge support to achieve action on improving population health with a specific focus on prevention measures, for the benefit of staff, patients and the wider community.

2. A number of 'strategic core commitments' have been considered in line with commitments in the NHS Long-Term Plan, sub-regional prevention priorities and in particular the Cheshire & Merseyside Population Health Framework.

3. The strategic core commitments align with a range of NHS Provider Trusts, offering the opportunity for different providers to adopt the Cheshire & Merseyside Prevention Pledge.

Background and Analysis

4. Since April 2022 work has continued within the Trust to embed the actions agreed with the commitments. Two Prevention Pledge Community of Practice meetings have taken place (May and September 2022) these events have provided an opportunity to showcase the work of the Trust and meet other phase 1 & 2 sites. During this time a six month measurement of indicators aligned to chosen commitments has been undertaken and joint working agreed on the sustainability agenda with Liverpool University Hospital NHS Foundation Trust.

5. Action tracker for August 2022 is attached at Appendix 1.

Conclusion

6. The Trust will continue to work towards achievement of all fourteen commitments.

Recommendation

To note

Author: Jane Mullin, Deputy Chief People Officer
Date: 20 September 2022

Appendix 1- Prevention Pledge Action Tracker August 2022

The Walton Centre NHS Foundation Trust

Prevention Pledge Action Tracker

Element	Outcome	Status	Progress	Upcoming Actions	Action Owner	Completion Date	Metric	Comment
Programme Set Up	Executive sponsor in place		Andy Nicolson, Deputy CEO identified as Executive Lead	Action Tracker to be presented to Trust Board in March 2022	AN	01/01/22	N/A	Complete
Programme Set Up	Working Group in place		Deputy Directors identified as working group	Monthly meetings for working group (last Tuesday in the month)	JM	01/02/22	Group TOR	Complete
Programme Set Up	Prevention Pledge Plan outlining actions and completion dates		Plan created	Plan to be shared with Executive Directors	Working group (WG)	01/02/22	Agreed plan	Complete
Programme Set Up	Governance structure established		Plan agreed with CEO	Meetings arranged to ensure progress is being made	WG	01/01/22	Agreed plan	Complete
PP - Systems & Environmental	1.Prioritise a long-term focus on well-being, prevention and early intervention ensuring health in all policies; embedding prevention within our governance structures, appointing an Executive Sponsor for prevention (including MECC) and making 'prevention everybody's business'.		Well-being and prevention incorporated into refreshed Trust Strategy Neurosciences Board Linked to HCP- acute, social care & community sectors all involved Refreshed Well-being strategy for staff	To be approved at SPC/LNC Opening of Wellbeing Hub	JR JM	31/03/22	Refreshed strategies and associated action plans Meeting with Divisional Directors to embed prevention in all service developments All new service plans to have prevention as an integral aspect of the development Number of staff participating in H&W activities	People sub strategy to be developed Neurology Division updated Complete H&WB Strategy approved by Board June 22

Prevention Pledge Action Tracker

			NED appointed as Board Wellbeing Guardian					Wellbeing Guardian appointed
PP - Systems & Environmental	2. Create the conditions to support service managers and staff teams to take a quality improvement approach to review and transform services to embed prevention.		Service Transformation Team in place- staff training to support leadership & building ideas Patient experience training – specific to teams/wards Single/joint procurement portal	Continued review of projects at Transformation Board	LV	On going	Action plans	QIA agreed and completed for all projects
PP - Systems & Environmental	3.Guided by Marmot principles; develop approaches to prevention, working with our partners 'at place', to address inequalities & deliver local priorities and prevention ambitions set out within the NHS Long Term Plan & in COVID recovery plans		Involvement in a number of place-based strategies and interventions designed at reducing inequalities in line with NHS Long Term Plan / COVID recovery	Consider prevention work in the community re head injury and helmets Work with local acute Trust re falls prevention/frailty Work with local acute Trust re back pain/injury Leading on the collaboration of pain services across North Merseyside linking in with the medicines optimisation project In line with the above working with Sports England on improving	SN SN JR	31/12/22	Project Milestone achievements for relevant projects, as reported to Trust Board Outcome measure from the evaluation undertaken by University of Sheffield	Due September 2022

				access to exercise for patients with LTC. This is also in partnership with the Neuro Therapy Centre Work with local acute Trust re cancer patients Work with Local acute Trusts to support patients neurological care and treatment closer to home	JR RP JD		Outcome of RANA and acute neurology pilot Audit of INNS?	
PP - Systems & Environmental	4. Work in partnership in the utilisation of common prevention pathways across Trusts, supporting secondary and tertiary prevention that reduces the impact of established disease through lifestyle advice and cardiac or stroke rehabilitation programmes.		Integrated Neurology Nurses RANA	Continue pathway work commenced in covid re stroke prevention/early presentation Develop role of AHP's in providing advice linking to other neurological care pathways	JD	31/03/22 30/09/22	Number of patients treated via RANA pathway- baseline information May 2022 Number of advice session provided by AHP's- baseline information May 2022	
PP - Systems & Environmental	5. Increase social value by establishing anchor practices, that positively impact on the wider determinants of health & the climate 'health' emergency, when making decisions on procurement, purchasing and through our organisation's corporate social responsibilities.		Emphasis of Trust's social responsibility as an anchor institution within draft Trust strategy, for approval in 2021. Involvement in a number of place-based strategies and interventions demonstrating the Trust's commitment	Collaborative procurement service across a number of specialist Trusts Promote the Trust as an employer to local schools	HW JM	31/03/22 31/03.22	Service in place Number of visits to schools over the year- baseline information May 2022, number of events attended.	Work on-going with Liverpool City Region Careers Hub

			to its social responsibility.	Consider employing local community as a priority	JM	31/03/22	Monitor local recruitment	
				Active partner in the Everton Minds programme	JR	31/03/22		Trust is a partner in the development of the Health Zone Development - a purpose built health and social care facility. Part of the Goodison Park legacy. Key Updates: • Strategic Development Framework being developed • Key investors identified and proceeding to formal tender process • Regular meetings being held between Everton Minds and Everton Exec Team to drive momentum and ensure project is active in next 6-12 months • Update partnership MoU being drafted • Consensus from health partner meeting was for

								EitC to own and manage the Health Zone
				Anchor Institutions Charter	JM	15/07/22	Participation in programmes Baseline information -May 2022	C&M HCP Anchor Institutions Charter launched in July 2022. Trust signed up to Charter on 15/07/22. Will be delivered through Social Value, Sustainability and PREVENT Pledge initiatives
				Apply for Social Value Award	JM	31/03/22	May 2022 application commenced	Trust has signed the C&M HCP Social Value Charter in May 2022. Application for Social Value Award and Quality Mark Level 1 in progress. First meeting of internal working group held on 07/09/22.
				Participation in Liverpool Citizens Alliance	JM	31/03/22	Success with application - May 2022 commitment made Involvement in alliance baseline information May 2022- number of apprentices in post.	Trust have committed to being a member- relationship being developed. Core group being convened and training identified

Prevention Pledge Action Tracker

				Widening of the apprenticeship programme				
PP- Brief Intervention / MECC / Social Prescribing	6. Systematically adopting and embedding a 'MECC approach' from commissioning contracts to service delivery, increasing the number of brief or very brief interventions with patients supporting them to eat well, be physically active, reduce harm from alcohol and tobacco and promote mental well-being.		MECC training package	Audit of current staff training to identify opportunities to increase MECC compliance. Incorporation of well-being, prevention and early intervention elements into strategy and policy review process	NM	30/09/22	Number of staff trained Number of patients/clients receiving a MECC contact Number of new staff inductions that include mandatory MECC training at a basic competency level	
PP- Brief Intervention / MECC / Social Prescribing	7.Work with primary care, local authorities and VCSO's to systematically refer to sources of non-clinical support through social prescribing, aligned with community capacity building & to reduce impact on GP consultation rates, A&E attendance, hospital stays & re-admission, medication use, and social care.		Patient & family centred care steering group to inform holistic approach Nursing advice lines Enhanced triage Pathway navigators in clinical areas Best supportive care pilot with	In partnership with the voluntary sector supporting the implementation of the Health Coaches for patients with LTC Via the Wellbeing sub group with Liverpool City Council to consider the use of shinyminds resilience app in social prescribing	SN JM	30/06/22 April 2022	Length of Stay baseline May 2022 Implementation and use of app May 2022 Zero users	

Prevention Pledge Action Tracker

			Whiston for cancer patients					
PP- Brief Intervention / MECC / Social Prescribing	8. Support workforce development, providing training and/or resources to frontline staff to offer brief advice and/or referral in supporting patients to eat well, be physically active, reduce harm from tobacco and alcohol and promote mental wellbeing.		MECC training Staff well being advocates Internal communications i.e. Walton Weekly, posters etc	Audit of current staff training to identify opportunities to increase MECC compliance. Incorporation of well-being, prevention and early intervention elements into strategy and policy review process	NM	30/09/22	Number of staff trained/participating in training Number of patients receiving a MECC contact Number of new staff inductions that include mandatory MECC training at a basic competency level	Regular sessions held with MHFA and Advocates Wellbeing teams pilot in 4 areas.
PP - Health & Well-being for Staff, Patients & Visitors	9.Ensure a smoke-free environment, linked to support to stop smoking for patients and staff who need it		Smoke free site Smoking cessation support in place		JM	31/12/22	Smoke-free policy in place and actions related to policy complete. Further education planned for staff	Discussions ongoing with LUFT to collaborate with their tobacco dependence treatment service
PP - Health & Well-being for Staff, Patients & Visitors	10. Provide workplace health programmes for NHS staff and foster an organisational culture that promotes workplace resilience and creates opportunities for staff to eat well, be active, reduce harm from tobacco and alcohol and promote mental wellbeing		Staff well-being programme Trained MHFA across the Trust Internal communications i.e. Walton Weekly, posters etc	Review of staff experience action plan at sub board level Review staff rest facilities Respond to staff need re well being Launch of new Wellbeing Strategy Monthly wellbeing newsletter Introduction of ambassadors for the Trusts resilience app	JM	Quqrterly 28/02/22 28/02/22 28/02/22 28/02/22	Reduction in staff absence May 2022 data Reduction in the number of staff leaving May 2022 data the Trust Improving number of staff recommend the Trust as a place to work and receive treatment Pulse Survey- April 20220 data	Monthly newsletter in place Monthly Wellbeing Wednesday commenced August 2022
PP - Health & Well-being for Staff, Patients & Visitors	11a. Review food and drink provision across all our NHS buildings, facilities and providers in line with Hospital Food Standards and the		New catering contract from 1st April 2022	As part of new provision to audit staff and public food provision on site to identify opportunities to	LV	01/04/22	Percentage of drink lines stocked which are sugar free, including energy drinks, fruit juices and milk-based drinks Percentage of pre-packed	New Bistro open in Main Centre

Prevention Pledge Action Tracker

	NHS Standard Contract, to make healthier foods and drinks more available (including vending and onsite catering), convenient and affordable and limit access to less healthy foods and drinks such as those high in fat, sugar and/or salt.			further the availability of healthy food and drink			sandwiches and other savoury pre-packed meals available contain 400kcal or less per serving and don't exceed 5g fat per 100g Need to get baseline data from ISS	
PP - Health & Well-being for Staff, Patients & Visitors	11b. Increase public access to fresh drinking water on NHS sites (keeping single use plastics to a minimum) and encouraging re-useable bottle refills.		All staff members provided with re-usable drink bottle Fresh water fountains available in staff areas	Audit to be undertaken of current facilities on site	JM	31/12/22	Water points across the Trust	
PP - Health & Well-being for Staff, Patients & Visitors	12. Support the sub-regional physical activity strategy; to promote and create opportunities for staff, patients and visitors to be physically active both on and off site and in line with active travel and sustainable management plans.		Some physical activity promotion to staff, including the offer of subsidised gym membership sessions and the invitation to take place in the NHS games. Aligned with initiatives at local government Charity events- Hope Mountain Hike, virtual London marathon	Audit of staff physical activity Work with MSP to promote physical activity	JM	31/03/22 On going On going	Proportion of staff participating in regular physical activity Wellbeing survey baseline Nov 2022 Participating in Autumn 2022 games May 2022 baseline info	Participation in NHS NW games. Partnership with HYPE bikes for 10 bikes free to staff Walk Walton during May 22
PP - Health & Well-being for Staff, Patients & Visitors	13. Sign up to the 'Prevention Concordat for Better Mental Health for All' and to embed the Prevention Concordat across health and care policies and practices.			Paper to be produced outlining the requirements of the Prevention Concordat and the benefits to the Trust to implement the	JM		Number of staff who have participated in training provided Baseline data May 2022- not commenced	Waiting for approval of C&M action plan from Office for Health Improvement and Disparities.

				Strategy				
PP- Governance	14. Monitor the progress of the pledge against all commitments and to publish the results of our progress at regular intervals.		Action plan	Review with Executive team	All DD	Quarterly	RAG rated action plan to be reviewed at Board	