NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 2nd September 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
2 September 2021
Virtual Meeting
09:30am – 11:45am

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	S Crofts	N/A
2	09.30	Declaration of Interests	S Crofts	N/A
3	09.35	Minutes and actions of meeting held on 1 July 2021	S Crofts	Decision (d)
4	09.40	Patient Story	L Salter	Information (v)
STRATEGIC CONTEXT				
5	10.00	Chair and Chief Executive's Update	S Crofts / J Ross	Information (v)
PERFORMANCE & GOVERNANCE				
6	10.10	Recovery & Restoration Update	M Woods	Information (v)
7	10.20	Integrated Performance Report	CEO/Execs	Assurance (d)
8	10.40	Workforce Race Equality Standard Report	M Gibney	Assurance (d)
9	10.50	Workforce Disability Equality Standard Report	M Gibney	Assurance (d)
10	11.00	SBAC Key Issues Report	S Rai	Assurance (d)
11	11.05	Audit Committee Chair's Report	S Rai	Assurance (d)
12	11.10	Charity Committee Chair's Report	S Rai	Assurance (d)
13	11.15	Quality Committee Key Issues Report	S Crofts	Assurance (d)
14	11.20	RIME Committee Chair's Report	S Crofts	Assurance (d)
15	11.25	Remuneration Committee Key Issues Report	S Crofts	Assurance (d)
16	11.30	Business Performance Committee Chair's Report	D Topliffe	Assurance (d)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Quarterly Governance Report • Nursing Revalidation Report • Medical Education Annual Report				
CONCLUDING BUSINESS				
17	11.35	Any Other Business	J Rosser	Information

Date and Time of Next Meeting:
7 October 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

1st July 2021

Present:

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

In attendance:

Mr J Baxter	Executive Assistant
Mr P Buckingham	Interim Corporate Secretary
Ms D Lee	Safeguarding Matron (item TB58-21/22 only)
Mr A Lynch	Equality and Inclusion Lead (item TB61-21/22 only)
Ms L Gurrell	Head of Patient and Family Experience (item TB51-21/22 only)
Ms A Woollam	Patient (item TB51-21/22 only)

Observing:

Mr C Cheeseman	Public Governor – Cheshire
Ms E Parr	Communications and Marketing Manager

Trust Board Attendance 2021-22

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

TB48-21/22 Welcome and apologies

Ms Rosser welcomed those present to the meeting via Microsoft Teams and noted that Mr C Cheeseman was observing in his capacity as Public Governor for Cheshire.

TB49-21/22 Declarations of interest

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

TB50-21/22 Minutes of the meeting held on 10th June 2021

Mr Burns noted that the second sentence of the third paragraph under item TB41-21/22 should read "Mr Gibney clarified that there were some staff members who had built up an excess leave allocation and this would be reviewed on a case by case basis."

Following completion of this amendment the minutes of the meeting held on 10th June 2021 were agreed as a true and accurate record.

TB51-21/22 Patient Story

Ms Gurrell and Ms Woollam joined the meeting.

Ms Gurrell introduced Ms Annette Woollam who presented her patient story and noted that she had been undergoing treatment for lung cancer and began immunotherapy when she found herself unable to communicate effectively. This issue continued for approximately ten days before Ms Woollam contacted the cancer helpline who recommended she called 999. Ms Woollam underwent a scan that confirmed that the cancer had spread to her brain, the Trust called her in for emergency surgery and Ms Woollam then had an inpatient stay on Chavasse Ward. Ms Woollam reported that staff were caring and welcoming and although all staff she had encountered were wearing masks she could see that staff were smiling at all times. Ms Woollam praised Mr Brodbelt and reported that her experience in the Trust was faultless.

Ms Woollam also praised NWAS and noted that when she had called for an ambulance she could not remember her own name, address or date of birth however the call handler stayed on the line with her until the ambulance arrived.

Ms Salter noted that she was very proud of the support and care that the staff at the Trust had provided and queried how the communication was from the Trust to her family during her stay. Ms Woollam informed that Mr Brodbelt had personally called her husband straight after the procedure to explain and discuss the procedure and the Nursing team had kept her family informed throughout her stay.

Ms Rai questioned if there was anything the Trust could have done differently or any lessons that could be learned from her stay, Ms Woollam clarified that there was nothing that she felt could have been done differently at the Trust.

The Chair thanked Ms Woollam for joining the Board to share her story noting her bravery for presenting such an emotional experience. The Chair also noted that she would write to the Chair of NWAS to pass on the patients praise and thanks.

Ms Gurrell and Ms Woollam left the meeting.

TB52-21/22 Chair & Chief Executive's Report

Ms Ross provided an update noting that an increase in the number of Covid positive cases was resulting in a risk to the delivery of the recovery programme being realised. The number of hospital admissions for Covid was increasing however this was currently

manageable but would have an impact on recovery. It was noted that it was mostly younger patients who were testing positive and the associated staffing isolation was becoming an operational pressure. Weekly Cheshire and Mersey Critical Care Network calls were in the process of being set up as requests for mutual aid were beginning to be received and emergency departments were still under pressure. Mr Crofts queried if the increases in ITU admissions were from younger or older patients and if it was known if they were vaccinated. Ms Ross confirmed that it remained mostly older patients who were being admitted to ITU and community prevalence was mostly younger patients however it was a mix of both vaccinated and un-vaccinated patients.

Professor Thakkar recognised the impact that staff isolation would have on recovery plans and highlighted the need for clear concise messaging around maintaining services and keeping patients safe. Ms Ross noted that there would be consistent messaging across Cheshire and Mersey Trusts and all Trusts would remain engaged in system decisions.

It was noted that LAMP testing and booster vaccination programmes were now being prioritised.

The Trust roadmap had been paused and it was noted that the Board Development session on 6th July would be a virtual session held via Microsoft Teams, it was also confirmed that Executive and Non-Executive walkabouts had been paused again.

Work around the single oversight framework had been finalised and work was underway to understand this.

The Chair reported that the Corporate Secretary position had been successfully recruited and the successful candidate would begin in post following the 3 month notice period required for their current role. Mr Buckingham noted that the recent appointment of a Corporate Secretary required Board approval and a paper would be submitted to the next meeting to seek approval.

Interviews for the Chair position at the Cheshire and Mersey Partnership would be held during the week commencing 5th July.

The Board:

- **noted the report.**

TB53-21/22 Progress Against Trust Strategy 2018-23

Ms Ross provided a presentation detailing progress against the Trust strategy at the end of Q1 2021/22 and noted that there was a need to review and refresh the strategy as it had been developed in 2018 and there had been a number of significant changes within the health service since that time. All objectives originally agreed in the strategy remained and continued to be reviewed with all updates having been highlighted to provide assurance that work was continuing against each objective.

Each of the Trust ambitions was presented and discussed and progress against each ambition was detailed; an overview of this is provided below.

Deliver best practice care

It was noted that the Trust had taken on the regional stroke service during the pandemic and was continuing to work closely with LUFT around this service. It was also highlighted that the thrombectomy service would move to a 24/7 service from October 21.

It was also reported that head and neck cancer services continued to be supported by the Trust and weekly calls regarding mutual aid were held.

Critical Care work was ongoing to prepare for winter pressures and ongoing resilience. Weekly capacity and demand calls were in place to keep this under review.

Provide more services closer to patients homes

The Trust continued to utilise the estate currently available and improve provision of services where possible such as utilising remote consultations and transferring spinal services to the Trust. The Trust also continued to support recovery and restoration plans with mutual aid.

Invest and be financially strong

It was recognised that this area had been a challenge due to changes on the financial regime and remaining financially viable was less within theTrusts gift than previously.

Lead research, education and innovation

There would be a larger discussion around research, innovation and medical education later on the agenda under item TB60-21/22 and it was noted that there had been a number of delays in this area due to the pandemic however the teams had continued with business as usual as far as was practicable with a number of the larger research studies continuing. The department had also undertaken and assisted with Covid related research projects.

Adopt advanced technology and treatments

It was recognised that it had been difficult to make progress in this area during the pandemic however it was hoped that some areas could be advanced utilising the digital aspirant funding to provide increased resilience and a decreased reliance on LUFT. The Trust website was currently undergoing a redesign and it was also recognised that agile working had been introduced across the Trust.

Ms Rai queried what the timescale for launching the new website was and it was clarified that the business case had been signed off during the last financial year and internal work was ongoing to populate the new website and test the functionality. This would continue for the next few weeks prior to moving to wider testing and training, it was hoped that the website would go live in early August.

Be recognised as excellent in all we do

It was noted that the Trust had been reaccredited as gold standard in IIP and IIP Health and Wellbeing awards. The Trust had procured life-size screens to assist with virtual visiting and had undertaken a vaccination programme for all staff and patients. The Trust was also aligning itself with the new ways of working with the CQC. It was also recognised that there had been an improvement in patient survey outcomes.

Mr Topliffe recognised that the Trust ambitions had been moderated by the pandemic however noted it was good to see how much had been achieved despite this. Mr Topliffe

also noted the RAG rating for some of the ambitions required further review to ensure consistency.

Mr Crofts highlighted that the next strategy would provide an opportunity for the Trust to position itself in an influential position within the new regime and recognised that the Trust would work to becoming an exemplar and achieving recognition for being forward thinking.

Ms Ross noted that three key aims for each ambition under the Trust commitments would be submitted to Board in September and work to achieve these would be undertaken while the updated strategy was formulated.

The Board:

- **noted the progress made against the Trust strategy.**

TB54-21/22 Board Assurance Framework

Mr Buckingham presented the Board Assurance Framework and noted that this would be reviewed in parallel with the strategy. The Q1 position against all 15 BAF entries had been reviewed by risk leads and discussed at length at both Quality Committee and Business Performance Committee. The BAF would also be discussed at the next RIME Committee meeting.

It was noted that the scoring for Risk ID013 should be increased to 12 and it was also clarified that the target score for Risk ID014 should read 2 x 3 = 6.

Ms Rai noted that Risk ID005 would be kept under review and may change for the next update.

Ms Bentley queried if the report following the audit of the LASTLAP initiative recorded under Risk ID003 was available, Ms Salter clarified that this was monitored at the Health and Safety Committee and this would be shared following the meeting.

The Board:

- **approved the amendments to the board assurance framework.**

TB55-21/22 Recovery and Restoration Update

Ms Ross provided an update on recovery and restoration progress and noted that the Trust was currently overachieving in all sections however recognised that the plan increased significantly in July and staffing risks related to isolation may cause progress to go off trajectory.

The numbers of outstanding P2 patients was improving and the number of 52 week breaches were reported to be lower than trajectory.

The wider system was currently delivering their recovery plans however some Trusts were beginning to experience difficulties in maintaining their progress and it was recognised that there would be challenging times ahead.

The Board:

- **noted the update.**

TB56-21/22 Integrated Performance Report

Ms Ross provided an overview of the Integrated Performance Report (IPR) noting that the report had been discussed in detail at Business Performance Committee and Quality Committee meetings as noted within the Chair's reports. It was highlighted there had been a significant reduction in the number of open complaints and an improvement in the quality and timeliness of responses. Mandatory training compliance had increased however there was some concern regarding vacancy figures with some staff taking early retirement due to the pandemic. All cancer and diagnostic targets continued to be met and progress continued to be made against average wait targets however this was not yet at the target set prior to Covid.

Quality

Mr Crofts provided an overview of all HCAI targets noting that issues regarding MSSA remained. Two cases of C.Difficile had been reported in month giving a year to date total of 3 against a trajectory of 5. All other HCAI were reported to be within trajectories.

Workforce

Mr Gibney advised that workforce metrics continued to improve including PDR and staff appraisal rates.

Finance

Mr Topliffe noted that there had been a surplus delivered for M2 however this was slightly below the planned surplus.

The Board:

- **noted the integrated performance report.**

TB57-21/22 Medical Revalidation Report

Dr Nicolson presented the medical revalidation annual report and noted that revalidations had been put on hold nationally for 6 months due to Covid however revalidations were now back on track. Dates for revalidation of Junior Doctors had been put on hold for 12 months and it was recognised that it would take some time for this position to fully recover. Guidance had been amended regarding appraisals this year with additional focus being placed on wellbeing.

Ms Rai noted that there had been one deferral due to documentation and queried if there had been any issues identified, Dr Nicolson confirmed that no issues had been identified and a deferral was classed as a neutral act however repeated deferral requests would not be granted.

Ms Bentley queried if there had been any occasion for responding to concerns raised at Trust Board previously, Dr Nicolson stated that this section related to medical staff and although some instances had been raised there had been no formal notifications to Board required.

The Board:

- **approved compliance with Responsible Officers Regulations 2010.**

TB58-21/22 Safeguarding Annual Report

Ms D Lee joined the meeting.

Ms Salter noted that the number of safeguarding referrals had increased by 676% since 2017 and wished to record her thanks to the team for all the work they had undertaken.

Ms Lee presented the safeguarding annual report and noted that there had been an increase in the number of DoLS breaches reported via Datix and it was highlighted that this was a national issue due to delays in best interest assessors attending Trusts.

It was noted that with regards to the Covid vaccination rollout programme the Safeguarding Team had undertaken best interest in relation to the Mental Capacity Act to ensure patients were provided with best opportunity to give consent and robust measure were in place around this.

One application had been made to the Court of Protection regarding a patient who was against an urgently required surgical intervention however did not have capacity. It was noted that this patient did regain capacity prior to surgery and the application process was cancelled.

The numbers of child referrals had dropped due to the restrictions on visiting however some issues had been identified during virtual appointments.

All mandatory training KPIs had been met within the team with the exception of one. It was noted that the Trust had implemented processes to ensure the provision of assessment and treatment of patients under the mental health act following whistleblowing concerns raised with the CQC.

The Chair queried if it was felt that sufficient support was available for staff attending court cases and Ms Lee confirmed that sufficient support was available and staff had a good knowledge base. Dr Nicolson recognised that court cases could be very difficult and noted the support provided by the safeguarding team and nursing teams along with the legal team.

Ms Rai queried how many patients with learning disabilities were typically under the care of the Trust each year and Ms Lee confirmed that she did not have this information to hand however would forward this information to Ms Rai following the meeting. It was highlighted that continual audits regarding risk assessments and reasonable adjustments were undertaken and there had been 15 patients with learning disabilities during May and 2 patients with learning disabilities during June.

Ms D Lee left the meeting.

The Board:

- **noted the safeguarding annual report and approved the safeguarding plan for 2021/22.**

TB59-21/22 Major Incident Plan

Mr Woods presented the major incident plan and noted that this formed one of the EPRR core standards which would be submitted to Trust Board later in the year for approval. It was noted that the version control sheet required updating and this would be amended to reflect the review undertaken in April 2021.

Ms Bentley queried when the last major incident occurred and if the Trust undertook mock major incidents to ensure the plan was fit for purpose. Ms Ross clarified that the last major incident was the recent power outage and if the plan was not used for a period of 12 months then a mock incident would be undertaken.

The Board:

- **received and noted the major incident plan for assurance.**

TB60-21/22 Research, Innovation and Medical Education Annual Report

Mr Gibney presented the Research, Innovation and Medical Education annual report and noted that the research element of the report had been discussed at RIME Committee however the Innovation and Medical Education elements of the report had not yet been submitted to RIME Committee for discussion.

Mr Gibney highlighted that there continued to be a lot of education undertaken within the research team and although business as usual had been suspended Covid research had been prioritised and the Trust had been acknowledged for their support regarding this. It was noted that commercial income was a concern due to the suspension of business as usual.

It was noted that the number of weeks of medical education offered to students had doubled in year and medical education had continued to be offered despite the pandemic. There were 5 Universities in the region however none have a Neurosciences Unit and the Trust was the leader in this field.

Ms Rai queried how the Trusts application to become a teaching hospital was progressing. Mr Gibney highlighted that the process had been suspended due to the pandemic however there was clarity regarding the criteria and an indicative plan was in place. The Trust had a strong application however there was a requirement for a University employed Non-Executive Director.

The Board:

- **considered and noted the research, innovation and medical education annual report.**

TB61-21/22 Equality, Diversity and Inclusion Annual Report

Mr A Lynch joined the meeting.

Mr Lynch presented the Equality, Diversity and Inclusion annual report and noted that this report fulfilled a statutory duty however the data contained in the report was analysed elsewhere.

Professor Thakkar queried if intersectional data in relation to the inpatient and population data presented under section 4 of the report was recorded to identify if elderly patients from black, Asian and minority ethnic backgrounds encountered additional difficulty in accessing the Trusts services. Mr Lynch confirmed that this data was not gathered on an intersectional basis however this intersectionality would be a key data stream to be examined moving forward and steps were being taken to ensure this data would be gathered. An overview of data mapped throughout the pandemic was provided and it was recognised that this data was useful in mapping themes down to postcode level. Professor Thakkar recognised that steps were being taken to try and address this and questioned if the same approach was also being taken within research participation to ensure findings were applicable to all patients groups. Mr Gibney noted that this would form part of the service that the Trust wanted to shape and progress.

Ms Bentley noted that there had been a lot of data collection and queried if there were any reasons why staff were under-reporting disabilities. Mr Lynch clarified that there were a number of reasons for this and that people did not like to classify themselves as being disabled. There was also some stigma attached to this such as a fear of being treated differently, not necessarily within the Trust but across the NHS there was a feeling that this could affect future career prospects. Professor Thakkar noted that this was not unique to the Trust and the same issue had been identified within the University setting.

Mr Gibney noted that the Trust was also working to educate and shine a light on gender equality and this had been recognised across the region. Work was ongoing with local councils around health and social care and a working collaboration was in place on a growth platform. Ms Salter highlighted that there had been a national push on attracting males to a Nursing profession in recent years and Nurses were also attending schools to provide presentations about their roles.

Mr A Lynch left the meeting.

The Board:

- **noted the equality, diversity and inclusion annual report.**

TB62-21/22 Quality Committee Key Issues Report

Mr Crofts provided an update from the meeting of the Quality Committee held on 17th June 2021 and highlighted that some of the data relating to management of patients that had been included in the KPI report presented to Quality Committee had been outdated due to the timings of the production of the report. The information team were working with clinical teams to determine how this information should be processed.

New national cleaning standards had been published and these would need to be implemented within the next six months.

A comprehensive presentation had been provided detailing what quality looks like to the HR team from staff recruitment through to the health and wellbeing agenda.

The Board:

- **noted the Quality Committee key issues report.**

TB63-21/22 Business Performance Committee Key Issues Report

Mr Topliffe provided an update from the meeting of the Business Performance Committee held on 22nd June 2021 and noted that there had been no alerts to be escalated. An overview of areas of assurance was provided and it was recognised that all sections relating to performance had been covered previously on the agenda.

An updated People Action Plan had been presented which included actions from the recent survey and national people plan. The Operational Workforce Group had been formed to lead on this work.

Top priorities would be reviewed at the end of each meeting of the Business Performance Committee moving forward and an overview of progress would be presented on the key issues report under the Advise section.

The Board:

- **noted the Business Performance Committee key issues report.**

TB64-21/22 Any Other Business

Ms Rai provided an update from the Strategic Black, Asian and Minority Ethnic Committee meeting held on 14th June 2021and noted that data regarding BAME patients and staff had been collated and this would be reviewed and presented going forward. The nurses from India recruited as part of the international recruitment campaign were currently under quarantine in London and were looking forward to joining the Trust. Feedback from the North West BAME Committee was presented and it was noted that KPIs would be reviewed for introduction and monitoring.

Mr Cheeseman wished to record his congratulations to Ms Ross on her appointment to the Chief Executive role and noted that although there was a lot to discuss on the agenda the time allocation for each item was correct with well streamlined presentations provided allowing for robust challenge.

There being no further business the meeting closed at 12.30pm

Date and time of next meeting
Thursday 2nd September 2021 at 09:30 via Microsoft Teams

TRUST BOARD
Matters arising Action Log
September 2021

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
01/07/21	TB53-21/22	**Trust Strategy 2018-2023** Executive Team to review and identify three Commitments for each Ambition in 2021/22. Outcomes to be presented to the Board of Directors on 2 September 2021.	Ms Ross		02/09/21	
01/07/21	TB54-21/22	**Board Assurance Framework** Ms Salter to circulate the report completed following an audit of the LASTLAP initiative recorded under Risk ID003 to the Board.	Ms Salter		02/09/21	

Actions not yet due

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

REPORT TO TRUST BOARD

Date 02/09/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Michael Woods Title: Interim Director of Operations and Strategy
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence Name: Laura Abernethy Title Access & Performance Director
Previously considered by:	• Committee No committees during August 2021

Executive Summary

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

Key performance highlights are detailed below:

Key Performance Indicators – Caring

High Performing Measures

Complaints – The number of complaints received has significantly reduced over the last eight months, both in raw numbers and when adjusted for total patient contacts.

This reduction has brought the Trust in line with the national average for written complaints received per 1000 WTE at the latest published period (Q4 2020/21).

Key Performance Indicators – Safe

Opportunity for Improvement Measures

Infection Control – There are currently four MSSA instances reported year to date against a year end trajectory of eight. The rate per 100,000 bed days is currently at 26.92, which is significantly above the latest national average of 9.94.

There are currently four C.Diff instances year to date against a year end trajectory of 5. The rate per 100,000 bed days is currently at 26.92; however this month has just fallen within the upper control limit.

Harm Free Care – Incidences of harm

Key Performance Indicators – Well Led

High Performing Measures

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

Opportunity for Improvement Measures

Nursing Turnover - Remains above the 10% target, performance has improved significantly over the last year; however this is the second consecutive month whereby the rate has increased.

The Nursing vacancy rate is currently 6.51% and Medical is 0%. Nursing turnover remains high due to registered staff successfully being recruited into internal specialist nurse positions and career progression externally, two have returned to the ward areas, one from an internal position and one from an external post. The two divisional matrons have recently reviewed the skill mix across all areas and staff have been redeployed to maintain patient safety and to enhance staff clinical development.

Sickness/Absence - Sickness/Absence levels in July 2021 were above the target of 4.75% at 6.15%.

Appraisals – Appraisal compliance in July 2021 is 80% which is an improvement when compared with March 2021. The training team are continuing to work with individual departments to improve compliance

remain low and are performance within expected variation. There was one moderate harm fall reported in month.

Key Performance Indicators – Responsive

High Performing Measures

Cancer Standards – Two Week Wait

Cancer Standards – 31 Day First Definitive Treatment

Cancer Standards – 31 Day Subsequent Treatment

Cancer Standards – 28 Day Faster Diagnosis

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

Underperforming Measures

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

Key Performance Indicators – Effective

Opportunity for Improvement Measures

Activity – During July 2021 the Trust exceeded the national threshold of 95% for daycase activity and overall outpatient activity combined, however elective activity was below at 78.68%. Under-performance in month for elective activity is in the main due to staff availability.

Related Trust Ambitions	• Best Practice Care • Be financially strong • Be recognised as excellent in all we do
Risks associated with this paper	Associated access and performance risks all contained in divisional and corporate risk registers.
Related Assurance Framework entries	Associated BAF entries: • 001 Covid-19

	• 003 Performance Standards • 005 Quality
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• No
Action required by the Board	• To consider and note

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Board KPI Report
September 2021

Data for July 2021 unless indicated

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Explanation of SPC Charts and Assurance Icons

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

All SPC charts will follow the below Key unless indicated

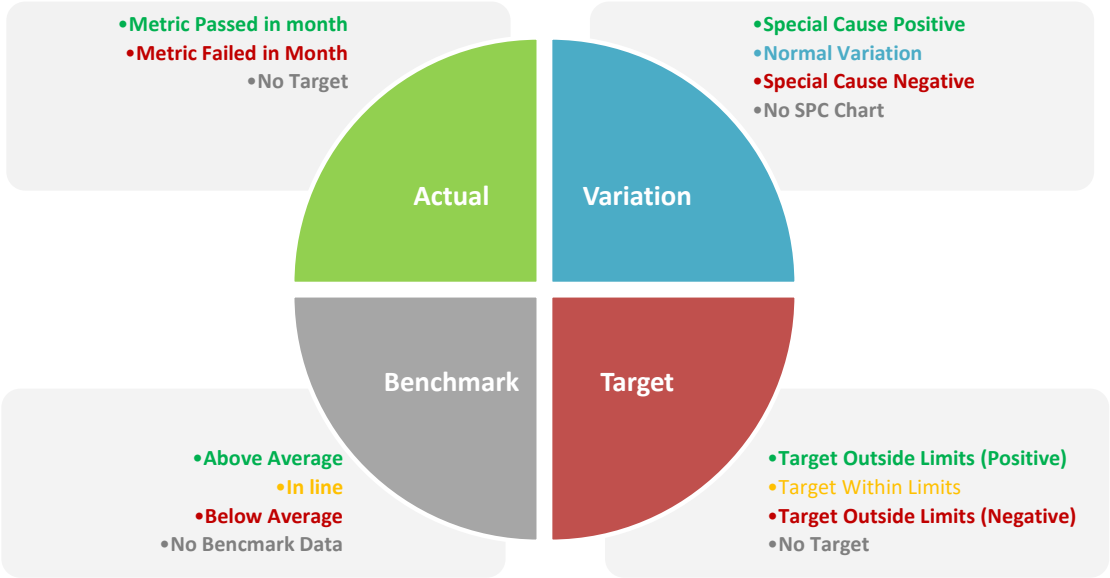
Actual — UCL — Average — LCL — National Average — Target

= Part of Single Oversight Framework

= Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

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



SPC Chart Rules

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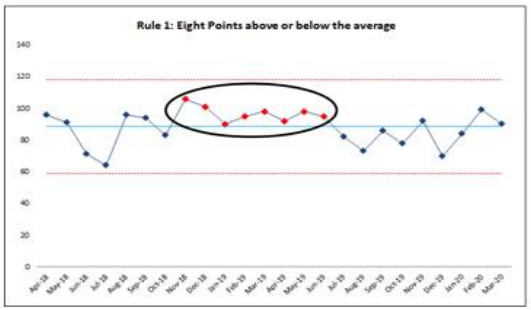
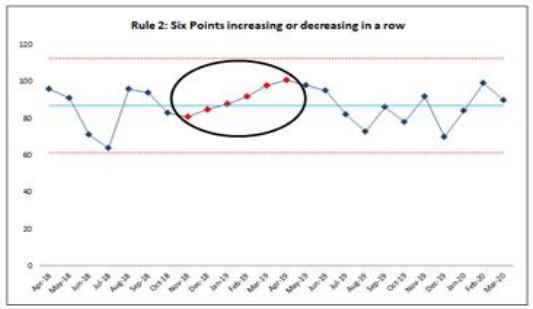
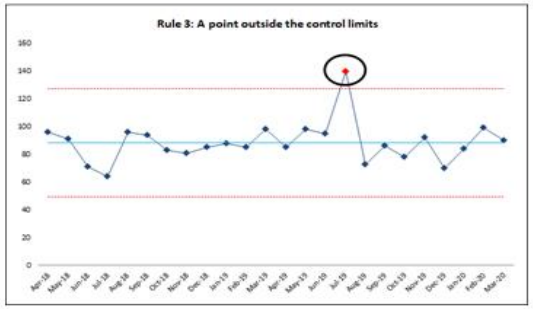
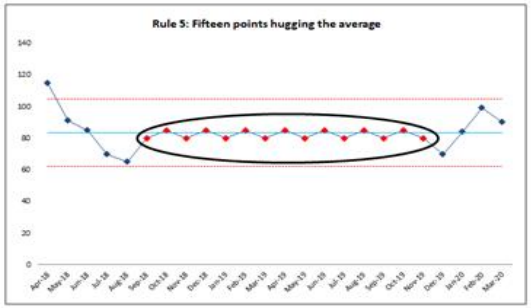
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).









All SPC charts will follow the below Key unless indicated

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

Operational

Effective - Theatres

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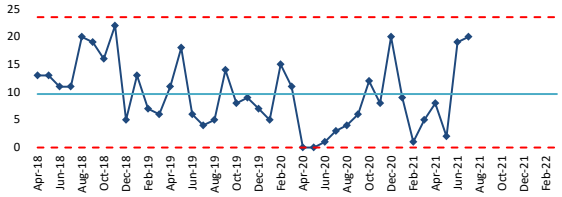
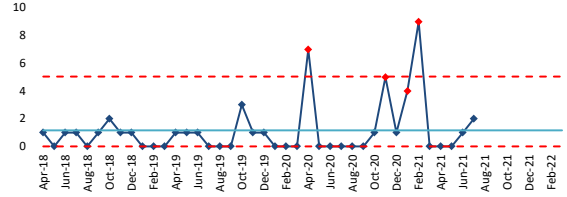
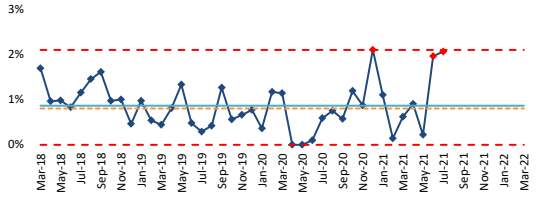
Number of Cancelled operations non clinical (on day)



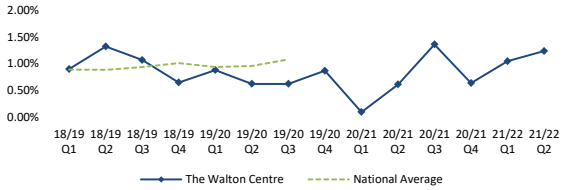
Number of cancelled operations not re-admitted within 28 days



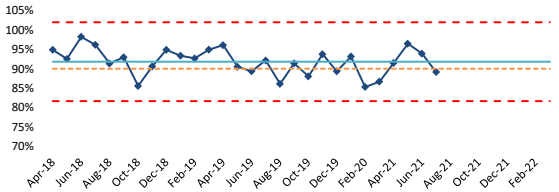
% of Cancelled operations non clinical (on day)



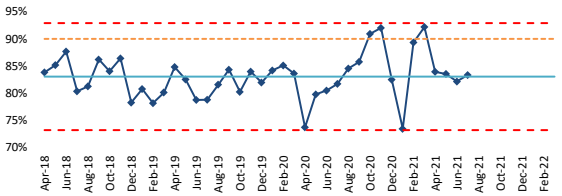
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



Operational

Effective - Activity Recovery Plan

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

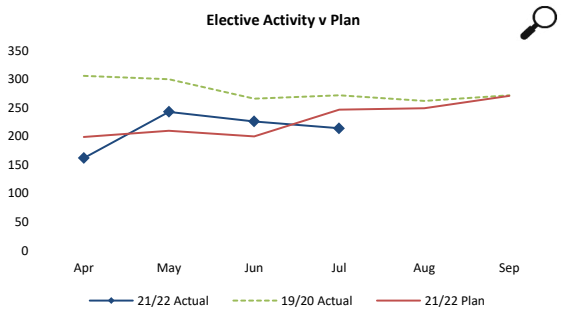
July 21 Activity Performance

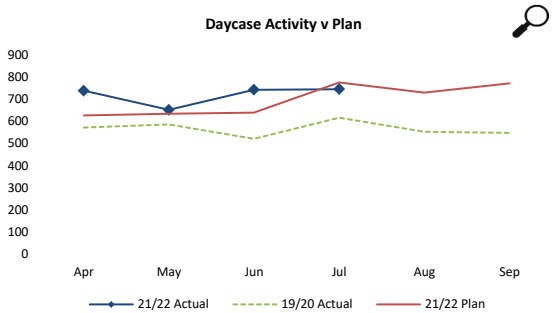
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	96.12%	95%
Elective	78.68%	95%
Elective & Daycase Total	**91.59%**	**95%**
Non Elective	96.55%	-
New Outpatients	90.08%	95%
Follow Up Outpatients	104.09%	95%
Outpatient Total	**99.32%**	**95%**

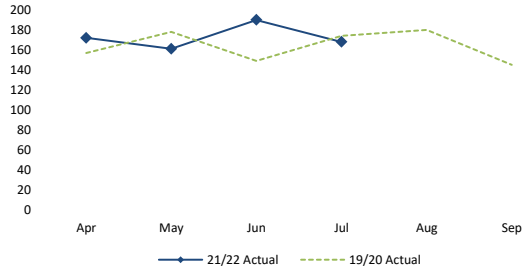
As part of plans to restore services to pre-COVID levels, each Trust was required to include trajectories and timescales for delivery of 100% of the pre-COVID activity levels (comparing with the baseline of actual 19/20 SUS activity levels). The Trust is forecasting delivery of 100% of all elective activity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

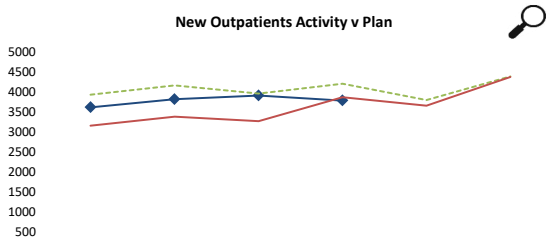
On 9th July the Trust received updated guidance stating that Elective Recovery Fund thresholds have been reviewed and have be en adjusted to 95% of 2019/20 activity levels from 1 July 2021. The Trust is currently reviewing the impact this will have from an income perspective; daily operational huddles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

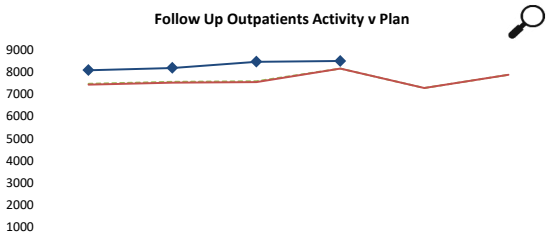
During July 2021 the Trust exceeded the national threshold of 95% for daycase activity and overall outpatient activity combined, however elective activity was below at 78.68%. Under-performance in month for elective activity is in the main due staff availability.









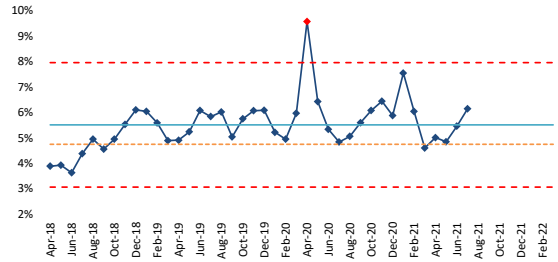


Workforce

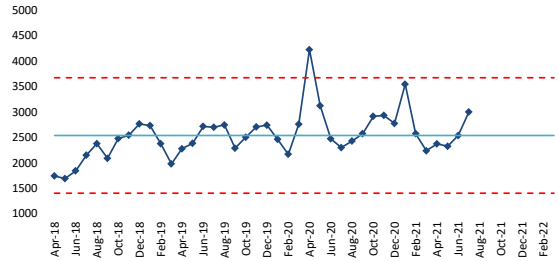
Well Led - Workforce KPIs

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

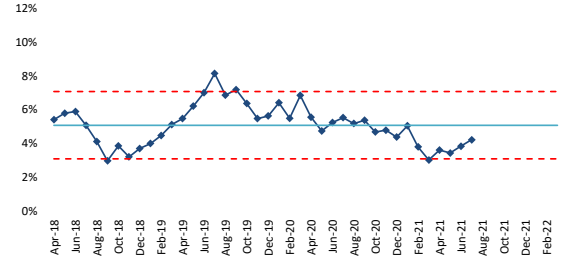
Sickness/Absence (Monthly)



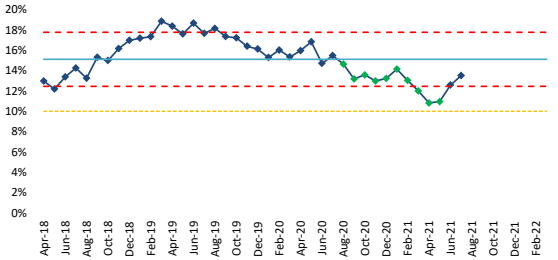
Lost Days due to Sickness/Absence (Monthly)



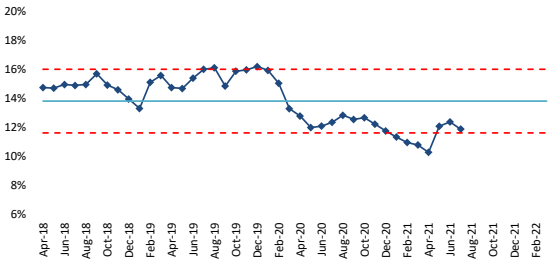
Overall Vacancy Level %



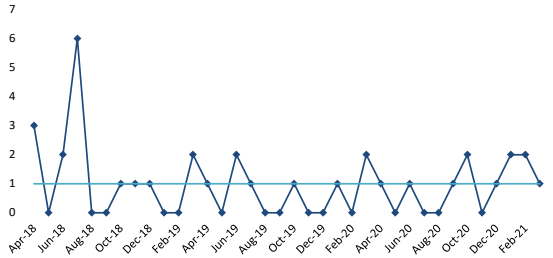
Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



Medical Leavers

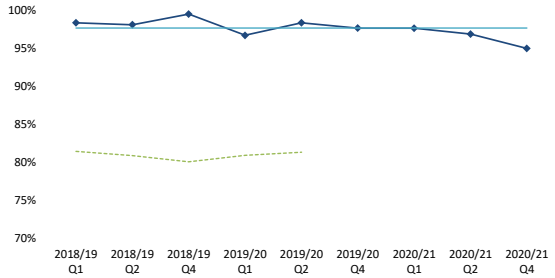


Workforce

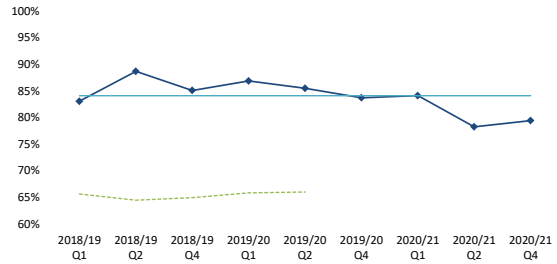
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust
Excellence in Neuroscience

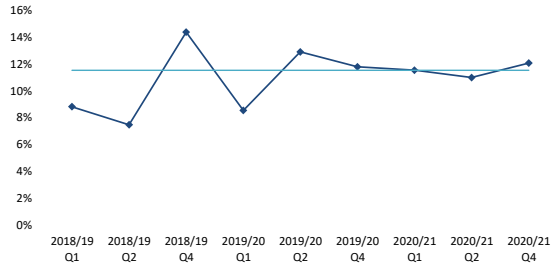
Staff FFT - % Recommend as Place of Care



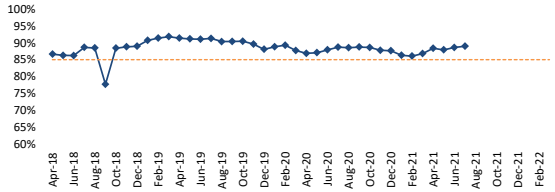
Staff FFT - % Recommend as Place of Work



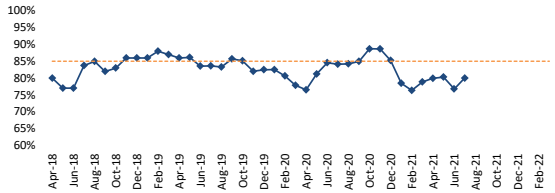
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



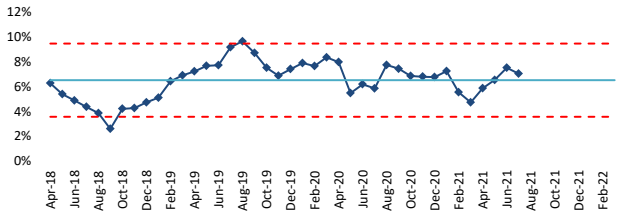
Quality of Care

Well Led - Workforce KPIs

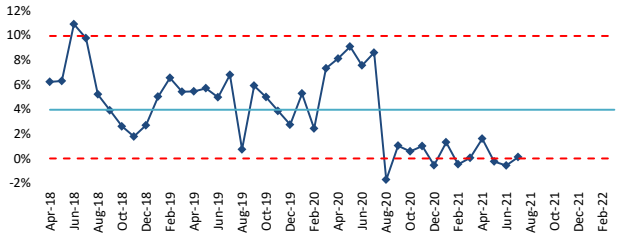
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

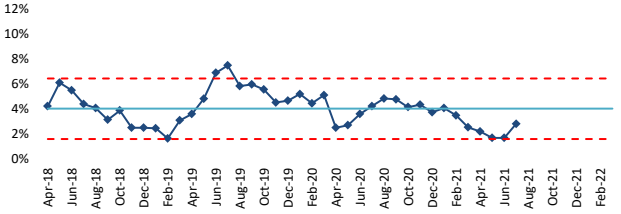
Nursing Vacancy Level %



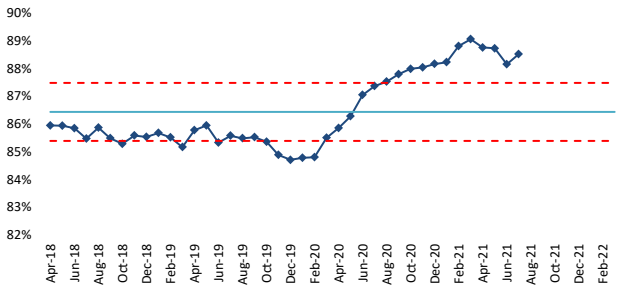
Medical Vacancy Level %



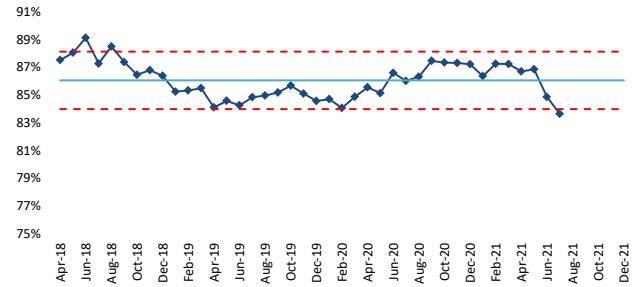
Other Staff Vacancy Level %



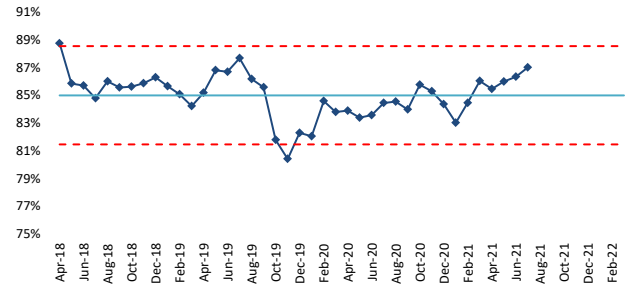
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical

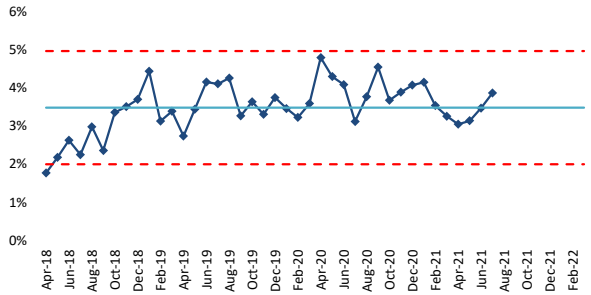


Quality of Care

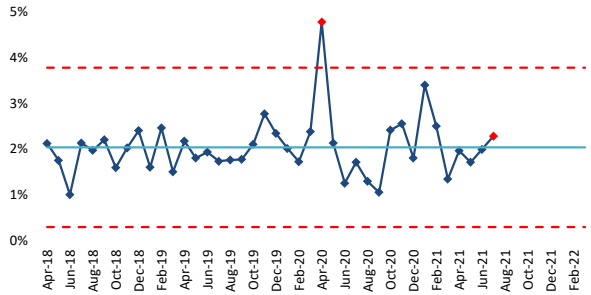
Well Led - Workforce KPIs

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

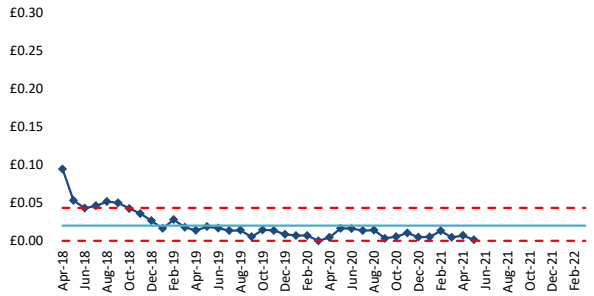
Long Term Sickness/Absence (Monthly)



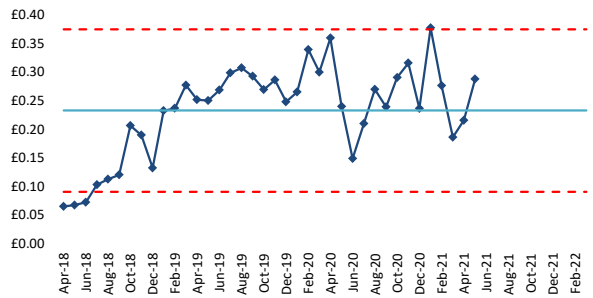
Short Term Sickness/Absence (Monthly)



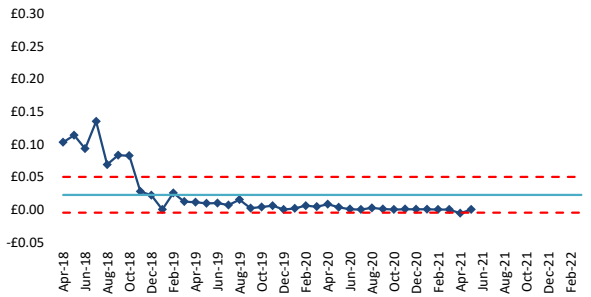
Nursing & HCA Overtime Spend (£m)



Nursing & HCA Bank Spend (£m)



Nursing & HCA Agency Spend (£m)



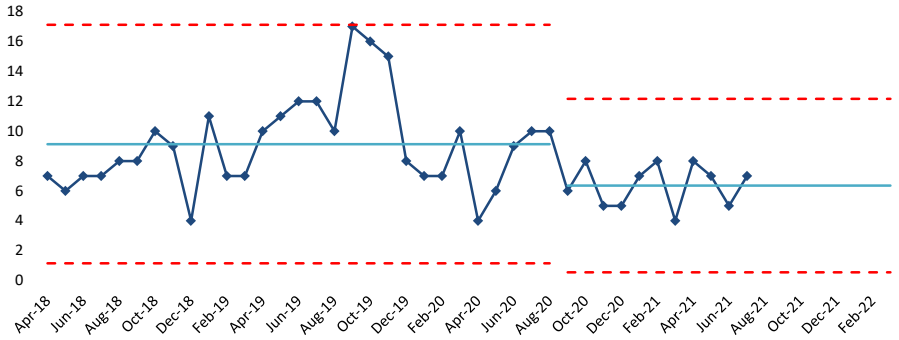
Quality of Care

Caring - Complaints

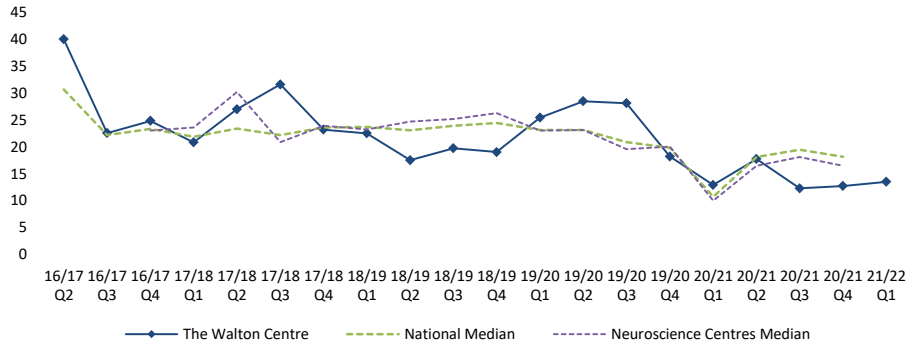
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

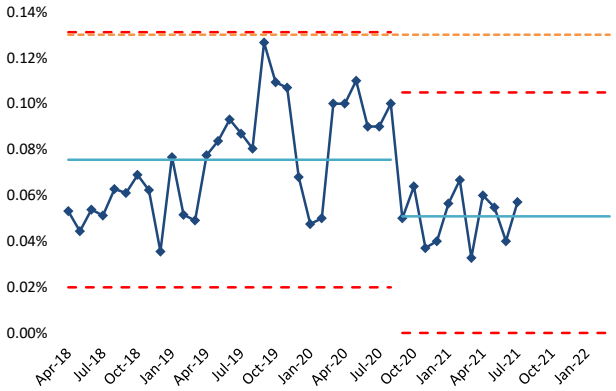
Total Complaints Received in month



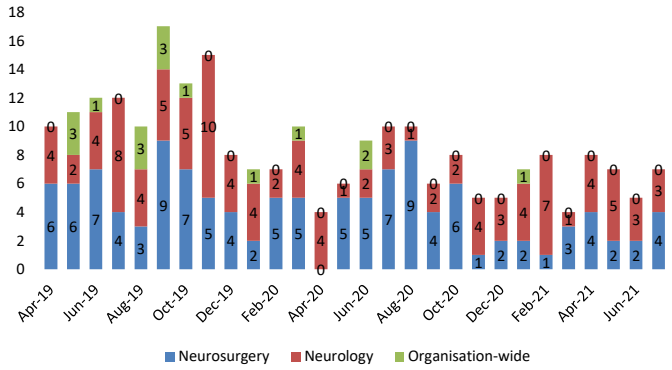
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In July 2021 the Trust received 7 complaints. 3 Neurology, 4 Surgery.

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

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

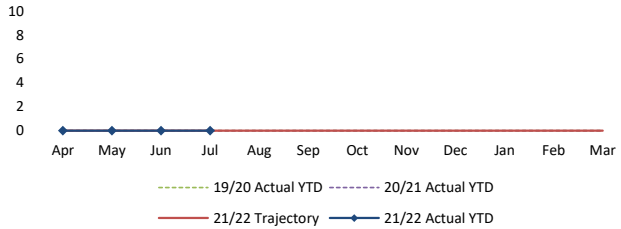
Quality of Care

Safe - Infection Control

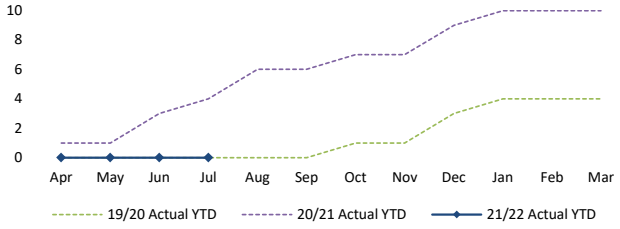
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

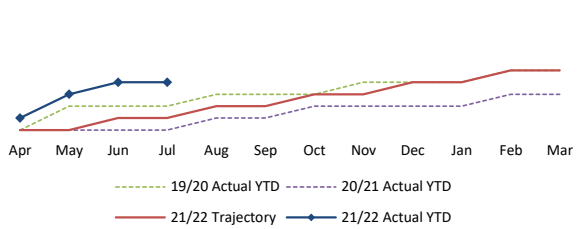
MRSA Bacteraemia



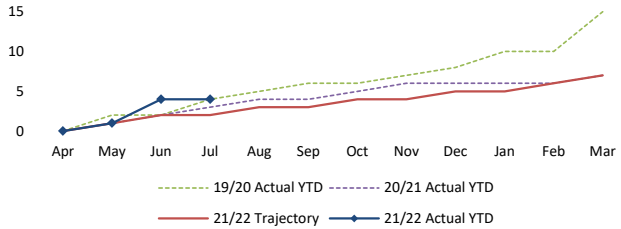
CPE



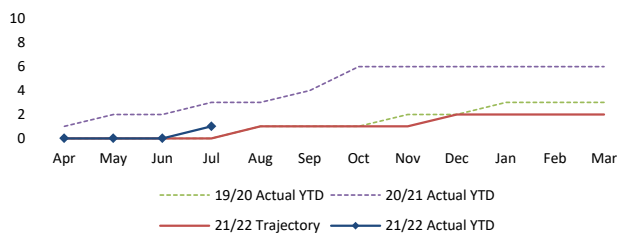
C.Diff



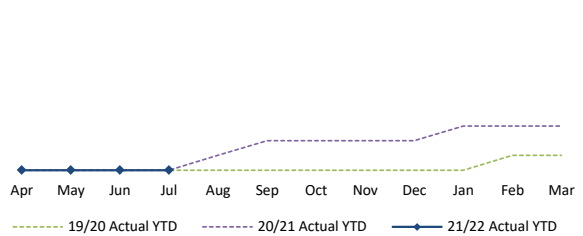
E.Coli



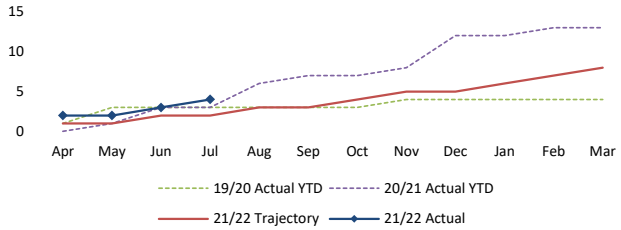
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2021/22

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns								**0**
Caton								**0**
Chavasse				2				**2**
CRU								**0**
Dott							1	**1**
Horsley			4	2	1		3	**10**
Lipton								**0**
Sherrington								**0**
Total	**0**	**0**	**4**	**4**	**1**	**0**	**4**	**13**

July Breakdown by Ward

1x MSSA - Horsley
1x KB - Horsley

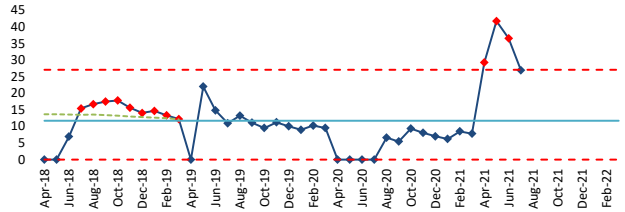
Quality of Care

Safe - Infection Control

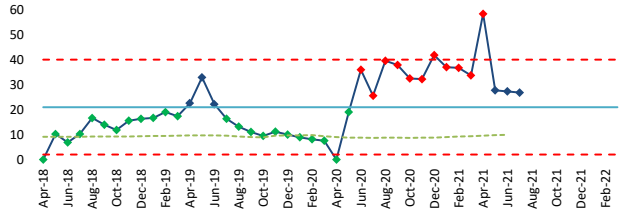
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

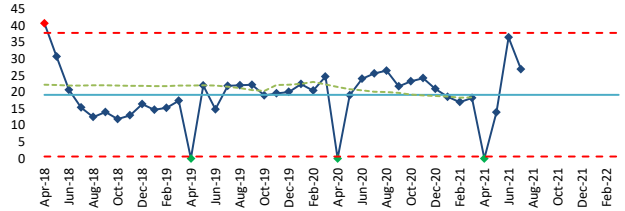
C.Diff Rate per 100,000 Bed Days YTD



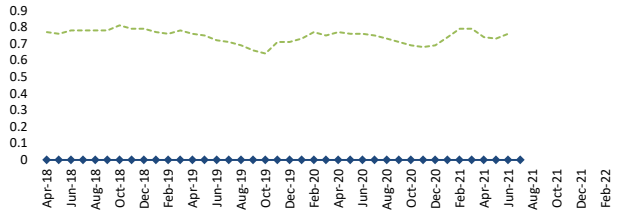
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

There are currently four MSSA instances reported year to date against a year end trajectory of eight. When measured against the benchmark standard of per 100,000 beds the current YTD rate is 26.92 which is significantly above the latest national average (9.94).

There have been four C.Diff instances year to date against a year end trajectory of 5. The rate per 100,000 bed days is currently at 26.92

All other infections are within their trajectories. E.Coli rate per 100,000 bed days have typically been better or in line with the average, while MRSA has been consistently better.

Due to a counting and coding change nationally there is a delay in publishing the national E.Coli rate

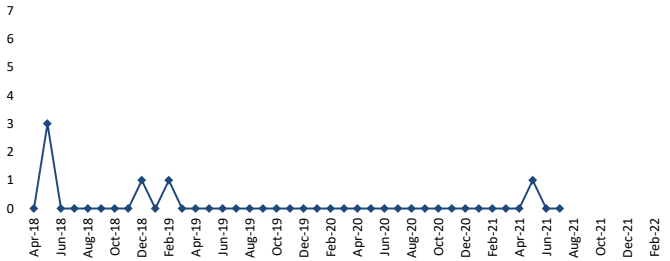
Quality of Care

Safe - Harm Free Care

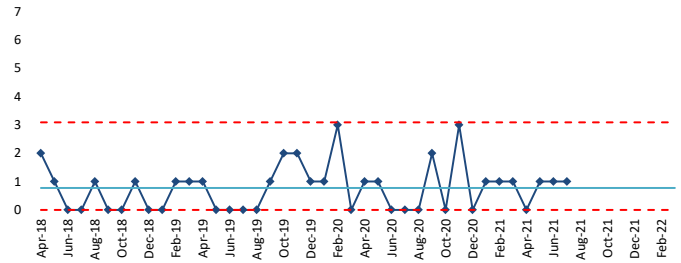
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

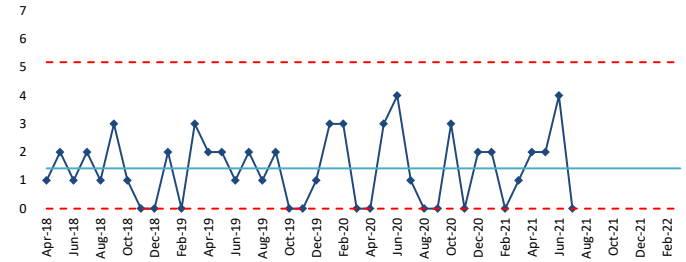
Total Moderate or Above Harm Inpatient Falls



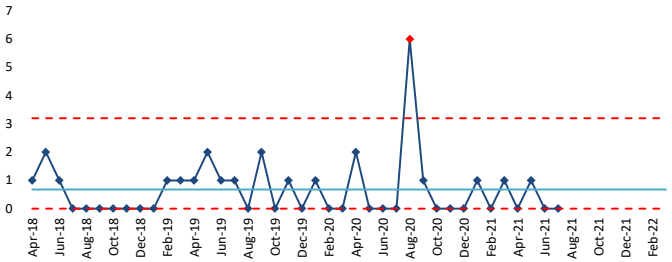
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

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

There was one Hospital Acquired Pressure Ulcers in month

There were zero CAUTI incidence in month

There were no VTE incidences in month

All harm measures are within normal variation.

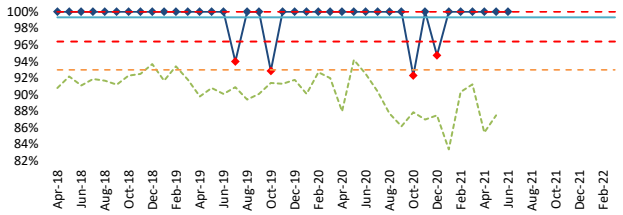
Operational

Responsive - Cancer

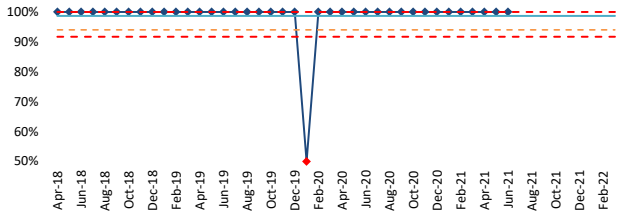
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

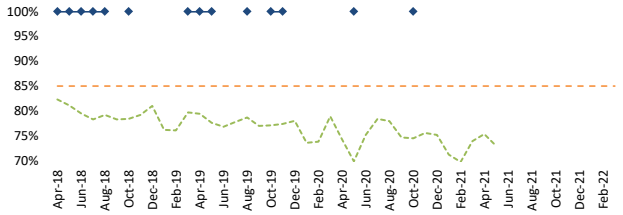
14 Day Performance



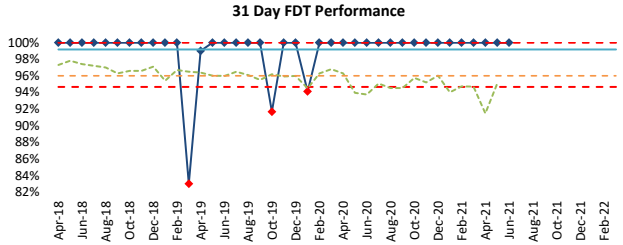
31 Day Subsequent Performance



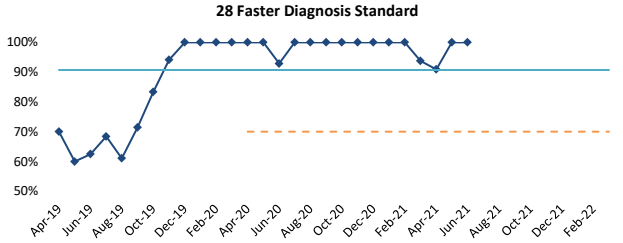
62 Day GP Urgent Referral



31 Day FDT Performance



28 Faster Diagnosis Standard



Narrative

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

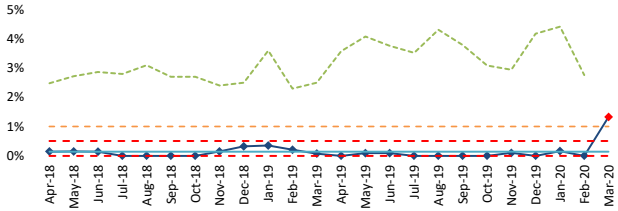
Operational

Responsive - Diagnostics

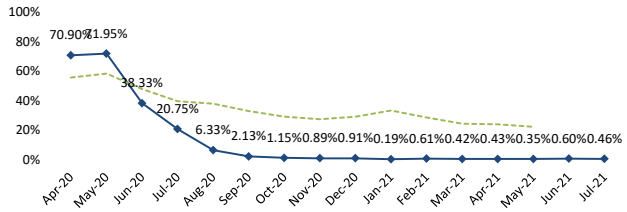
The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

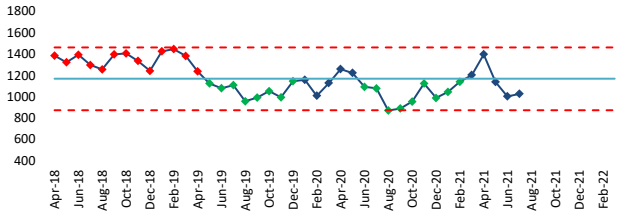
6 Week Diagnostic Performance (18/19 - 19/20)



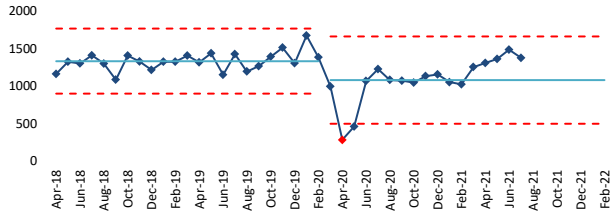
6 Week Diagnostic Performance (20/21 - 21/22)



Total Diagnostic Waits at Month End



Total Diagnostic Activity in Month



Narrative

The Diagnostic 6 week standard has continued to meet the target since November 2020 with performance at 0.46% in July 2021. Performance has improved significantly since May 2020, however due to Infection Prevention and Control measures Radiology capacity is at 90% therefore any increase in demand may impact performance.

Ward Scorecard

July 2021

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

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

WELL LED

Finance

Trust I&E	In month			Year to date			H1 plan		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Patient Care Income	9,368	9,137	(231)	37,473	38,199	726	56,223	56,309	86
Exclusions	2,063	2,145	82	8,252	8,673	421	12,379	13,231	852
Private Patients	9	2	(7)	35	5	(30)	52	7	(45)
Other Operating Income	458	515	57	1,832	2,025	193	2,734	3,004	270
Total Operating Income	**11,898**	**11,799**	**(99)**	**47,592**	**48,902**	**1,310**	**71,388**	**72,551**	**1,163**
Pay	(6,274)	(6,290)	(16)	(24,819)	(25,206)	(387)	(37,470)	(37,963)	(493)
Non-Pay	(2,895)	(2,720)	175	(11,069)	(11,603)	(534)	(16,691)	(16,662)	29
Exclusions	(2,063)	(2,146)	(83)	(8,253)	(8,889)	(636)	(12,379)	(13,597)	(1,218)
COVID	(163)	(68)	95	(644)	(355)	289	(966)	(524)	442
Total Operating Expenditure	**(11,395)**	**(11,224)**	**171**	**(44,785)**	**(46,053)**	**(1,268)**	**(67,506)**	**(68,746)**	**(1,240)**
EBITDA	**503**	**575**	**72**	**2,807**	**2,849**	**42**	**3,882**	**3,805**	**(77)**
Depreciation	(487)	(487)	0	(1,948)	(1,945)	3	(2,922)	(2,920)	2
Profit / Loss On Disp Of Asset	0	16	16	0	52	52	0	52	52
Interest Receivable	0	0	0	0	0	0	0	0	0
Financing Costs	(53)	(50)	3	(212)	(197)	15	(318)	(295)	23
Dividends on PDC	(127)	(127)	0	(508)	(508)	0	(762)	(762)	0
I & E Surplus / (Deficit)	**(164)**	**(73)**	**91**	**139**	**251**	**112**	**(120)**	**(120)**	**0**
Capital donations I&E impact	**20**	**(2)**	**(22)**	**80**	**51**	**(29)**	**120**	**120**	**0**
I & E Surplus / (Deficit)	**(144)**	**(75)**	**69**	**219**	**302**	**83**	**0**	**0**	**0**

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

The current H1 plan includes:

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

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

In month 4, the Trust reported a £75k deficit position. This is a £69k improvement on the planned in month position of £144k deficit. This improvement in month is due to an over-performance in Isle of Man activity, injury recovery scheme income and Health Education England funding, as well as lower spend than planned on clinical supplies to deliver increased ERF activity offset by a reduced ERF income.

The position includes £1,942k elective recovery fund against a planned position of £1,312k, £630k above plan (relating to over performance national trajectories in M1-3). In M4 the Trust was under the 95% trajectory (estimated 90.4%) and as such no ERF income has been assumed. Please note NHSE/I has yet to confirm ERF income values for M2-4 to the Trust therefore this may be subject to change.

The in-month position includes £68k spend incurred as a result of COVID-19.

STATEMENT OF FINANCIAL POSITION - 2021/22	March-21	July-21	Movement
	£'000	£'000	£'000
Intangible Assets	869	830	(39)
Tangible Assets	86,164	84,864	(1,300)
TOTAL NON CURRENT ASSETS	**87,033**	**85,694**	**(1,339)**
Inventories	1,157	1,507	350
Receivables	7,523	7,542	19
Cash at bank and in hand	35,689	34,840	(849)
TOTAL CURRENT ASSETS	**44,369**	**43,889**	**(480)**
Payables	(25,914)	(24,665)	1,249
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,569)	(1,473)	96
TOTAL CURRENT LIABILITIES	**(27,761)**	**(26,416)**	**1,345**
NET CURRENT ASSETS/(LIABILITIES)	**16,608**	**17,473**	**865**
Provisions	(720)	(705)	15
Finance Lease	(63)	(51)	12
Loans	(23,635)	(22,937)	698
TOTAL ASSETS EMPLOYED	**79,223**	**79,474**	**251**
Public Dividend Capital	30,513	30,513	0
Revaluation Reserve	2,947	2,947	0
Income and Expenditure Reserve	45,763	46,014	251
TOTAL TAXPAYERS EQUITY AND RESERVES	**79,223**	**79,474**	**251**

STATEMENT OF CASH FLOW - 2021/22	July-21 plan	July-21 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**139**	**251**	**112**
Non-Cash Flows In Operating Surplus/(Deficit)	2,575	2,666	91
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**2,714**	**2,917**	**203**
Increase/(Decrease) In Working Capital	(37)	(216)	(179)
Increase/(Decrease) In Non-Current Provisions	(7)	(14)	(7)
Net Cash Inflow/(Outflow) From Investing Activities	(3,680)	(2,534)	1,146
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**(1,010)**	**153**	**1,163**
Net Cash Inflow/(Outflow) From Financing Activities	178	(1,002)	(1,180)
NET INCREASE/(DECREASE) IN CASH	**(832)**	**(849)**	**(17)**
OPENING CASH	**35,689**	**35,689**	**0**
CLOSING CASH	**34,857**	**34,840**	**(17)**

COVID-19 expenditure:

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

In month Actual: £68k.

Year to date Actual: £355k.

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

COVID -19 Expenditure	Apr-21 Actual £'000	May-21 Actual £'000	Jun-21 Actual £'000	Jul-21 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	57	49	249
Decontamination	0	7	3	0	10
Agile working	0	12	1	0	13
Other	20	1	43	19	83
TOTAL	**113**	**70**	**104**	**68**	**355**

Other spend includes providing free car parking for staff.

Capital

In month variance - £256k below plan.

Year to date variance - £1,141k below plan.

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

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

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

CAPITAL

	In month			Year to date			Forecast		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
Division									
Heating & Pipework	92	87	5	367	266	101	1,100	900	200
Estates	0	0	0	0	0	0	850	738	112
IM&T	81	17	64	323	148	175	969	969	0
Neurology	0	0	0	0	9	(9)	2,349	1,703	646
Neurosurgery	0	0	0	0	0	0	2,594	2,185	409
Corporate	0	0	0	0	0	0	491	150	341
Capital Slippage	(40)	0	(40)	(166)	0	(166)	(2,150)	(442)	(1,708)
TOTAL (excl. external funding)	**133**	**104**	**29**	**524**	**423**	**101**	**6,203**	**6,203**	**0**
Donated Assets	20	20	0	32	32	0	32	32	0
Digital Aspirant	302	75	227	1,208	168	1,040	3,623	3,623	0
TOTAL (incl. external funding)	**322**	**95**	**227**	**1,240**	**200**	**1,040**	**3,655**	**3,655**	**0**
TOTAL	**455**	**199**	**256**	**1,764**	**623**	**1,141**	**9,858**	**9,858**	**0**

Capital spend in month is £199k.

- **Heating & Pipework**: £87k – Phase 4 works;
- **IM&T:** £17k - Staffing in relation to specific projects;
- **Donated Assets:** £20k cell path macro imager (Labs)
- **Digital Aspirant (PDC funded):** £75k – Whiteboard development.

The year-end capital forecast is £9.9m (including external funding) which is in-line with the agreed funding allocations. This assumes that a further £0.4m slippage is managed within the current forecast to bring anticipated spend back in line with the annual capital allocation.

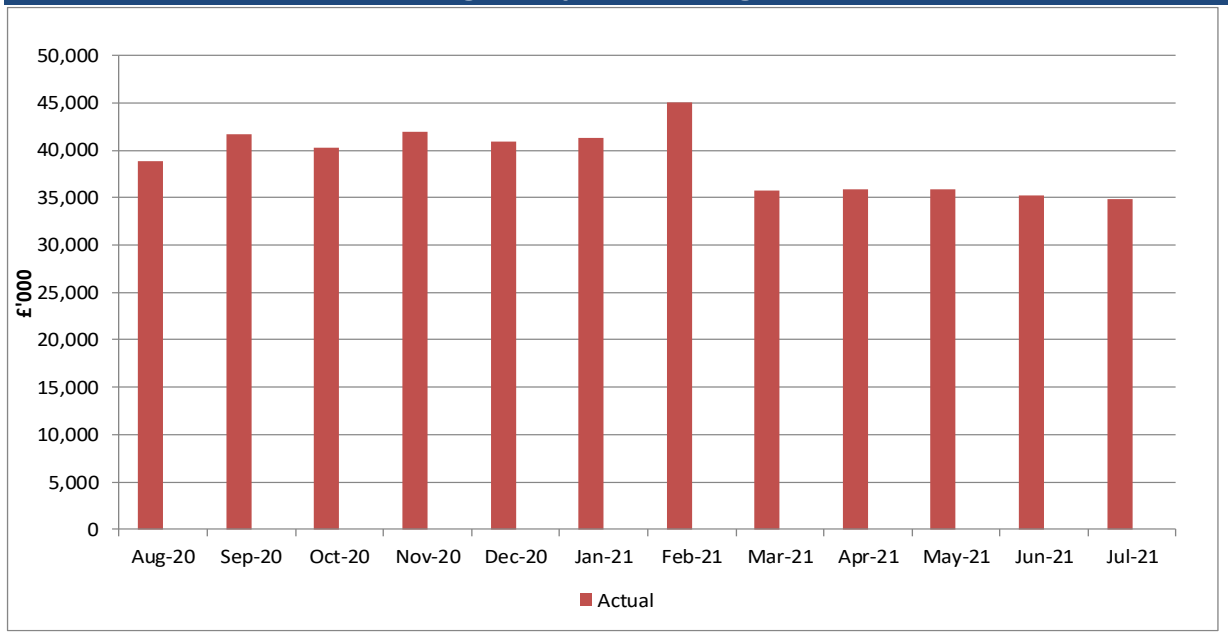
Work is ongoing with clinical and operational leads to prioritise capital spend for 21/22 to ensure that it is delivered in line with agreed funding levels.

As of the end of July:

Actual Cash Balance: £34.8m.

Number of days operating expenses = 91 days.

Cashflow against plan (Rolling 12 months)



The Trust cash balance at the end of July was £34.8m. This is a reduction of £0.4m compared with the end of June due to an increase in receivables, in month capital expenditure and a reduction in capital payables.

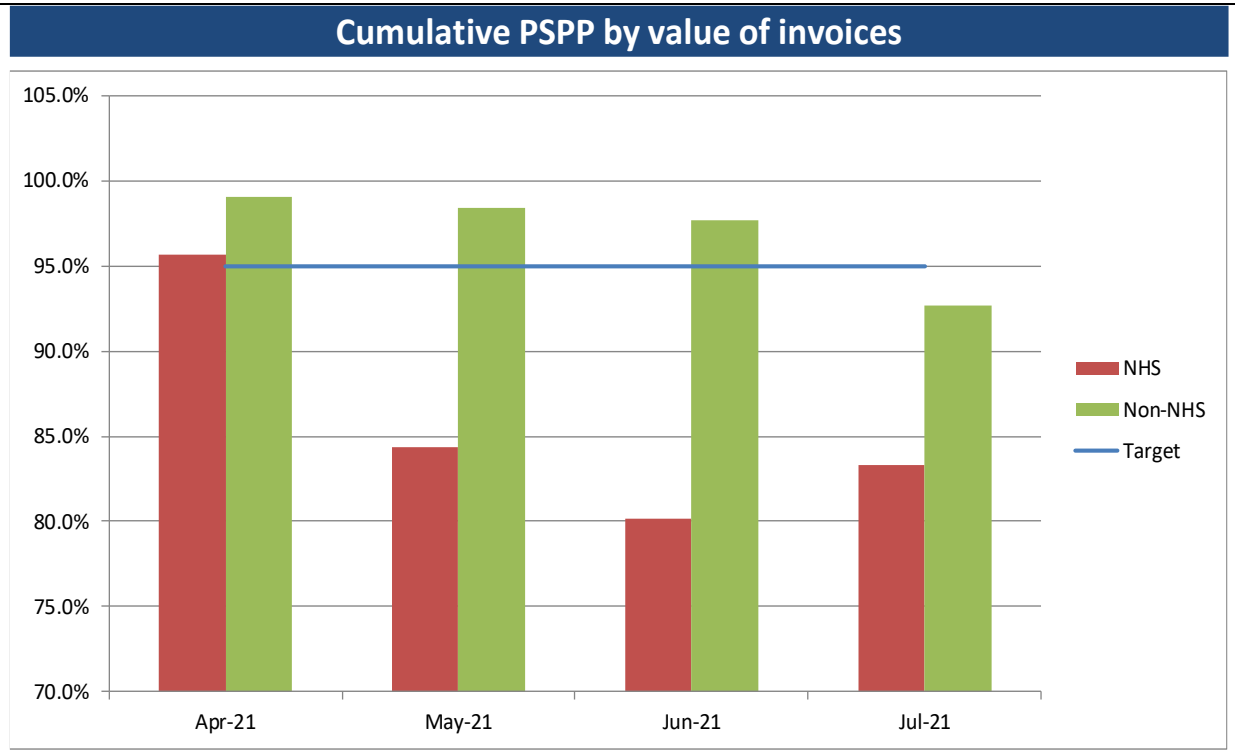
The reduction of cash in March 21 was due to the reversal of the advanced block payments that had been received from commissioners during 20/21, by the Trust each month for the new financial arrangements to cover the COVID-19 pandemic.

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

Better Payments Practice Code (BPPC):

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

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



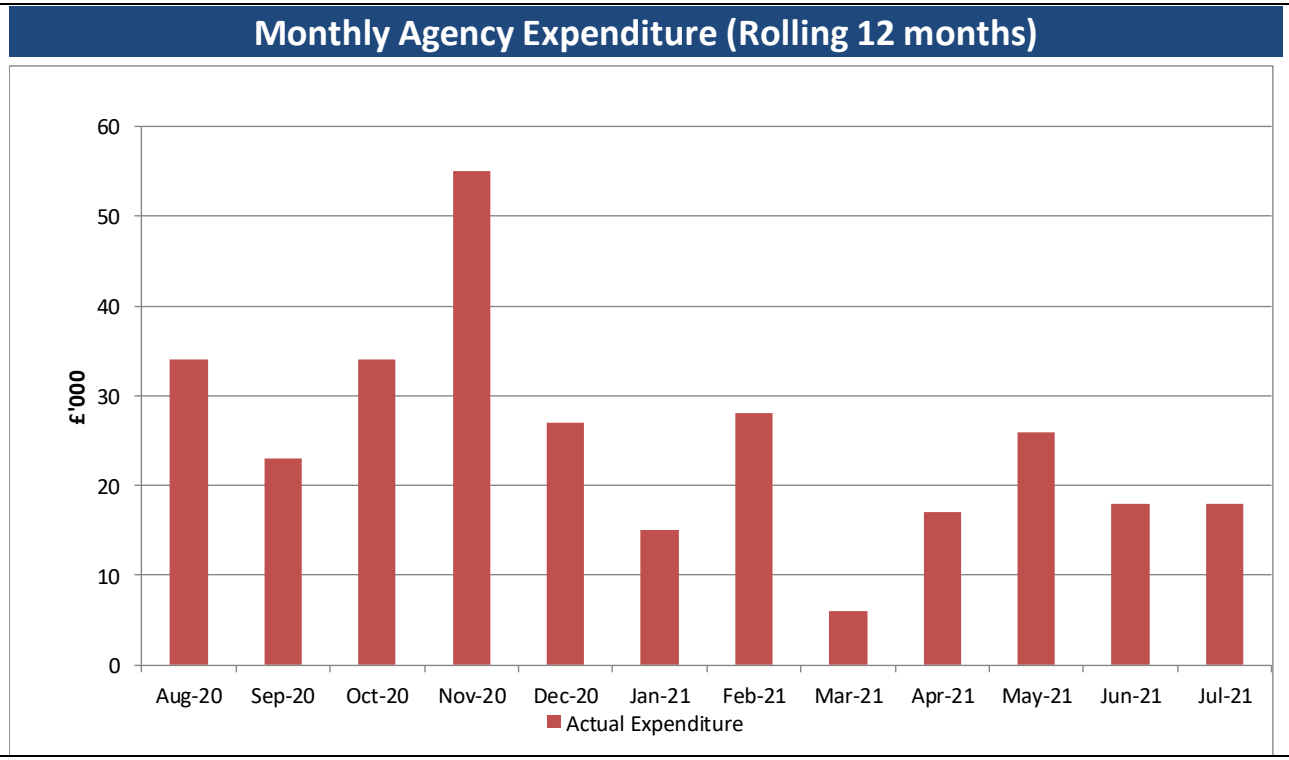
The Trust BPPC percentage (by value) at the end of July against the target of 95.0% was:

- Non NHS 92.7%;
- NHS 83.3%.

This has seen deterioration in non-NHS payments of 5.0% (due to a low volume but high value NHS Logistics invoices paid outside the 30 days limit) and an improvement in NHS payments of 3.1% since the end of June.

The finance team are reviewing the monitoring and payment processes to bring the payment to within 30 days.

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

Agency Expenditure: In month Actual: £18k. Year to date Actual: £79k.		Agency spend incurred in July was £18k, in line when compared to June. At the end of July, £5k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions in 2021/22

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

- Delay of 2021/22 business planning until 2nd half of 21/22, with finance regime of 2020/21 to continue for at least 6 months of 2021/22 (H1);
- Payment by Results (PbR) continued suspension for the first 6 months of the year and income being based on block values determined nationally (based on 2020/21 Q3 levels plus 0.5% inflation, incorporating a 0.28% efficiency requirement) and adjusted for the impact of CNST increases;
- System funding has been allocated to C&M HCP for M1-6 which has been distributed to all organisations and included within organisational H1 plans to cover costs in relation to Top-up, COVID-19 (in relation to reasonable COVID-19 expenditure), growth and CNST;
- The trust is currently being monitored against plans for April to September forecast to break-even submitted to NHSE/I and C&M HCP on 26nd May;
- System level financial targets have also been submitted with a forecast for the system to breakeven at the end of H1;
- An Elective Recovery Fund (ERF) came into effect in April 21 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M1-M6). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then may receive a retrospective financial penalty. The elective recovery scheme will be monitored at C&M HCP system level. The H1 plan incorporates forecast income and expenditure to deliver the trusts activity plan for H1 plan based on national trajectory requirements (operational and clinical teams will work to deliver these planned activity levels), further guidance has now been issued by NHSE/I increasing the trajectory threshold from 85% to 95% for M4-M6 which has now put the elective recovery fund income in the plan for that period at risk as the Trust would need to considerably over-perform the 95% threshold to recover the same levels of planned income. The current H1 forecast does not take account of the reduced income following the increase in national activity trajectories;
- 2021/22 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this includes an allocation of additional PDC (Digital Aspirant Funding) allocated for IM&T innovation;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

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

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

RISK	COMMENT/ ACTIONS
Access to Elective Recovery Fund	The operational requirements for 2021/22 to aid restoration of outpatient and elective inpatient services within the NHS, the Trust is required to meet national targets for activity and income as follows:

	• Overall outpatient and elective activity value against 2019/20:
	  ○ 70% for April 2021;
	  ○ 75% for May 2021;
	  ○ 80% for June 2021; and
	  ○ 95% from July to March 2022 - updated trajectory.
	
	Elective recovery gateway criteria; in order to receive additional funding for over-performing the national operational requirements per above the following criteria must also be met:
	• Addressing health inequalities;
	• Transforming outpatient services;
	• System-led recovery;
	• Clinical validation, waiting list data quality and reducing long waits; and
	• People recovery
	
	In addition the elective recovery fund will be managed and monitored at system level, therefore if the trust meets the national recovery targets set there is a risk that if the C&M HCP does not meet the requirements that the Trust will not receive the additional funding to meet the increased levels of activity.
	
	As the national activity trajectory has increased to 95% from 1st July it is highly unlikely that the ERF income assumed in the H1 plan will be received which will impact on the Trust's ability to deliver a breakeven position at the end of H1.

Future NHS Financial Framework	As a result of the current national position with COVID-19, notification has been received that 2021/22 financial planning was deferred. In addition to this, it has been confirmed that current financial arrangements will remain in place for at least the 1st half of 2021/22. Current national guidance states that H1 funding will be based on Q3 20/21 spend extrapolated for 6 months with system allocations for

	providers to achieve a breakeven position. Further work has been undertaken to understand the financial forecast for H1 and final financial plans have been submitted to the HCP and NHSE/I. It is currently unclear at what the financial framework will be for H2 onwards, but it is anticipated that there will be an increased efficiency requirement for the 2nd 6 months of 21/22. The finance team are currently reviewing plans for H2.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be in H2 of this financial year and as such planning to deliver recurrent savings is difficult. Clearly the delay in 2021/22 business planning may impact on national efficiency requirements and it is currently not clear what internal efficiencies may need to be delivered to meet expected financial plans. However recurrent efficiencies will be required to be delivered in 2021/22 and work is being undertaken to identify these. Although national efficiency targets are still to be set, it is anticipated that they will increase compared to H1 levels.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as elective activity was suspended during the first wave of the pandemic and fewer patients will be able to be seen given the additional PPE/ social distancing requirements). There is also a result of delivering activity as a result of the increased in COVID infection rates in the community as there may be an increase in the number of staff required to self-isolate (and as such not be available to work on site). There is also a potential impact on our services (for example spinal) and if we are required to support other Trusts in the region with critical care surge capacity.

QIP Reporting

The Walton Centre NHS Foundation Trust

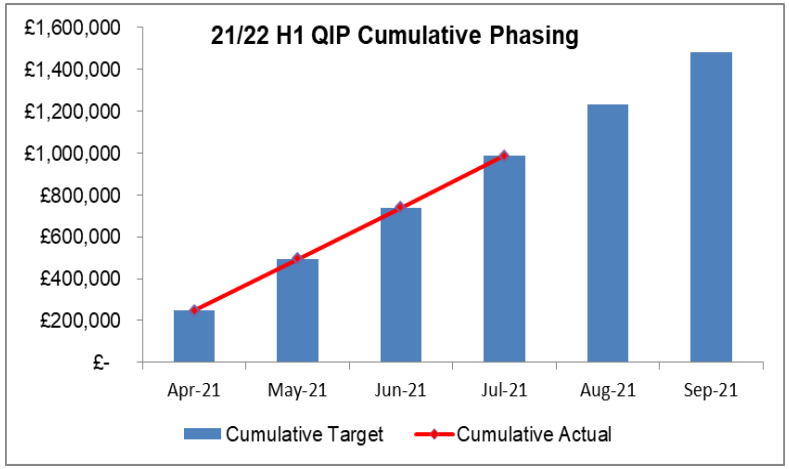
In order to deliver the Trust's control total target for H1 in 2021/22, we need to deliver the QIP target.

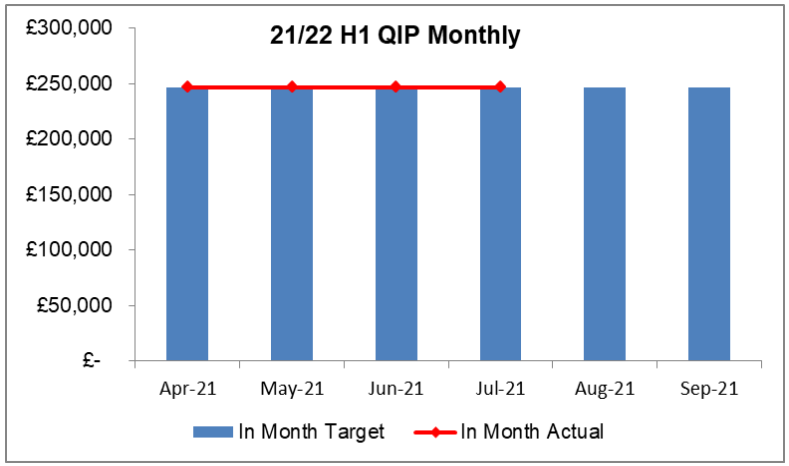
It is currently anticipated that the Trust will deliver financial breakeven by the end of H1, meaning that the H1 QIP target will have been delivered.

The biggest challenge is achieving the H2 QIP target, which is likely to be a minimum of 3% (£2.1m).

There is greater emphasis to focus on recurrent QIP schemes that will continue to deliver efficiencies over the next three years.

Scheme	H1 Plan			YTD Plan			YTD Actual			YTD Variance		
	Recurrent	Non-Recurrent	Total	Recurrent	Non-Recurrent	Total	Recurrent	Non-Recurrent	Total	Recurrent	Non-Recurrent	Total
Sherrington Ward Closure	250,000		**250,000**	124,998		**124,998**		123,000	**123,000**	(124,998)	123,000	**(1,998)**
Ward Clerks - stop night shifts	11,691		**11,691**	2,338		**2,338**			**0**	(2,338)	0	**(2,338)**
Radiology RIS Maintenance contract	4,000		**4,000**			**0**			**0**	0	0	**0**
Bunzl procurement savings	7,369		**7,369**	3,684		**3,684**			**0**	(3,684)	0	**(3,684)**
General ward reconfiguration			**0**			**0**		50,000	**50,000**	0	50,000	**50,000**
General schemes	1,826,940		**1,826,940**	608,980		**608,980**		567,000	**567,000**	(608,980)	567,000	**(41,980)**
	2,100,000	**0**	**2,100,000**	**740,000**	**0**	**740,000**	**0**	**740,000**	**740,000**	**(740,000)**	**740,000**	**0**





The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
02/09/2021

Title	**Workforce Race Equality Standard (WRES) Findings and Actions Trust Board 2021**
Sponsoring Director	Name: Mike Gibney Title: Mike Gibney, Director of Workforce and Innovation
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	N/A
Executive Summary The WRES requires Trusts to demonstrate progress against nine indicators of workforce race equality and report and publish the results on an annual basis.	
Related Trust Ambitions	Equality, Diversity, and Inclusion (ED&I) 5 Year Vision Overall ED&I Walton Centres commitment: ● We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.
Risks associated with this paper	
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	Yes
Any associated legal implications / regulatory requirements?	WRES reporting and publication is required of the Trust by NHSE/I. The WRES also helps to demonstrate the Trust's compliance with its Public Sector Equality Duty in respect of race equality under the Equality Act 2010.
Action required by the Board	The Board is requested to: • Approve the WRES Report 2021.

The Walton Centre NHS Foundation Trust

Workforce Race Equality Standard (WRES) Findings and Actions

Trust Board

2021

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1. Introduction

Introduction The WRES requires Trusts to demonstrate progress against nine indicators of workforce race equality. The indicators focus upon Board level representation and differences between the experience and treatment of White and BME staff. In addition to producing and publishing the WRES PDF template and action plan on the Trust website and intranet, we are also required to submit a return via the NHS England, Strategic Data Collection Service (SDCS) system to enable further comparisons to be made between NHS trusts. This reporting period covers 01 April 2019 to 31 March 2021. The 2019, 2018 and 2017 WRES Reports are also available on The Walton Centre Website: https://www.thewaltoncentre.nhs.uk/175/equality-and-diversity.html

It is important to note that the data in this report refers mostly to figures and staff experience from 2019 and preceding years. It does not capture the data after March 2020; therefore it does not reflect the significant change and activity that the Trust has undertaken in response to COVID-19 and the Black Lives Matter movement.

3 Summary of Key Points

Workforce Race Equality Standard (WRES) Findings and Actions, Trust Board 202

Indicator 1) The percentage of BME staff in each of the AfC Bands 1-9.

This indicator has improved slightly in terms of the overall percentage of BME staff in the organisation.

- As at 31 March 2021 there were a total of 1497 members of staff employed within the organisation.
- Of this total, the number of BME staff employed was 148 (9.9%).
- In March 2020 there were a total of 1452 members of staff employed within the organisation.
- Of this total, the number of BME staff employed was 138 (9.5%).
- In March 2019 the total BME Staff recorded was 133 (9.41%).
- In March 218 the total of BME staff was 181 (12.95%)
- In March 2017 the total BME staff was 9%
- In March 2016 the total BME staff was 8.4%

(Note -The 2018 BME percentage appears to have been boosted by a temporary period in which there were higher numbers of junior medics at the Trust many of whom were BME.)

If the 2018 figure is discounted as a fluctuation from the normal situation, we can see a small year on year increase in the numbers of BME staff at the Trust year on year from 2016 onward.

Indicator 2) The relative likelihood of staff being appointed from shortlisting across all posts.

This indicator remains positive in that it shows no evidence of discrimination at the shortlisting to appointment stage of recruitment. The Trust is having success in attracting a much larger percentage or applications from BME communities than their national or regional demographic.
More work may have to be done to increase BME success rates from application to shortlisting.
The number of White applicants was 3583 (69.9%).
The number of BME applicants was 1453 (28.3%).
Undisclosed ethnicity 91 (1.8%).

The number of White applicants shortlisted was 1140. The number of BME applicants shortlisted was 208. The number of Undisclosed ethnicity shortlisted 5.

(31.8 %) of White applicants were shortlisted.
(14.3%) of BME applicants shortlisted

Appointed:

115 (10.1%) of shortlisted White candidates were appointed.
21(10.1%) of BME candidates were appointed from shortlisting.

Relative likelihood of shortlisting/appointed:
White = 0.1009; BME = 0.1010

The relative likelihood of White candidates being appointed from shortlisting compared to BME candidates = 1.
A figure above 1 would indicate that white candidates are more likely than BME candidates to be appointed from shortlisting.

Indicator 3) The relative likelihood of BME staff entering the formal disciplinary process.

This indicator has not changed significantly.
For the year to March 2021 the Trust had 6 (60%) White staff entering into a formal disciplinary investigation. There were 4 (40%) BME staff entering into this process in this period.
Relative likelihood of BME staff entering the formal disciplinary process compared to white staff is therefore 0.027/0.0045 = 6.00 times greater.
Complex statistical analysis of such low numbers of disciplinaries is relatively meaningless. If disciplinaries remain at such low levels within the Trust it may be more useful monitor the numbers of BME disciplinaries to see if they rise across a significant period. No such pattern is discernible yet.

Indicator 4) The relative likelihood of staff accessing non-mandatory training and CPD.

(Note. At the time of producing this report this data was still being collated.
The data will be submitted in accordance with WRES reporting deadlines and be made available for Trust Board Scrutiny on 2/9/2021.)

Indicator 5) The percentage of staff experiencing harassment, bullying or abuse from patients.

This indicator has improved a little.

	2017	2018	2019	2020
White	21.8%	26.2%	25.3%	21.7%
BME:	46.3%	29.3%	35.1%	32.6%

There has been a (2.5%) decrease in the percentage of BME staff experiencing harassment, bullying or abuse from patients. This has been a slightly larger decrease for White staff. (10.7%) More BME staff experienced harassment, bullying or abuse from patients in staff in last 12 months.

Steps have been taken to provide more support for BME staff when such incidents occur, however these figures will be discussed with BAME staff to identify the cause and find more preventative measures.

Staff are encouraged to report all incidents of harassment, bullying or abuse from patients.
All reported incidents of harassment, bullying or abuse from patients are addressed by managers and appropriate actions are taken to safeguard staff.

Indicator 6) The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.

This indicator deteriorated a little this year reversing the very slight improvements in previous years.

	2017	2018	2019	2020
White	17.7%	19.3%	16.4%	18.9%
BME	24.4%	23.2%	21.6%	23.9%

This indicator has seen a slight increase for both White staff and BME staff. This positive trend for BME staff from previous years has moved back close to 2017 levels. (5%) more BME staff than White staff responded that they have experienced harassment, bullying or abuse in staff in last 12 months. Of the 46 BME staff respondents to this question, (5%) equates to approximately 2 or 3 more BME respondents saying that they experienced harassment, bullying or abuse in staff in last 12 months.

The 2019 gap was (5.2%). In 2018 the gap was (3.9%).

Indicator 7) The percentage believing that trust provides equal opportunities for career progression or promotion.

There has been a very small drop in the percentage of BME staff believing that trust provides equal opportunities for career progression or promotion

	2017	2018	2019	2020
White	**90.3%**	**92.8%**	**92.5%**	**88.1%**
BME	**71.4%**	**91.7%**	**77.8%**	**76.9%**

There has been a slightly larger drop in the percentage of White staff believing that trust provides equal opportunities for career
(11.2%) fewer BME staff than White staff believe that trust provides equal opportunities for career progression or promotion. Of the 26 BME respondents this equates to about 3 people.
Of the 26 BME staff respondents to this question, (11.2%) equates to approximately 3 more BME respondents saying that they experienced harassment, bullying or abuse in staff in last 12 months.
There is evidence from the BAME Staff Group meetings that this may be associated with greater awareness amongst BME staff of the disproportionately low numbers of staff (with the exception of Medical staff) at Band 7 and above, as reported in previous WRES reports.
These figures will be discussed with BAME staff to identify the cause and remedial actions.

Indicator 8) In the last 12 months have you personally experienced discrimination at work from a manager/team leader or other colleagues.

This indicator has improved a little.

	2017	2018	2019	2020
White	**6.2%**	**4.3%**	**4.5%**	**4.0%**
BME	**15.4%**	**10.7%**	**13.5%**	**10.6%**

.This reporting period has seen a small fall in the percentage of BME staff that experienced discrimination at work from a manager/team leader or other colleagues (6.6%) more BME staff than White staff reported that they experienced discrimination at work from a manager/team leader or other colleagues.

Indicator 9) The percentage difference between the organisations' Board voting membership and its overall workforce.

This indicator remains very positive.

2018	2019	2020	2021
-8.6%	- 0.1%	+7.2%	+5.5

As at 31st March 2021 the Trust Board has 13 voting member with 2 (15.4%) BME members and 11 (84.6%) White members. This percentage is both higher than the percentage of BME staff in the workforce (9.9%) = +5.5 which is a positive figure for Board diversity in terms of race equality.

2. WRES Indicators and Findings

WRES Indicator 1 Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff
Narrative As context for the narrative provided below, according to the Office of National Statistics, 2011 Census, (5.5%) of the Merseyside population has a Black, Minority Ethnic background (BME) which is lower than the North West average (9.8%). Source: Census 2011, www.ons.gov.uk The overall percentage figure for Indicator 1, rose by a miniscule amount in this reporting year, rising from the 2020 figure of 9.41% to the 2021 figure of (9.9%) for BME staff in the organisation. This new figure remains approximately in line with the BME census figures for the North West and is well above the BME census figures for Merseyside. These figures provide no justification for further positive actions to boost the overall numbers of BME staff at the Trust. However, the comparatively low percentage of staff in the non-clinical workforce and the low numbers of clinical and non-clinical staff at Band 7 and above justifies further positive actions to boost BME staff numbers in these areas. • As at 31 March 2021 there were a total of 1497 members of staff employed within the organisation. • Of this total, the number of BME staff employed was 148 (9.9%). • In March 2020 there were a total of 1452 members of staff employed within the organisation. • Of this total, the number of BME staff employed was 138 (9.5%). • In March 2019 the total BME Staff recorded was 133 (9.41%). • In March 218 the total of BME staff was 181 (12.95%) • In March 2017 the total BME staff was 9% • In March 2016 the total BME staff was 8.4% The main narrative relating to Indicator 1 is situated with the tables below.
Actions completed: – The Trust has set up a committee specifically to oversee WRES progress and advance equality for BME staff – All jobs are advertised on a specialist BME jobs website. – Signed up to NHS Employers Diversity and Inclusion Partners Programme – 30+ ED&I champions in place with role descriptor

- Signed up to RCN Cultural Ambassadors programme
- Explored introduction of an initiative whereby there must be a BME member of staff on any appointing panel.
- This measure has been
- successfully tested regarding the recruitment of a Board member in 2018 and the exploration of the possibility of using Cultural Ambassadors for this is continuing. This action will have to be further embedded before exploring the possibilities for clinical and other roles. However, appreciation must be given to the limited number of BME staff available to do this
- Board level ED&I lead is in post
- The appointment of a full-time Equality and Inclusion Lead post at the Trust
- Bespoke ED&I Cultural Competence and Cultural Confidence Training for ED&I champions delivered by a specialist consultancy

Further proposed actions:

- Further exploration is needed to understand any barriers BME staff feel they face when applying for more senior positions or the reasons why they do not apply.
- Continue to monitor this indicator.

Indicator 1 Findings: 2020 Whole Workforce 31 March 2021 Tables.

Total staff	White total	BME Total	Total unknown
1497	1338 (89.7%)	148 (9.9%)	11 (0.7%)

Non Clinical workforce Total: 388 Staff

1a) Non Clinical workforce	White Non Clinical staff numbers	White staff as a percentage of Non Clinical staff	White Non Clinical staff as a percentage of all staff	BME Non Clinical staff numbers	BME staff as a percentage of Non Clinical staff	BME Non Clinical staff as a percentage of all staff	Unknown/ null
Under Band 1	0	(0.0%)	(0.0%)	0	(0.0%)	(0.0%)	0
Band 1	0	(0.0%)	(0.0%)	0	(0.0%)	(0.0%)	0
Band 2	79	(20.4%)	(5.3%)	1	(0.3%)	(0.1%	0
Band 3	74	(19.1%	(4.9%)	2	(0.5%)	(0.1%)	0
Band 4	91	(23.5%)	(6.1%)	3	(0.8%)	(0.2%)	0
Band 5	43	(11.1%	(2.9%)	1	(0.3%)	(0.1%)	0
Band 6	23	(5.9%	(1.5%)	0	(0.0%)	(0.0%)	0
Band 7	23	(5.9%)	(1.5%)	2	(0.5%)	(0.1%)	0
Band 8A	19	(4.9%)	(1.3%)	0	(0.0%)	(0.0%)	0
Band 8B	11	(2.8%)	(0.7%)	0	(0.0%)	(0.0%)	0
Band 8C	5	(1.3%)	(0.3%)	0	(0.0%)	(0.0%)	0
Band 8D	4	(1.0%)	(0.3%)	0	(0.0%)	(0.0%)	0
Band 9	1	(0.3%)	(0.1%)	0	(0.0%)	(0.0%)	0
VSM	6	(1.5%)	(0.4%)	0	(0.0%)	(0.0%)	0
Totals	379	(97.7%)	(25.3%)	9	(2.3%)	(0.6%)	0

Of the 388 Non Clinical staff, 10 (2.3%) are recorded as BME. These figures indicate an decrease of 1 Non Clinical BME staff since March 2020. There are now 0 BME staff at BAND 7+, where there was previously 1. The Trust now has 2 BME staff at BAND 7 where there were previously none. The majority of this BME staff group remain at Band 4 and below which is an improvement on the previous year then the majority were at Band 3 and below.

Though it is an undesirable the comparatively low numbers of Non Clinical BME staff does not currently present a risk to the organisation in terms of The Equality Act 2010. This is because there is no indication that this imbalance is caused by discriminatory practices on the part of the Trust and it is currently balanced by the overall number of BME staff at the Trust, which is roughly in line with regional and local race equality demographics. The Non Clinical BME staffing imbalance does, however warrant targeted action in terms of the Trusts commitments as set out in The Equality, Diversity and Inclusion (ED&I) 5 Year Vision and the Trusts general desire to improve equality of opportunity. The Trust intends to examine ways to better promote Non Clinical job opportunities to BME communities.

Clinical workforce Total: 966 Staff

1b) Clinical workforce	White Clinical staff numbers	White staff as a percentage of Clinical staff	White Clinical staff as a percentage of all staff	BME Clinical staff numbers	BME staff as a percentage of Clinical staff	BME Clinical staff as a percentage of all staff	Unknown/null
Under Band 1	0	(0.0%)	(0.0%)	0	(0.0%)	(0.0%)	0
Band 1	0	(0.0%	(0.0%)	0	(0.0%)	(0.0%)	0
Band 2	164	(17.0%)	(11.0%)	13	(1.3%)	(0.9%)	1
Band 3	94	(9.7%)	(6.3%0	1	(0.1%)	(0.1%)	0
Band 4	31	(3.2%)	(2.1%)	1	(0.1%)	(0.1%)	1
Band 5	210	(21.7%)	(14.0%)	34	(3.5%)	(2.3%)	0
Band 6	145	(15.0%)	(9.7%)	14	(1.4%)	(0.9%)	1
Band 7	156	(16.1%)	(10.4%)	5	(0.5%)	(0.3%)	0
Band 8A	68	(7.0%)	(4.5%)	2	(0.2%)	(0.1%)	0
Band 8B	11	(1.1%)	(0.7%)	0	(0.0%)	(0.0%)	0
Band 8C	5	(0.5%	(0.3%	0	(0.0%)	(0.0%)	0
Band 8D	4	(0.4%)	(0.3%)	0	(0.0%)	(0.0%)	0
Band 9	0	(0.0%)	(0.0%)	0	(0.0%%	(0.0%)	0
VSM	3	(0.3%)	(0.2%)	2	(0.2%)	(0.1%)	0
Totals	891	(92.2%)	(59.5%)	72	(7.5%)	(4.8%)	3

Clinical workforce

At 966 this section of the workforce has seen an increase in overall numbers rising from 930 in 2020. This rise has mostly been in the numbers of White staff. The current make up the Clinical workforce is 27 (7.5%) BME staff, which is an increase in only 1 BME staff member in this period.
The majority of these BME Staff remain clustered around pay Bands 5 and 6 with a smaller spike in their numbers at Band 2. There has been an increase of 2 in the number of Clinical BME staff at pay Bands 6+. There are currently 5 BME Clinical staff at pay Band 7 and 2 at VSM level.

Medical workforce Total: 143 Staff

Medical	White Medical staff numbers	White staff as a percentage of Medical staff	White Medical staff as a percentage of all staff	BME Medical staff numbers	BME staff as a percentage of Medical staff	BME Medical staff as a percentage of all staff	Unknown/null
Consultants	56	(39.2%)	(3.7%)	43	(30.1%)	(2.9%)	7
of which Senior medical manager	TBC	(0.0%)	(0.0%)	TBC	(0.0%)	(0.0%)	TBC
Non-consultant career grade	3	(2.1%)	(0.2%)	4	(2.8%)	(0.3%)	1
Trainee grades	9	(6.3%)	(0.6%)	20	(14.0%)	(1.3%)	0
Other grades	0	(0.0%)	(0.0%)	0	(0.0%)	(0.0%)	0
Totals	68	(47.6%)	(4.5%)	67	(46.9%)	(4.5%)	8

There are currently 143 Medical staff 67 (46.9%) of whom are recorded as BME. This relatively high number of BME Medical staff is a reflection of the national racial demographic of Medical staff which is currently very different from the National or regional racial profile of the general population. In short, the international nature of the medical labour market leads to a much larger representation of BME staff than the average proportion of BME people in the National population. Government figures for November 2018 indicated that (38.8%) of the NHS Medical workforce was recorded as BME.

Source:
https://www.ethnicity-facts-figures.service.gov.uk/workforce-and-business/workforce-diversity/nhs-workforce/latest

WRES Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts.			
2018	**2019**	**2020**	**2021**
Relative likelihood of White staff being appointed from shortlisting compared to BME staff = 1.50 times greater. The total number of applicants shortlisted was 1429. Of these 96 (13.7%) were BME. 26 (13.3%) of these BME shortlisted applicants went on to be appointed. 1233 (86.3%) of applicants were white. 245 (19.9%) of those white shortlisted applicants went on to be appointed.	The number of White applicants was 548. The total Number of BME applicants was 91. The number of White applicants shortlisted was 131. The number of BME applicants shortlisted was 22. The percentage of White applicants shortlisted was (23.91%) The percentage of BME applicants shortlisted was (24.18%) The relative likelihood of White staff being appointed from shortlisting compared to BME staff = (0.99%) less likely. This indicator has improved to such an extent that there is no longer a significant gap at the Trust between White staff and BME staff in terms of their chances of being shortlisted from appointment.	The number of White applicants was 394. The total Number of BME applicants was 66. The number of White applicants shortlisted was 154. The number of BME applicants shortlisted was 22. The percentage of White applicants shortlisted was (39.09%) The percentage of BME applicants shortlisted was (33.33%) The relative likelihood of White staff being appointed from shortlisting compared to BME staff = (7.10%) more l White shortlisted applicants were appointed.	The number of White applicants was 3583 (69.9%). The number of BME applicants was 1453 (28.3%). Undisclosed ethnicity 91 (1.8%). The number of White applicants shortlisted was 1140. The number of BME applicants shortlisted was 208. The number of Undisclosed ethnicity shortlisted 5. (31.8 %) of White applicants were shortlisted. (14.3%) of BME applicants shortlisted Appointed: 115 (10.1%) of shortlisted White candidates were appointed. 21(10.1%) of BME candidates were appointed from shortlisting. Relative likelihood of shortlisting/appointed: White = 0.1009; BME = 0.1010 The relative likelihood of White candidates being appointed from shortlisting compared to BME candidates = 1. A figure above 1 would indicate that white candidates are more likely than BME candidates to be appointed from shortlisting.

Narrative

This indicator remains positive in that it shows no evidence of discrimination at the shortlisting to appointment stage of recruitment.
The Trust is having success in attracting a much larger percentage or applications from BME communities than their national or regional demographic. Shortlisting shows a much smaller percentage of BME candidates being successful than White candidates. Another positive is that appointments of those shortlisted shows that at interview BME and White candidates have the same chance of susses at the Trust.
Shortlisting is the only part of the recruitment process that is showing poorer results for BME candidates in this reporting period. Applications are already anonymised to eliminate unconscious bias. As a consequence it will be difficult for the Trust to address this effectively, short of taking positive actions e.g. offering guaranteed interviews to BME applicants who meet the specified criteria.

Actions

Actions completed:

- 30+ ED&I champions in place with role descriptor agreed
- Board level lead identified
- E&D Policy uploaded to all adverts on NHS jobs to highlight equal opportunity expectations.
- Coaching programme includes BME staff to further support staff.
- Reciprocal Mentoring programme

Further proposed actions:

- The Trust is undertaking and Equality review of its shortlisting procedures
- Explore the possibilities for ensuring that recruitment panels have current information about the ED&I profile of the Bands and sections of the workforce that they are recruiting too.
- Additional E&D training module will be mandatory for all recruiting managers, in addition to the basic module.
- Further explore the introduction of an initiative whereby there must be a BME member of staff on any appointing panel (as above).
- Explore additional advertising to reach BME groups
- Continue to monitor

WRES Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation. This indicator will be based on data from a two year rolling average of the current year and the previous year.			
2018	2019	2020	2021
Relative likelihood of BME staff entering the formal disciplinary processes compared to White staff = 0.72 times less Total number of White and BME staff 1398 Total number of disciplinaries 32 Total disciplinaries of white staff 28. Total disciplinaries of BME staff 3.	For the year to March 2019 the Trust had 3 White staff entering into a formal disciplinary investigation. There were no BME staff entering into this process in this period.	For the year to March 2020 the Trust had 14 (87.50%) White staff entering into a formal disciplinary investigation. There were 2 (12.50%) BME staff entering into this process in this period. BME staff were 7 times less likely to enter into formal disciplinary than White staff.	For the year to March 2021 the Trust had 6 (60%) White staff entering into a formal disciplinary investigation. There were 4 (40%) BME staff entering into this process in this period. Relative likelihood of BME staff entering the formal disciplinary process compared to white staff is therefore 0.027/0.0045 = 6.00 times greater.
Complex statistical analysis of such low numbers of disciplinaries is relatively meaningless. If disciplinaries remain at such low levels within the Trust it may be more useful monitor the numbers of BME disciplinaries to see if they rise across a significant period. No such pattern is discernible yet.			
Further proposed actions: – Continue with the Cultural Ambassadors Programme – Continue to monitor			

WRES Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.			
Year to March 2018	Year to March 2019	Year to March 2020	**2021**
(Note. At the time of producing this report this data was still being collated. The data will be submitted in accordance with WRES reporting deadlines and be made available for Trust Board Scrutiny on 2/9/2021.)			

WRES Indicator 5	2020 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months			
	1017	**2018**	**2019**	**2020**
White Staff	21.8%	26.2%	25.3%	21.7%
BME Staff	46.3% BME staff responded 41	29.3% BME staff responded 58	35.1% BME staff responded 37	32.6% BME staff responded 46
White Average benchmark group	22.1%	22.1%	21.0%	16.6%
BME Average benchmark group	15.6%	18.5%	20.2%	18.6%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts				

Findings 2020/2021	**Narrative**
	There has been a (2.5%) decrease in the percentage of BME staff experiencing harassment, bullying or abuse from patients. This has been a slightly larger decrease for White staff. (10.7%) More BME staff experienced harassment, bullying or abuse from patients in staff in last 12 months. Steps have been taken to provide more support for BME staff when such incidents occur, however these figures will be discussed with BAME staff to identify the cause and find more preventative measures. Staff are encouraged to report all incidents of harassment, bullying or abuse from patients. All reported incidents of harassment, bullying or abuse from patients are addressed by managers and appropriate actions are taken to safeguard staff.

Further proposed actions:
The Trust offers BME peer support to BME staff in regard to all incidents of harassment, bullying or abuse from patients. In addition, the Trust will now provide “Bystander Training for staff so that they feel confident to challenge and support each other if there are incidents of harassment, bullying or abuse from patients
Such incidents are currently reported immediately to senior ward staff and recorded on DATIX, so that they can be addressed. The Trust will now also immediately inform the most senior member of staff on duty at the Trust at the time of the incident to further ensure that the initial response is appropriate and adequate

WRES Indicator 6	2020 NHS Staff Survey Results > WRES > Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months			
	2717	**2018**	**2019**	**2020**
White Staff	17.7%	19.3%	16.4%	18.9%
BME Staff	24.4% BME staff responded 41	23.2% BME staff responded 56	21.6% BME staff responded 37	23.9% BME staff responded 46
White Average benchmark group	22.5%	25.1%	23.2%	21.6%
BME Average benchmark group	25.3%	27.3%	29.4%	28.7%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts				

Findings 2020/2021	**Narrative**
	Indicator 6) The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months. This indicator deteriorated a little this year reversing the very slight improvements in previous years. This indicator has seen a slight increase for both White staff and BME staff. This positive trend for BME staff from previous years has moved back close to 2017 levels. (5%) more BME staff than White staff responded that they have experienced harassment, bullying or abuse in staff in last 12 months. Of the 46 BME staff respondents to this question, (5%) equates to approximately 2 or 3 more BME respondents saying that they experienced harassment, bullying or abuse in staff in last 12 months. . The 2019 gap was (5.2%). In 2018 the gap was (3.9%).

Further proposed actions:

- The Trust will consult with BME staff and the Staff Race Equality Network to identify the divisions and areas of the Trust where there are higher levels of staff harassment, bullying or abuse and where there may be problems with the working culture. Training will be provided where appropriate to address any problem areas.
- Self-stretch targets will be set to reduce levels of harassment, bullying or abuse where these are found to be at higher levels
- The Trust will provide "Bystander Training for staff to better challenge and support each other if there are incidents of harassment, bullying or abuse from staff.
- The Trust will introduce monitoring of this indicator to ensure that figures are examined every second month in order to drive progress.

WRES Indicator 7	Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion			
	2717	**2018**	**2019**	**2020**
White Staff	90.3%	92.8%	92.5%	88.1%
BME Staff	71.4% BME staff responded 21	91.7% BME staff responded 36	77.8% BME staff responded 27	76.9% BME staff responded 26
White Average benchmark group	89.1%	88.5%	88.4%	88.6%
BME Average benchmark group	76.0%	76.1%	75.6%	72.9%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts				

Findings 2020/2021	**Narrative**

There has been a very small drop in the percentage of BME staff believing that trust provides equal opportunities for career progression or promotion. There has been a slightly larger drop in the percentage of White staff believing that trust provides equal opportunities for career (11.2%) fewer BME staff than White staff believe that trust provides equal opportunities for career progression or promotion. Of the 26 BME respondents this equates to about 3 people.
Of the 26 BME staff respondents to this question, (11.2%) equates to approximately 3 more BME respondents saying that they experienced harassment, bullying or abuse in staff in last 12 months.

There is evidence from the BAME Staff Group meetings that this may be associated with greater awareness amongst BME staff of the disproportionately low numbers of staff (with the exception of Medical staff) at Band 7 and above, as reported in previous WRES reports. These figures will be discussed with BAME staff to identify the cause and remedial actions

Further proposed actions:

- The Trust has adopted ambitious new targets to increase the number of BME staff at the Trust in pay bands 6+.
- The Trust will promote these BME recruitment targets to staff widely.
- The Trust will also undertake activities to boost encourage and assist BME staff to take up these opportunities for advancement within the Trust.
- The Trust will introduce a new Mentoring Programme to encourage and better prepare BME staff to move into higher pay bands.
- The Trust will recruit mentors from across the organisation to ensure that BME staff can receive mentoring from staff to help them to progress to the next the pay bands above their present positions
- The Trust will introduce a new Training Programme to encourage and better prepare BME staff to move into higher pay bands
- Trust will reshape its BME Reciprocal Mentoring programme to take account of social distancing and to foster a more collective experience for BME staff on the programme

WRES Indicator 8	Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months			
	2717	**2018**	**2019**	**2020**
White Staff	6.2%	4.3%	4.5%	4.0%
BME Staff	15.4% BME staff responded 39	10.7% BME staff responded 56	13.5% BME staff responded 37	10.6% BME staff responded 47
White Average benchmark group	5.9%	6.2%	5.5%	5.7%
BME Average benchmark group	14.6%	13.2%	13.0%	15.0%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts				

Findings 2020/2021	**Narrative**
	This reporting period has seen a small fall in the percentage of BME staff that experienced discrimination at work from a manager/team leader or other colleagues. (6.6%) more BME staff than White staff reported that they experienced discrimination at work from a manager/team leader or other colleagues.
	Further proposed actions: – The trust will take steps to increase the visibility of BAME staff and understanding of conscious and unconscious bias at the Trust. – The Trusts Building Rapport training already addresses these issues; however the Trust is exploring how we can involve more BAME staff members in delivering elements of the programme and discussing the issues with managers. – The Trust will provide “Bystander Training for staff to better challenge and support each other if there are incidents of discrimination of harassment, bullying or abuse from a manager/team leader or other colleagues. – The Trust will gain further feedback from BME staff and explore with them how the Trust can work to improve this indicator.

WRES Indicator 9: Percentage difference between the organisations' Board voting membership and its overall workforce.
2021
As at 31st March 2021 the Trust Board has 13 voting member with 2 (15.4%) BME members and 11 (84.6%) White members. This percentage is both higher than the percentage of BME staff in the workforce (9.9%) The = +5.5 which is a positive figure for Board diversity in terms of race equality.
Action completed: Consideration has now been given to the previous lack of diversity when reviewing Non-Executive terms of office or appointing new members. This has improved the racial diversity of the Board. A BME member of staff now sits on any executive or non-executive appointing panel.

End of report.

For more information, please contact:
Andrew lynch
Equality and Inclusion Lead
HR Department
The Walton Centre NHS Foundation Trust
Sid Watkins Building
Lower Lane
Liverpool
L9 7BB
Email: Andrew.Lynch2@thewaltoncentre.nhs.uk
Telephone: 0151 556 3396

The Walton Centre NHS Foundation Trust

Appendix - Equality Impact Assessment (EIA) Form

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Part

1. Person(s) Responsible for Assessment: **Andrew Lynch** 2. Contact Number: **0151 556 3396**

3. Department(s): **HR** 4. Date of Assessment: **24.08.21**

5. Name of the policy/procedure being assessed: **Workforce Race Equality Standards (WRES) 2019 Findings**

6. Is the policy new or existing?
New Existing

7. Who will be affected by the policy (*please tick all that apply*)?
Staff Patients Visitors Public

8. How will these groups/key stakeholders be consulted with? N/A This document is the result of a consultation process.

9. What is the main purpose of the policy? This document sets out the findings of the Walton Centre Workforce Disability Equality Standards monitoring for 2020**.**

10. What are the benefits of the policy and how will these be measured? Improving race equality and reducing discrimination in Trust processes and staff, patient and visitor behaviour. This will be measured through the WRES metrics**.**

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? Yes, The Equality, Diversity and Inclusion 5 Year Vision.

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? None, these findings are intended to promote and support equality for all staff.

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
Age	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Sex	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other	

				protected characteristics.	
Race	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Religion or Belief	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Disability	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Sexual Orientation	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Pregnancy / maternity	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Gender Reassignment	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Marriage & Civil Partnership	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	
Other	✓			Race equality is defined within the context of the Equality Act and the report discusses promotion of Race equality relating to all other protected characteristics.	

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) The purpose of this report is to set out how Workforce Race Equality will be promoted throughout the Trust in line with the Trust's Public Sector Equality Duty under the Equality Act 2010, therefore there is likely to be a positive impact on other protected characteristic, as according to this legislation all people are protected equally.

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? This report supports a Human Rights based approach to supporting staff.

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Clare Duckworth, Matron for further support.

Action	Lead	Timescales	Review Date
N/A	N/A	N/A	N/A

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken ✓

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: Andrew Lynch Date: 024.08.21

Signed: Andrew Lynch

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داوابکرێت یان ئەگەر بەباش زاندرا دەکرێت

وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە

پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ٠١٥١٥٢٥٣٦١١.

一经要求，可对此信息进行翻译，或者如果愿意的话，可以安排口译员。如需这些服务的额外信息，请联络Walton中心，电话是：0151 525 3611。

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
02/09/2021

Title	**Workforce Disability Equality Standard (WDES) Findings and Actions Trust Board 2021**
Sponsoring Director	Name: Mike Gibney Title: Mike Gibney, Director of Workforce and Innovation
Author (s)	Name: Andrew Lynch Title: Equality and Inclusion Lead
Previously considered by:	N/A
Executive Summary The WDES is a series of evidence-based Metrics that provide the Trust with a snapshot of the experiences of their Disabled staff in key areas.	
Related Trust Ambitions	Equality, Diversity, and Inclusion (ED&I) 5 Year Vision Overall ED&I Walton Centres commitment: ● We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.
Risks associated with this paper	
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	Yes
Any associated legal implications / regulatory requirements?	WDES reporting and publication is required of the Trust by NHSE/I. The WDES also helps to demonstrate the Trust's compliance with its Public Sector Equality Duty in respect of disability equality under the Equality ACT 2010
Action required by the Board	The Board is requested to: • Approve the WDES Report 2021.

The Walton Centre NHS
NHS Foundation Trust

Workforce Disability Equality Standard (WDES) Findings and Actions

Trust Board 2021

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1. Introduction

The NHS Workforce Disability Equality Standard (WDES) is designed to improve workplace experience and career opportunities for Disabled people working, or seeking employment, in the National Health Service (NHS). The WDES follows the NHS Workforce Race Equality Standard (WRES) as a tool and an enabler of change. The WDES is a series of evidence-based Metrics that will provide NHS organisations with a snapshot of the experiences of their Disabled staff in key areas. By providing comparative data between Disabled and non-disabled staff, this information can be used to understand where key differences lie; and will provide the basis for the development of action plans, enabling organisations to track progress on a year by year basis. The WDES is based on ten evidence-based Metrics which take effect from 1 April 2019. The majority of the data in this report is taken from the 2020/21 financial year with the notable exception of the staff survey responses, which were originally published in 2020 but gathered in the 2019. The WDES is mandated in the NHS Standard Contract to enable comparisons to be made between NHS trusts and the WDES metrics data is reported to NHS England via the completion of the WDES online reporting form. This data is also for publication on The Walton Centre Website:
https://www.thewaltoncentre.nhs.uk/175/equality-and-diversity.html
The 2020/21 WDES metrics data have been reported to NHS England in line with the required schedule.

This report indicates the need for the Trust to refocus its efforts in terms of disability equality and in particular on renewing and strengthening our dialogue with Disabled staff at the Trust. The Trust remains close to the rather low National average for the overall NHS declaration rates for Disables staff in NHS trusts, however, despite some encouraging figures on recruitment, this report shows the Trust has not made significant improvements to disability inequalities in the year to 31st March 2021 and some indicators show decreased results on the previous year. None of the data indicates that the Trust is in danger of experiencing serious issues in regard to disability equality in the near future, instead the picture presented by comparison with previous WRES reports is one of modest progress followed by modest setbacks. Another way of stating this would be to say that the disability equality performance trajectories are rather flat year on year. The Walton Centre is definitely not an outlier in this respect, but the Trust's commitment to disability equality is not yet being fully reflected in terms of the current data and outcomes for disabled staff.

There are 8.4 million people of working age (16-64) that reported they were Disabled in October-December 2020, which is (20%) of the working age population. https://researchbriefings.files.parliament.uk/documents/CBP-7540/CBP-7540.pdf
On the 31st March 2021 there were 1497 staff members employed within The Walton Centre. Of those, the proportion of staff recorded as Disabled on the Electronic Staff Records system (ESR) was 46 (3.1%) this compares with the 2019/20 figure for Disabled staff of 40, which was (2.72%) measured against the then total staff number of 1452. This shows that the number of Disabled staff at the Trust has increased by 6 while the total number of staff has risen by 55 in this reporting period. This indicates that (10%) of new staff recruited to the organisation in the year to 31st March 2021 were Disabled. Whilst this is a higher percentage than the (3.1%) figure for the whole workforce, recruitment alone is unlikely, in the short term, to significantly boost the percentage of Disabled staff for the whole organisation to anything near the figure of (20%); the working age population for Disabled people in the UK 2020. As context, under-declaration of disabilities in the current workforce is a problem for

the NHS in general and the Trust remains close to the average across NHS trusts for the declared rates of representation of Disabled people in the workforce. National WDES figures indicate an overall NHS figure of (3.6%) of non-clinical and (2.9%) of the clinical workforce (excluding medical and dental staff) had declared a disability through the NHS Electronic Staff Record. For medical and dental staff, (1.94%) of trainee grades, (1.2%) of non-consultants career grade and (0.8%) of consultants had declared a disability. (NHS Workforce Disability Equality Standard (WDES) Annual Report 2019) https://www.england.nhs.uk/wp-content/uploads/2020/03/nhs-wdes-annual-report-2019.pdf

2.

Summary of key points

This report indicates the need for the Trust to refocus its efforts in terms of disability equality and in particular on renewing and strengthening our dialogue with Disabled staff at the Trust. The Trust remains close to the rather low National average for the overall NHS declaration rates for Disables staff in NHS trusts, however, despite some encouraging figures on recruitment, this report shows the Trust has not made significant improvements to disability inequalities in the year to 31st March 2021 and some indicators show decreased results on the previous year. None of the data indicates that the Trust is in danger of experiencing serious issues in regard to disability equality in the near future, instead the picture presented by comparison with previous WRES reports is one of modest progress followed by modest setbacks. Another way of stating this would be to say that the disability equality performance trajectories are rather flat year on year. The Walton Centre is definitely not an outlier in this respect, but the Trust's commitment to disability equality is not yet being fully reflected in terms of the current data and outcomes for disabled staff.

Metric1)

The Walton Centre Workforce as at 31 March 2021: Total staff 1497, Disabled staff 46 (3.1%) Non-disabled staff 1169 (78.3%), Unknown 282(18.8%). Comparison National WDES figures indicate overall NHS Disabled staff figures of (3.6%) of non-clinical and (2.9%) of the clinical workforce (excluding medical and dental staff) had declared a disability through the NHS Electronic Staff Record. For medical and dental staff, (1.94%) of trainee grades, (1.2%) of non-consultants career grade and (0.8%) of consultants had declared a disability. The Trusts reported figures are the best data we have, but they are unlikely to accurately reflect the true numbers of Disabled staff, because we know from our conversations with staff on this subject that Disabled staff are often reluctant to share this information due to the general stigma in society around disability, and responses to the staff survey are often much higher than the declared numbers of Disabled staff at the Trust.

An indication of the where Disabled staff are in Trust in relation to NHS pay grades:

- Of the 393 non-clinical staff, there are 9 Disabled staff, 2 of these staff are at NHS pay band 7+.
- Of the 871 Clinical staff, there are 33 Disabled staff, 24 of these staff are at pay bands 5-7 and 1 is at NHS pay band 7+.
- Of the 143 Medical staff, there are 4 Disabled staff, 1 of whom is on Medical & Dental Staff, Non-Consultants career grade.

As a consequence the Trust incorporated information on this lack of disability diversity into Equality and Diversity Training for managers in 2020 and 2121.

Metric 2)

For the 2020/21 reporting period the number of Disabled candidates shortlisted was 66, the number appointed was 7. The likelihood of shortlisted disabled candidates being appointed was 0.11. The percentage of Disabled staff appointed from shortlisting (17%).
The number of Non-disabled candidates shortlisted was 1296 the number appointed was 211. The likelihood of shortlisted Non-disabled candidates being appointed was 0.16. The percentage of non-disabled staff appointed from shortlisting (16%).
The data shows that there was an insignificant difference in the percentage of Disabled and non-disabled staff being appointed from shortlisting.

Metric 3) There were no disciplinaries of Disabled staff in the reporting period. It is not possible to form firm conclusions from this figure other than to observe that, with only 46 staff recorded as Disabled it is not surprising to have low figures for the number of disciplinaries involving those few Disabled staff. To have greater confidence in this Metric the Trust will take steps to increase the numbers of staff recorded as Disabled on ESR.

Metric 4) Staff Survey results

The NHS Staff Survey does not give a separate score for the overall Disability equality responses, instead the overall score is given in regard to equality, which combines both the Disability equality and race equality responses the following table provides that combined. This overall score is not required by the WDES, but for context in terms of the NHS Staff Survey data presented in this report, please note the following Equality Diversity and Inclusion score (0 -10), which shows the 2020 Walton Centre staff survey results as slightly above the average for participating trusts.

The best organisation	9.5
The Walton Centre FT	9.3
Average	9.2
Worst	8.4
Responses	542

Source: The Walton Centre NHS Foundation Trust
2020 NHS Staff Survey
Summary Benchmark Report
https://cms.nhsstaffsurveys.com/app/reports/2020/RET-summary-2020.pdf

Disabled staff experienced higher levels of harassment, bullying or abuse than non-disabled staff. This is the case for all the sources of the abuse asked about. The general levels of harassment, bullying or abuse have increased from all sources asked about except from patients. When harassment, bullying or abuse occurs, Disabled staff are slightly more likely to report harassment, bullying or abuse than none disabled staff:

- (4.1%) more Disabled staff than non-disabled staff responded that they have experienced harassment, bullying or abuse from Patients/service users, their relatives or other members of the public.
- (3.4%) more Disabled staff than non-disabled staff responded that they have experienced harassment, bullying or abuse from managers.
- (5.7%) more Disabled staff than non-disabled staff responded that they have experienced harassment, bullying or abuse from other colleagues.
- (3.1%) more Disabled staff than non-disabled staff responded that they have experienced harassment, bullying or abuse at work had been reported it. This latter figure is positive because the Trust encourages staff to report such incidents.

The Trust will introduce actions to better support Disabled staff who experienced harassment, bullying and explore ways to reduce the number of these incidents.

Metric 5) Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.

There has been close to a (10%) fall in the number of Disabled staff responding that they believe that the Trust provides equal opportunities for career progression or promotion. This figure is now at (81%). 63 Disabled staff responded. The previous year there were high numbers of both Disabled and Non-disabled staff saying they believe that the Trust provides equal opportunities for career progression or promotion and there was no significant percentage difference in their responses. The 2020 percentage difference in responses between Disable and non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion was (7.2%) fewer for Disabled staff than for non-disabled staff.

Metric 6) Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.

This metric has seen a notable deterioration with a (15.6%) rise in the percentage of Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This compares with a (6.4%) increase in relation to non-disabled staff saying the same. This indicates a general deterioration against this indicator which is more pronounced for Disabled staff. It must be noted that the relevant staff survey data was collected in 2019 which was before the period when Covid-19 could possibly influenced these responses. The Trust will engage more with staff to explore the causes more thoroughly.

Metric 7) Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.

(45.5%) of the 99 Disabled staff that responded said that they are satisfied with the extent to which their organisation values their work. The 2020 percentage difference in staff saying that they are satisfied with the extent to which their organisation values their work is (13.8%) less positive responses from Disabled staff than non-disabled staff. The 2019 figure was (10.1%) fewer positive responses from Disabled staff than non-disabled staff.

This metric has deteriorated for both Disabled and non-disabled staff, however the change has been worse in terms of responses from Disabled staff than from non-disabled staff. In 2020 there were (6.2%) fewer Disabled staff saying that they are satisfied with the extent to which their organisation values their work. The figure for non-disabled staff was (2.5%) fewer staff saying that they are satisfied with the extent to which their organisation values their work.

The Trust remains slightly above the benchmark metric in respect of Yes responses from both Disabled and non-disabled staff in respect of this question. .

Metric 8)

(70%) of the 50 Disabled staff who responded said Yes their employer has made adequate adjustment(s) to enable them to carry out their work. This percentage is lower than the previous year by (16.1%). These figures, however, require further exploration to establish their full significance. The (30%) of the 50 of Disabled staff who did not respond Yes to this question may not have needed or requested a reasonable adjustment at all. The Trust can be assured that reasonable adjustments are made for staff whenever such needs are identified or Disabled staff request them via the Trust's Tailored Reasonable Adjustments Template. http://intranet/intranet_new/546/tailored-reasonable-adjustment-template.html

Metric 9a) The Total number of responses to the 2020 Walton Centre Staff Survey was 547, a response rate of 39%, which breaks down as 432 Non-disabled staff responses and 102 Disabled staff responses. The Staff engagement score for the Trust is 7.6 which is the same as the previous year.

Metric 9b) Yes – The Trust has taken action to facilitate the voices of Disabled staff. The Trust has set up a Staff disability Equality Group the Group, which has met 3 times.

Metric 10) There is now 1 Trust Board member recorded as Disabled. This is an improvement on previous WDES reporting when there were 0 Disabled Trust Board Members. One is much better than none but the Trust has further work to do if the Trust Board is to reflect the percentage of Disabled people in the UK workforce at some future date.

2. WDES Metrics and Findings

METRIC 1	Percentage of staff in AfC pay Bands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce. Organisations should undertake this calculation separately for non-clinical and for clinical staff. Cluster 1: AfC Band 1, 2, 3 and 4 Cluster 2: AfC Band 5, 6 and 7 Cluster 3: AfC Band 8a and 8b Cluster 4: AfC Band 8c, 8d, 9 and VSM (including Executive Board members) Cluster 5: Medical and Dental staff, Consultants Cluster 6: Medical and Dental staff, Non-consultant career grade Cluster 7: Medical and Dental staff, Medical and dental trainee grades Note: Definitions for these categories are based on Electronic Staff Record occupation codes with the exception of medical and dental staff, which are based upon grade codes.	
	Narrative	**Action**
Findings 2020/2021	There are relatively few staff recorded as Disabled by the Trust. Unfortunately, this is not surprising as it reflects the National picture across the NHS. There are 393 Non Clinical staff comprising: 9 Disabled staff, 316 Non-disables staff and 68 Unknown. The number of non-clinical Disabled staff has declined from 15 to 9. This is accounted for by the reduced numbers of Disabled staff in Cluster (Band 1 - 4) which has dropped from 13 to 7 in this period. • There are 2 non-clinical Disabled staff above Cluster (Band 1 – 4) i.e.: 1 Disabled Staff member in Cluster (Band 5 - 7) and 1 Disabled Staff member in Cluster (Bands 8c - 9 & VSM) There are 961 Clinical staff comprising: 33 Disabled staff, 739 non-disabled staff and 189 Unknown. This is an increase of 10 Disabled Clinical staff in the reporting period. • 8 of these Clinical Disabled staff are in Cluster (Bands 1 - 4) • 24 of these Clinical Disabled staff are in Cluster (Band 5 - 7) • 1 of these Clinical Disabled staff is in Cluster (Bands 8c - 9 & VSM)	**Actions completed:** – The Trust now advertises all job vacancies online via https://disabilityjob.co.uk/ – A Disability themed Berwick/engagement session was held on 6th July 2019. This session was used to introduce the WDES to staff and use this as a trigger for ongoing dialogue with Disabled and non-disabled staff about how we view and value colleagues with Disabilities and different abilities. – That meeting also relaunched disability networking at the Trust and has formed a group of Disabled staff and allies to

	There are 143 Medical staff comprising: 4 Disabled staff, 114 Non-disabled staff and 25 Unknown. This is an increase of 2 Disabled Medical staff in the reporting period. • 3 (Medical & Dental Staff, Consultants) • 1 (Medical & Dental Staff, Non-Consultants career grade) Data from the Trust and across the NHS suggests that a reasonable objective in relating to Metric 1 would be to increase ESR disability declaration levels. This step will help the organisation to identify to what extent the lower numbers of Disables staff at higher pay Bands is a feature of the workforce demographic and to what extent it reflects a reluctance of staff at those higher pay Bands to declare a disability.	champion Disability Equality at the Trust. – Signed up to NHS Employers Diversity and Inclusion Partners Programme Level 2 30+ ED&I champions in pace with role descriptor – The appointment of a full-time Equality and Inclusion Lead post at the Trust **Proposed further actions:** – Further exploration is needed to understand any barriers Disabled staff feel they face when applying for more senior positions or the reasons why they do not apply. – ED&I Strategy Refresh – consultation with Disabled staff – Continue to monitor this indicator. **Links to EDS2 and Trust** **Further proposed actions:** – The WDES/Disability Equality Working Group will work with the Trust's Equality and Inclusion Lead to develop further actions to increase the recording of Disabled people at all levels of the workforce.

Tables showing the numbers and relative positions of Disabled staff and Non-Disabled staff at the Trust in relation to AfC pay Bands.

2021 Whole Workforce

Total staff	Disabled	non-disabled	Unknown
1497	46 (3.1%)	1169 (78.3%)	282 (18.8%)

1a) There are 393 Non Clinical staff comprising: 9 Disabled staff, 316 Non-disables staff and 68 Unknown.	Disabled Staff		non-disabled staff		Total Unknown or Null		All Non Clinical Staff
	Totals	Percentages	Totals	Percentages	Totals	Percentages	Total
Cluster 1 (Bands 1 - 4)	7	3%	197	78%	46	19%	250
Cluster 2 (Band 5 - 7)	1	1.1%	76	82.6%	15	16.3%	92
Cluster 3 (Bands 8a - 8b)	0	0%	26	86%	4	14%	30
Cluster 4 (Bands 8c - 9 & VSM)	1	5%	17	81%	3	14 %	21

1b) There are 961 Clinical staff comprising: 33 Disabled staff, 739 non-disabled staff and 189 Unknown.	Disabled Staff		non-disabled staff		Total Unknown or Null		All Staff
	Totals	Percentages	Totals	Percentages	Totals	Percentages	Total
Cluster 1 (Bands 1 - 4)	8	3%	226	73%	72	24%	306
Cluster 2 (Band 5 - 7)	24	5%	439	77.%	102	18%	565
Cluster 3 (Bands 8a - 8b)	0	0%	68	84%	13	16%	81
Cluster 4 (Bands 8c - 9 & VSM)	1	11%	6	66%	2	23%	9

There are 143 Medical staff comprising: 4 Disabled staff, 114 Non-disabled staff and 25 Unknown	Disabled Staff		non-disabled staff		Total Unknown or Null		All Staff
	Totals	Percentages	Totals	Percentages	Totals	Percentages	Total
Cluster 5 (Medical & Dental Staff, Consultants)	3	3%	83	78%	20	19%	106
Cluster 6 (Medical & Dental Staff, Non-Consultants career grade)	1	12.5%	6	75%	1	12.5%	8
Cluster 7 (Medical & Dental Staff, Medical and dental trainee grades)	0	0%	25	86%	4	14%	29

Metric 2	Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts is 1.54	
Findings 2020/2021	**Narrative**	**Action**
	The for the 2020/21 reporting period the number of Disabled candidates shortlisted was 66, the number appointed was 7. The likelihood of shortlisted disabled candidates being appointed was 0.11. The percentage of Disabled staff appointed from shortlisting (17%). The number of Non-disabled candidates shortlisted was 1296 the number appointed was 211. The likelihood of shortlisted Non-disabled candidates being appointed was 0.16. The percentage of non-disabled staff appointed from shortlisting (16%). The data show that there was an insignificant difference in the percentage of Disabled and non-disabled staff being appointed from shortlisting. This is positive data in that it shows that current recruitment is not discriminatory, however, fair recruitment will not significantly change the relatively low percentage figures Disabled staff in the short term.	**Actions completed:** – The Trust is currently participating in the DWP Disability Confident employer scheme at Level 2, Disability Committed Employer. **Further proposed actions:** – Further explore the possibility of moving on to achieve Level 3 Disability Confident Leader. – Equality Review Recruitment Practices.

Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure. Note: i) This Metric will be based on data from a two-year rolling average of the current year and the previous year. ii) This Metric is voluntary in year one.	
Findings 2020/2021	**Narrative**	**Action**
	In the period covered there was 1 non-disabled staff that entered the formal capability process and 0 Disabled staff. This provides insufficient data to draw any useful equality conclusions about the formal capability process.	**Actions completed:** – Disability monitoring systems are in place with regard to the capability process, as measured by entry into the formal capability procedure. **Further proposed actions:** – Monitoring based on this will continue.

The NHS Staff Survey

The NHS Staff Survey does not give a separate score for the overall Disability equality responses, instead the overall score is given in regard to equality, which combines both the Disability equality and race equality responses the following table provides that combined. This overall score is not required by the WDES, but for context in terms of the NHS Staff Survey data presented in this report, please note the following Equality Diversity and Inclusion score (0 -10), which shows the 2020 Walton Centre staff survey results as slightly above the average for participating trusts.

The best organisation	9.5
The Walton Centre FT	9.3
Average	9.2
Worst	8.4
Responses	542

Source: The Walton Centre NHS Foundation Trust
2020 NHS Staff Survey
Summary Benchmark Report
https://cms.nhsstaffsurveys.com/app/reports/2020/RET-summary-2020.pdf

The majority of WDES data is taken from the 2020/21 financial year with the notable exception of the National Staff Survey responses which were published in 2020, but gathered via the 2019 survey.

Metric 4 Staff Survey Q13	For each of the following four Staff Survey Metrics, compare the responses for both Disabled and nondisabled staff. a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

A1) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from patients/service users.

	2018	**2019**	**2020**
WCFT Disabled Staff	36.4% 132 Disabled staff responded	32.5% 120 Disabled staff responded	25.7% 101 Disabled staff responded
WCFT Non-disabled Staff	24.4%	24.2%	21.6%
Disabled Average benchmark group	25.4%	27.8%	21.9%
Non-disabled Average benchmark group	20.0%	19.0%	16.3%

Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts

A2) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers.

	2018	**2019**	**2020**
WCFT Disabled Staff	9.9% 131 Disabled staff responded	5.9% 119 Disabled staff responded	11.9% 101 Disabled staff responded
WCFT Non-disabled Staff	7.3%	7.5%	8.5%
Disabled Average benchmark group	22.1%	15.1%	18.7%
Non-disabled benchmark group Average	11.0%	10.0%	9.8%

Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts

A3) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues.			
	2018	**2019**	**2020**
WCFT Disabled Staff	**22.0%** **132** Disabled staff responded	**15.1%** **119** Disabled staff responded	20.2% 99 Disabled staff responded
WCFT Non-disabled Staff	**14.7%**	**13.4%**	14.5%
Disabled Average benchmark group	30.5%	27.3%	25.4%
Non-disabled Average benchmark group	16.4%	16.6%	16.6%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			

B) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.			
	2018	**2019**	**2020**
WCFT Disabled Staff	**56.7%** **60** Disabled staff responded	**52.2%** **46** Disabled staff responded	56.4% 39 Disabled staff responded
WCFT Non-disabled Staff	**53.0%**	**50.7%**	53.3%
Disabled Average benchmark group	54.8%	53.4%	49.3%
Non-disabled Average benchmark group	46.9%	47.7%	48.4%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			

Findings 2020/2021	**Narrative**	**Action**
	A1) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers. This metric has continued to show improvement for both Disabled and Non-disabled staff, however at (25.7%) the metric continues to show higher rates of such behaviour experienced by Disabled staff than for Non-disabled staff and the percentage of Disabled staff experiencing harassment, bullying or abuse from patients is also higher at the Trust than for the Average benchmark group. The 2020 percentage difference in responses between Disable and non-disabled staff experiencing harassment, bullying or abuse from patients/service users is (4.1%) more for Disabled staff than for non-disabled staff. The 2019 figure was (8.3%) more for Disabled staff than for non-disabled staff. The gap has halved against a backdrop of fewer experiences of harassment for both disabled and non-disabled staff.	**Actions completed:** – General measures to counteract the various forms of bullying and harassment related to Metric 4 are in place e.g. the Bullying and Harassment policy and freedom to

	A2) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Managers. This metric shows a marked deterioration. After some improved experience in the previous year's report this metric has risen again to (11.9%). In comparison the figure for non-disabled staff is fairly constant, showing a small rise to (8.5%). Both of these figures are better than the benchmark figures, which are considerably higher for the benchmarked Disabled staff at (18.7%). The 2020 percentage difference in responses between Disable and non-disabled staff experiencing harassment, bullying or abuse from Managers is (3.4%) more for Disabled staff than for non-disabled staff. The 2019 figure was (1.6%) fewer for Disabled staff than for non-disabled staff. This shows a switch from Disabled staff experiencing slightly less harassment, bullying or abuse from Managers than non-disabled staff in 2019 to Disabled staff experiencing more such behaviours from Managers than non-disabled staff in 2020. **A3) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from Other Colleagues.** After improving last year this metric has deteriorated for Disabled staff and now stands at (22.2%). Whilst this is lower than the benchmark score it is still higher than for non-disabled staff at the Trust and the non-disabled staff benchmark. The 2020 percentage difference in responses between Disable and non-disabled **staff experiencing harassment, bullying or abuse from Other Colleagues** is (5.7%) more for Disabled staff than for non-disabled staff. The 2019 figure was (1.7%) more for Disabled staff than for non-disabled staff. The gap has widened in this period by (4%). **B) Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.** This metric has improved for both Disabled and non-disabled staff. At (56.4%) this metric is better than the figure for non-disabled staff and the benchmarks. The 2020 percentage difference in responses between Disable and non-disabled of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it is (3.1%) more for Disabled staff than for non-disabled staff. The 2019 figure was (1.5%) more for Disabled staff than for non-disabled staff. The gap has widened slightly over the last year but this is a positive change as the Trust wants more Disabled and non-disabled staff to report harassment, bullying or abuse if it happens and reporting has increased for all staff in respect of this metric.	speak up Guardian and information. **Further proposed actions:** – The Trust plans to explore with Disabled staff what extra steps can be taken to support disables staff in this respect. The Staff Disability Equality Group will inform these further actions. The EDI Steering Group will implement these further actions.

Metric 5 **Staff Survey** **Q14**	Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.		
	2018	**2019**	**2020**
WCFT Disabled Staff	**90.1%** **91** Disabled staff responded	**90.4%** **83** Disabled staff responded	81% 63 Disabled staff responded
WCFT Non-disabled Staff	**92.9%**	**91.8%**	88.2%
Disabled Average benchmark group	80.4%	80.5%	80.3%
Non-disabled Average benchmark group	87.4%	87.5%	87.4%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			

	Narrative	**Action**
Findings 2020/2021	This metric shows deterioration from previous years. There has been close to a 10% drop in the number of Disabled staff responding that they believe that the Trust provides equal opportunities for career progression or promotion. In 2020, of the 63 Disabled staff that responded, 51 (81%) agreed that the Trust provides equal opportunities for career progression or promotion and 12 (19%) disagreed. In 2019 there were 8 Disabled staff that responded No to this metric. This indicates that 4 more Disabled staff answered No to this question in 2020. The 2020 percentage difference in responses between Disable and non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion is (7.2%) fewer for Disabled staff than for non-disabled staff. The 2019 figure was (0.6%) fewer Disabled staff than for non-disabled staff. This indicates that a gap has opened up in regard to this metric that has not been seen in previous years.	**Actions completed:** (No specific disability targeted actions relating to this indicator have been implemented yet.) **Further proposed actions:** The staff WDES Disability Equality Working Group will consider the possibility of introducing a Disability Reciprocal Mentoring Scheme to help Senior Leaders within the Trust to better understand the barriers Disabled staff perceive in their way regarding progressing their career and to help disabled staff to network within the organisation and learn more about the possibilities for advancement.

Metric 6 Staff Survey Q11	Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.		
	2018	**2019**	**2020**
WCFT Disabled Staff	29.8% 94 Disabled staff responded	24.4% 78 Disabled staff responded	40.0% 60 Disabled staff responded
WCFT Non-disabled Staff	22.7%	14.9%	21.3%
Disabled Average benchmark group	30.8%	26.7%	29.8%
Non-disabled Average benchmark group	21.7%	20.6%	21.6%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			

Findings 2020/2021	**Narrative**	**Action**
	This metric has seen a notable deterioration with a (15.6%) rise in the percentage of Disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This compares with a (6.4%) increase in relation to non-disabled staff saying the same. This indicates a general deterioration against this indicator which is more pronounced for Disabled staff. It must be noted that the relevant staff survey data was collected in 2019 which was before the period when Covid-19 could possibly influenced these responses. The Trust will engage more with staff to explore the causes more thoroughly. The 2020 percentage difference in responses between Disable and non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties is (18.2%) more for Disabled staff than non-disabled staff. The 2019 figure was (9.5%) more for Disabled staff than non-disabled staff. This is a near doubling of the gap between Disabled and non-disabled staff perceptions in regard to this metric.	**Proposed actions:** – Include this information in Building Rapport training for managers 2021/22 – Use Walton Weekly to: publicise the figures to managers and staff. – Provide information on what presentism is and why it is better to be off work and get better properly than to come to work when this hinders recovery. – Remind managers and staff that being off work in relation to a disability is not to be viewed and dealt with in the same way as standard sick leave. – Give guidance on reasonable adjustments – Put this topic on the agenda for the WDES Disability Equality Working Group to identify actions to reduce incidents where disabled staff feel pressured to work when sick.

Metric 7 **Staff Survey** **Q5**	Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.		
	2018	**2019**	**2020**
WCFT Disabled Staff	**50.8%** **132** Disabled staff responded	**51.7%** **120** Disabled staff responded	45.5% 99 Disabled staff responded
WCFT Non-disabled Staff	**56.5%**	**61.8%**	59.3%
Disabled Average benchmark group	45.8%	44.3%	44.3%
Non-disabled Average benchmark group	56.3%	56.1%	55.6%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			

Findings 2020/2021	**Narrative**	**Action taken and planned including e.g. does the indicator link to EDS2 evidence and/or a corporate Equality Objective**
	This metric has deteriorated for both Disabled and non-disabled staff, however the change has been worse in terms of responses from Disabled staff than from non-disabled staff. In 2020 there were (6.2%) fewer Disabled staff saying that they are satisfied with the extent to which their organisation values their work. The figure for non-disabled staff was (2.5%) fewer staff saying that they are satisfied with the extent to which their organisation values their work. The Trust remains slightly above the benchmark metric in respect of positive responses from both Disabled and non-disabled staff in respect of this question. The 2020 percentage difference in staff saying that they are satisfied with the extent to which their organisation values their work is (13.8%) less positive responses from Disabled staff than non-disabled staff. The 2019 figure was (10.1%) fewer positive responses from Disabled staff than non-disabled staff The Trust needs to understand the details of why these figures are not so high for either Disabled or non-disabled staff and what the cause of the (13.8%) difference in perception is caused by and what more the organisation needs to do to show that we value our Disabled and non-disabled staff.	**Actions completed:** – The Berwick session of 9th July 2019 commenced the conversations with Disabled staff that will help the Trust to identify specific disability targeted actions relating to this indicator. **Further proposed actions:** – This metric will be put on the agenda for the WDES Disability Equality Working Group. – Work with staff to Celebrate Disability History Month raise awareness and foster a conversation about what it means to be Disabled. – Network with external Disability organisations to help to change the culture within the organisation to break down stigma about what it means to have a Disability.

Metric 8 Staff Survey Q28b	(The following NHS Staff Survey Metric only includes the responses of Disabled staff.) Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.		
	2018	**2019**	**2020**
WCFT Disabled Staff	80.0% 75 Disabled staff responded	86.1% 72 Disabled staff responded	70.0% 50 Disabled staff responded
Disabled Average benchmark group	75.2%	76.5%	77.0%
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			

Findings 2020/2021	**Narrative**	**Action**
	(70%) of the 50 Disabled staff who responded said yes their employer has made adequate adjustment(s) to enable them to carry out their work. This percentage is lower than the previous year by (16.1%). These figures require further exploration to establish their full significance. The (30%) of the 50 of Disabled staff who did not respond yes to this question may not have needed or requested a reasonable adjustment at all. This metric has changed on the 2019 figure with yes responses from Disabled staff changing by (16.1%) There is no way of knowing from this question whether the fall in reported reasonable adjustments is because Disabled staff haven't requested so many or don't need them this year. It would be more informative to know the number of Disabled staff who feel that they have asked for a reasonable adjustment which has been ignored or rejected without the reasons being explained. This staff survey questions is set nationally. The Trust can be assured that reasonable adjustments are made for staff whenever such needs are identified or Disabled staff request them via the Trust's Tailored Reasonable Adjustments Template. http://intranet/intranet_new/546/tailored-reasonable-adjustment-template.html	**Actions completed:** – Information on reasonable adjustments is given during induction training and information on them and how to access them is also made available via the staff intranet. **Further proposed actions:** – This Metric will be put on the agenda for the WDES Working Group. – Action will be taken to better determine if all disabled staff at the trust know about reasonable adjustments and are getting them when requested.

Metric 9 a)	NHS Staff Survey and the engagement of Disabled staff. For part a) of the following Metric, compare the staff engagement scores for Disabled, non-disabled staff and the overall Trust's score. For part b) add evidence to the Trust's WDES Annual Report: The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.		
	Staff engagement score (0-10)		
	2018	**2019**	**2020**
WCFT Disabled Staff	7.5	7.6	7.6
WCFT Non-disabled Staff	7.3	7.5	7.2
Disabled Average benchmark group	7.7	7.2	7.1
Non-disabled Average benchmark group	7.5	7.6	7.5
Average calculated as the median for the benchmark group of 14 Acute Specialist Trusts			
WCFT Respondent Headcount staff respondents	753	619	547
WCFT Disabled staff respondents	134	121	102
WCFT Non-disabled staff respondents	606	483	432
Findings 2020/2021	**Narrative**		**Action**
	The Total number of responses to the 2020 Walton Centre Staff Survey was 547, a response rate of 39%, which breaks down as 432 Non-disabled staff responses and 102 Disabled staff responses. The Staff engagement score for the Trust is 7.6 which is the same as the previous year. The engagement scores are auto-calculated on the WDES submission template. Following on from the original engagement activity for the WDES 2020 the Trust needs to take more action to facilitate the voices of Disabled staff to be heard.		**Actions completed:** – The Trust has started the process of engaging with Disabled staff to facilitate the hearing of a powerful Disabled staff voice. It is anticipated that this will help

Metric 9 a)	b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No) Note: For your Trust's response to b) If yes, please provide at least one practical example of current action being taken in the relevant section of your WDES annual report. If no, please include what action is planned to address this gap in your WDES annual report. Examples are listed in the WDES technical guidance.	to close the 6.8% gap in declaration rates between Disabled staff recorded on ESR and the number of Disabled –
	Yes – The Trust has taken action to facilitate the voices of Disabled staff. The Trust has set up a Staff disability Equality Group the Group, which has met 3 times.	**Further proposed actions:** – Further work needs to be done to strengthen and grow the membership of the Staff Disability Equality Group.

Metric 10	Board representation Metric – For this Metric, compare the difference for Disabled and non-disabled staff. Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board

	Disabled	Non-disabled	Disability unknown	Total
Total Board members	1	9	3	13
How many are voting members?	9	9	3	13
Number of non-voting members	0	0	0	0
Exec Board Members	1	5	1	7
Number of non-exec members	0	4	2	6
Number of staff in overall workforce	46	1169	282	1497
Total Board members - % by Disability	(7.96%)	(69.23%)	(23.80%)	
Voting Board members - % by Disability	(7.96%)	(69.23%)	(23.80%)	
Non-Voting Board Member - % by Disability	0	0	0	
Executive Board Member - % by Disability	(14.29%)	(71.29%)	(14.29%)	
Non-Executive Board Member - % by Disability	0	(66.67%)	(33.33%)	
Overall workforce - % by Disability	(3.7%)	(78.09)	(18.84%)	
Difference % (Total Board - Overall workforce)	(4.62%)	(-86%)	(4.24%)	
Difference % (Voting membership - Overall Workforce)	(4.62%)	(-86%)	(4.24%)	
Difference % (Executive membership - Overall Workforce)	(11.22%)	(-6.66%)	(-4.55%)	

	Narrative	**Actions**
Findings 2020/2021	The Trust Board has 1 member recorded as Disabled at the Trust. This is 1 more than in the previous reporting period. One is much better than none but the Trust has further work to do if the Trust Board is to reflect the percentage of Disabled people in the UK workforce at some future date. Total Board members - % by Disability (7.96%) Total overall workforce - % by Disability (3.1%) The percentage of Disabled Voting Board members is (4.86%) higher than the overall workforce. The Board has discussed the WDES and is informed on the reasons for Board members to declare if they have a disability. The disproportionately low representation of Disabled Board members will be taken into account during in the process of recruiting future Board members.	**Actions completed:** – The Trust Board has appointed one of its members as Board Equality Lead in order to ensure that the Board provides adequate leadership regarding disability and other equality related matters. No other specific disability targeted actions relating to this indicator have been implemented yet. **Further proposed actions:** The Board will take further positive actions to increase its disability make up when recruiting new Board members e.g. by advertising future Board recruitment opportunities at organisations that support Disabled people.

End of report.

For more information please contact:
Andrew lynch, Equality and Inclusion Lead, HR Department, The Walton Centre NHS Foundation Trust, Sid Watkins Building, Lower Lane, Liverpool, L9 7BB
Email: Andrew.Lynch2@thewaltoncentre.nhs.uk
Telephone: 0151 556 3396

Appendix A - Equality Impact Assessment (EIA) Form

The Walton Centre NHS Foundation Trust

This section must be completed at the development stage i.e. before ratification or approval. For further support please refer to the EIA Guidance on the Equality and Diversity section of the Intranet.

Par

1. Person(s) Responsible for Assessment: **Andrew Lynch** 2. Contact Number: **0151 556 3396**

3. Department(s): **HR** 4. Date of Assessment: **25.08.21**

5. Name of the policy/procedure being assessed: **WDES Findings 2021**

6. Is the policy new or existing?
New Existing

7. Who will be affected by the policy (*please tick all that apply*)?
Staff Patients Visitors Public

8. How will these groups/key stakeholders be consulted with? N/A This document is the result of a consultation process.

9. What is the main purpose of the policy? **This document sets out the findings of the Walton Centre Workforce Disability Equality Standards monitoring for 2019.**

10. What are the benefits of the policy and how will these be measured? **Improving disability equality and reducing discrimination in Trust processes and staff, patient and visitor behaviour. This will be measured through feedback, including but not limited to complaints, grievances and concerns raised.**

11. Is the policy associated with any other policies, procedures, guidelines, projects or services? **Yes, The Equality, Diversity and Inclusion 5 Year Vison.**

12. What is the potential for discrimination or disproportionate treatment of any of the protected characteristics? **None, these findings are intended to promote and support disability equality for all staff.**

Protected Characteristic	Positive Impact *(benefit)*	Negative *(disadvantage or potential disadvantage)*	No Impact	Reasons to support your decision and evidence sought	Mitigation / adjustments already put in place
Age	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Sex	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Race	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Religion or Belief	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Disability	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Sexual Orientation	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Pregnancy / maternity	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Gender Reassignment	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Marriage & Civil Partnership	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	
Other	✓			Defines disability within the context of the Equality Act and discusses promotion of disability equality relating to all other protected characteristics.	

If you have identified no negative impact for all please explain how you reached that decision and provide reference to any evidence (e.g. reviews undertaken, surveys, feedback, patient data etc.) **The purpose of this report is to set out how disability equality as defined within the context of the Equality Act will be promoted throughout the Trust and therefore there is likely to be a positive impact on other protected characteristic, as according to this definition anybody can become. Disabled.**

13. Does the policy raise any issues in relation to Human Rights as set out in the Human Rights Act 1998? **This report supports a Human Rights based approach to supporting staff with disabilities.**

If you have identified negative impact for any of the above characteristics, and have not been able to identify any mitigation, you MUST complete Part 2, please see the full EIA document on the Equality and Diversity section of the Intranet and speak to Hannah Sumner, HR Manager or Clare Duckworth, Matron for further support.

Action	Lead	Timescales	Review Date
N/A	N/A	N/A	N/A

Declaration

I am satisfied this document/activity has been satisfactorily equality impact assessed and the outcome is:

✓

No major change needed – EIA has not identified any potential for discrimination/adverse impact, or where it has this can be mitigated & all opportunities to promote equality have been taken

Adjust the policy – EIA has identified a need amend the policy in order to remove barriers or to better promote equality
You must ensure the policy has been amended before it can be ratified.

Adverse impact but continue with policy – EIA has identified an adverse impact but it is felt the policy cannot be amended.
You must complete Part 2 of the EIA before this policy can be ratified.

Stop and remove the policy – EIA has shown actual or potential unlawful discrimination and the policy has been removed

Name: Andrew Lynch Date: 24.08.21

Signed: Andrew Lynch

Translation Service

This information can be translated on request or if preferred an interpreter can be arranged. For additional information regarding these services please contact The Walton centre on 0151 525 3611

Gellir gofyn am gael cyfieithiad o'r deunydd hwn neu gellir trefnu cyfieithydd ar y pryd os yw hynny'n well gennych. I wybod rhagor am y gwasanaethau hyn cysylltwch â chanolfan Walton ar 0151 525 3611.

هذه المعلومات يمكن أن تُتَرْجَم عند الطلب أو إذا فضّل المترجم يمكن أن يُرَتَّب للمعلومة الإضافيّة بخصوص هذه الخدمات من فضلك اتّصل بالمركز ولتون على 0151 5253611

ئەم زانیاریە دەکرێت وەربگێڕدرێت کاتێك کە داوابکرێت یان ئەگەر بەباش زاندرا دەکرێت

وەرگێڕێك ئامادە بکرێت (ڕێك بخرێت) ، بۆ زانیاری زیاتر دەربارەی ئەم خزمەتگوزاریانە تکایە

پەیوەندی بکە بە Walton Centre بە ژمارە تەلەفۆنی ١٥١٥٢٥٣٦١١ .

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The Walton Centre NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 02/09/21		**Report of:** Strategic BAME Advisory Committee
Date of last meeting: 16/08/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • SBAC Work Plan • Update on general developments from NW SBAC assembly • Feedback from WCFT @Race forum • Update from the communications team • WRES action plan and approach • Plan approach to Black History month • Update on international recruitment
2.	**Alert**	• Recruitment targets for Band 6 and above posts to improve BAME representation have been set in accordance with guidance published by NHS England / Improvement relating to Workforce Race Equality Standard (WRES) Model Employer Goals. Progress against the targets will be monitored by the Committee.
3.	**Assurance**	• There were no items presented on the agenda for assurance.
4.	**Advise**	• Feedback from the WCFT @Race forum was provided and, in addition to the BAME recruitment targets noted above, the Committee discussed the introduction of allies across the Trust and how mentorship arrangements could be progressed. • Plans for distributing Trust anti-racism badges were discussed and it was agreed that these would be launched and distributed in October 2021. • Plans for celebrating Black History month were discussed and it was suggested that areas of focus would be black health, specifically around vaccine hesitancy and the associated history relating to this. Other areas for focus included celebrating the positive contributions made to medical progress by black people along with the contributions made to the NHS over the last 70 years and specifically within the Walton Centre. • An update on the international recruitment programme was provided and it was noted that 11 nurses had been recruited and were currently completing OSCE examinations, upon completion of these they would receive PINs and be able to start working on their assigned wards. It was hoped that a further 29 nurses would be recruited before the end of the year. • An update on the WRES action plan was provided and it was agreed that a small group would be formed to review and manage the required actions. • A communications plan for highlighting experiences of BAME staff during COVID would to be promoted within the next 8 weeks.

		• A communications plan would be developed to support the key messages relating to the BAME agenda • The 'Black Lives Matter' messages and movement continued to be of fundamental importance. • It was agreed that SBAC meetings would move from bi-monthly to being held on a quarterly basis.		
5.	Risks Identified	None		
6.	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 2/9/21		**Report of:** Audit Committee
Date of last meeting: 20/7/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report • Internal Audit Recommendation Report • Limited Assurance Report • Counter Fraud Progress Report • External Audit Progress Report • Losses and Compensation Report • Tender Waivers • Reappointment of Auditors • Board Assurance Framework • Managing Conflict of Interests Policy • Power Outage December 2020 – Controls Assurance • Private Discussion with Auditors
2.	**Alert**	• The Committee reviewed the External Audit Progress Report and was advised of a delay in issue of the Auditor's Annual Report. This was due to additional work as a result of changed requirements for the Value for Money (VFM) assessment. The Committee was advised that the VFM work was substantially complete with an expectation that the draft Auditor's Annual Report would be issued on or around 31 July 2021. It was agreed that an extraordinary Audit Committee meeting would be convened for consideration of the Auditor's Annual Report once the final version was available. • The Committee reviewed a report detailing outcomes from the Complex Discharge audit review as a separate agenda item and noted that the review had resulted in an assessment of Limited Assurance. The Committee noted that the discharge planning process within the Trust could be particularly complex and was advised of areas where improvements could be made which related to business continuity, pathways for complex discharge planning, roles and responsibilities and governance reporting. The Director of Nursing & Governance provided assurance on the timescales for addressing recommendations and the Committee requested a report on progress with the recommendations at its next meeting on 19 October 2021.

	Assurance	• The Committee considered the Internal Audit Progress Report and noted that four Audit Reports had been finalised since the last meeting on 20 April 2021. Outcomes from the audits were as follows: o Cyber Security – Substantial Assurance o Data Protection and Security Toolkit – Substantial Assurance o Complaints – High Assurance o Complex Discharge – Limited Assurance (see below) The Committee considered progress against the audit plan and agreed that some of the audit reviews planned for Quarter 4 should be brought forward to Quarter 3, if feasible, to mitigate the risk of a backlog at the end of the year. The Internal Audit Manager will review the audit schedule in conjunction with relevant Executive leads. • The Trust's Anti-Fraud Specialist presented a report which provided assurance on progress against the Anti-Fraud, Bribery & Corruption Work Plan during Quarter 1 2021/22. The Committee noted submission of the Counter Fraud Functional Standard Return (CFFSR), the annual statement of compliance against the national counter fraud standards, on 1 June 2021 following approval of the proposed submission by the Director of Finance and Chair of Audit Committee. Of the 13 components in the submission, 9 were green-rated and 4 were amber-rated. The Committee noted the corrective actions required to achieve a green rating for the amber-rated standards which will be progressed by the Anti-Fraud Specialist. • The Committee was assured that there is a robust process in place for regular scrutiny and review of the Board Assurance Framework (BAF) by the Executive Team, lead Committees and the Board Directors with the most recent quarterly review being completed with a report to the Board of Directors on 1 July 2021. The 15 principal risks which currently form the BAF were detailed in the report and the Internal and External audit representatives present at the meeting did not identify any weaknesses in internal controls which necessitated amendments to the BAF content. • Mr T Fitzpatrick, Head of Risk, joined the meeting to present a report which detailed progress against actions arising from a root cause analysis on a Power Outage which occurred on 2 December 2020. The Committee noted that 7 of the 11 actions were green-rated and was assured on progress with the remaining 4 amber-rated actions. The Committee also noted that remaining actions would be monitored by the Health, Safety & Security Group with progress reported via Chair's Reports to the Quality Committee and Business Performance Committee as appropriate.
	Advise	• The Committee reviewed the Internal Audit Recommendations Report and noted that 5 of the 19 outstanding audit recommendations related to two audit reviews originally carried out in 2017/18. In order to address these historic recommendations, the Committee requested that the relevant management leads attend the next Committee meeting on 19 October 2021 to provide assurance on progress or clearly identify any factors preventing progress.

		• A revised Managing Conflict of Interests Policy was presented and approved by the Committee. The Interim Corporate Secretary advised of the need to raise awareness of the requirement for staff generally to proactively declare interests and the Committee noted plans to include reminders in Walton Weekly on at least a quarterly basis. The Committee also noted that approval of the revised policy addressed relevant outstanding recommendations detailed in the Internal Audit Follow Up Report. • The Committee reviewed reports on the Losses and Compensation Register and Waivers of Standing Financial Instructions. No issues were identified through the Committee's consideration of these reports. • Following approval by the Council of Governors, the Committee confirmed the appointment of Grant Thornton LLP as the Trust's External Audit service provider with effect from 1 April 2021. The contract is for a two-year period with the option of up to two 12-month extensions. • On completion of the meeting, Committee members met privately with both External Audit and Internal Audit representatives. No issues were raised during the private discussion with audit representatives.		
2.	Risks Identified	•		
3.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 2/9/21		**Report of:** Walton Centre Charity Committee
Date of last meeting: 15/7/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Summary Reports from Investment Managers CCLA and Ruffer. • Finance Report as at 30 June 2021. • The Walton Centre Charity Committee Plan 2021-22. • Fundraising Activity Report. • Review of Walton Centre Charity Risk Register. • 5 applications for funding from The Walton Centre Charity and 11 applications from Training and Development department towards staff professional development. • Charitable Projects Process Update. • Stagnant Funds. • New Fundraising Strategy outline. • Annual Report and Accounts (draft). • Review of Investment Policy. • Annual Committee Effectiveness Review and Terms of Reference. • Cycle of Business.
2.	**Alert**	The Committee was presented with an application for funding for neurosurgery equipment for the Maiduguri Teaching Hospital, Nigeria. The Committee is only able to approve and apply charitable funds in line with the Charity's objectives. However, the objectives do allow for some flexibility (highlighted below) and on this occasion, and after considerable deliberation, the Committee agreed that the proposal could be funded from the designated Neurosurgical Neuro-Oncology Fund. *"The Trustees shall hold the Trust Fund upon trust to apply the income and, at their discretion so far as may be permissible, the capital, for any charitable purpose or purposes relating to the Walton Centre NHS Foundation Trust* ***and such other places as the Trustee shall from time to time determine."*** The decision to support the application was made following discussions around the following areas: • That the equipment may be scrapped if not donated to Maiduguri Teaching Hospital. • That funding was being made available for the transportation of the equipment by Maiduguri Hospital and donations for equipment received

		from Medtronic. • The General Purpose Fund would not be appropriate, as donors to this fund would reasonably expect their donations to benefit patients/staff at The Walton Centre. • Donations to the Neurosurgical Neuro-Oncology Fund had been made in recognition and thanks for the work of Mr Brodbelt and Mr Jenkinson, and in support of Research, Education, Training and Equipment. The Committee have asked for it to be documented that this was an ***exceptional*** approval.
3.	**Assurance**	• The Committee received and was asked to approve the Charity Plan for 2021/22 (draft). This was added to the cycle of business and would be used in order to make effective decisions and plan for the future in addition to monitor the progress and performance of the Charity. • The proposed Risk Register, together with risk appetite and risk categories were presented and discussed. It was suggested a smaller group be established to determine the risks for the Charity which would be aligned with the revised Trust Strategy once this was produced. • The annual review of the Investment Policy was presented and approved. The Committee would look to bring the amount of reserves and cash held by the Charity into line with that of similar sized trusts and would look for investment options for some of the cash currently held in a low interest bearing account. An options paper would be prepared and brought to the meeting in October 2021 for a decision. This information would then be incorporated into the Investment Policy.
4.	**Advise**	• The Committee approved the following funding applications: o 11 applications from the Training &Development department for part-funding towards professional development courses for staff. o Neurosurgery equipment for Maiduguri Teaching Hospital (circa £11250 + VAT). Exceptional approval as detailed in the Alert section of this report. o Headache Chatbot (£29,000 + VAT). o Staff Party (£5,930) to underwrite costs. o Galileo Vibration Therapy (£7,748 + VAT). o Parkinson's Disease study and Neuro imaging study (2 applications totalling £9,550) subject to RIME Committee approval. • The Committee members agreed they would approve via email the auditors to be appointed to undertake the independent examination of the Annual Report and Accounts on completion of the relevant procurement process. Grant Thornton LLP had provided a quote but were unable to carry out the work until Sept/October 2021. In order for the Annual Accounts to be ready for the October meeting an alternative company would need to be sourced. • The Committee noted the corporate/major donations received and the forthcoming events / initiatives which were detailed in the fundraising activity report. An update was provided on the NHS Charities Together Grants and the impact they might have. The Committee was assured that contingency plans were in place for the major events being organised.

		• The Charitable Project Prioritisation Process report advised the Committee on the progress of an open call for project ideas / expressions of interest which had been circulated to staff on 20 May 2021 via email. Out of the 3 projects received the Committee agreed to support the Neuro VR Simulator project. This enabled neurosurgeons and residents to practice and develop expert skills in open cranial and endoscopic brain surgery within an immersive, VR training environment. All agreed this should be taken forward as a future fundraising project. • The draft Annual Report and Accounts for the year ending 31 March 2021 were approved and the final version would be presented at the October meeting following an Independent Review. • The Committee was updated on the progress of the new fundraising strategy 2022-2025 and agreement was given to the delay of the new strategy and to approve the proposed bridging plan for 2021/22 instead. This was required due to the uncertainty of the current landscape following 18 months of the pandemic with the next 12 months being used to take time to settle and assess the impact on the Charity. • The responses received from members of the Committee to form the basis of the Effectiveness Review indicated a positive outcome. The Terms of Reference currently require 3 of the 4 voting members to be present at meetings to achieve a quorum and the Committee noted an inherent risk to continuity of decision-making. The Committee proposed an amendment based on 2 of the 4 voting members, one Non-Executive Director and one Executive Director, being present to achieve a quorum. Revised Terms of Reference, with the proposed amendment at s4.7, are included at Annex A to this report for approval by the Board of Directors.		
5.	Risks Identified	• None.		
6.	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

THE WALTON CENTRE CHARITY COMMITTEE
Terms of Reference

1.0 CONSITUTION

1.1 The WCFT's Charitable Funds Committee is constituted as a standing committee of the Board of Directors to exercise the Trust's functions as sole corporate trustee of The Walton Centre Charity registered charity number 1050050. Its constitution and terms of reference shall be as set out below, subject to any future amendment(s) by the Board of Directors.

1.2 The Committee is authorised by the Board of Directors (as Trustee) to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its function.

2.0 PURPOSE

2.1 The Committee is appointed to discharge the Trust Board's responsibilities as Corporate Trustee in the effective management of the Charity, including compliance with statutory and regulatory requirements in accordance with the guidance on NHS Charities set out by the Charity Commission.

In discharging its role members must act solely in the best interests of The Walton Centre Charity and in a manner consistent with the Charity Commission's requirements and expectations of Charity Trustees.

3.0 DUTIES AND RESPONSIBLITIES

3.1 The main functions of the Committee are to:

(a) inform the development of the Fundraising Strategy and objectives for the Charity's work for consideration by the Board and oversee their delivery.

(b) monitor the performance of the fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met

(c) receive reports detailing balances of the Charity's Funds.

(d) receive reports on all individual charitable non-pay transactions in excess of £1000

(e) approve expenditure of all individual charitable non-pay transactions

valued £5,000 up to £100k

(f) in line with charity law establish the strategy, policies, budget, spending priorities and criteria for spending decisions for each fund.

(g) appoint appropriate Investment Managers to provide investment advice and manage the Charity's investment portfolio.

(h) in conjunction with the investment managers, agree an investment policy which lays down guidelines in respect of:

- the balance required between income and capital growth.
- the balance of risk within the portfolio.
- any categories of investment which the Trust does not wish to include in the portfolio on ethical grounds.

And keep performance against these investments under review

(i) review the impact on the Charity of changes in legislation both of a charitable and non-charitable nature and make appropriate recommendations to the Trust Board, as Corporate Trustee, as to how any new requirements will be met.

(j) ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation.

(k) receive audit reports on the charity controls.

(l) approve new fundraising appeals and monitor fundraising targets.

(m) consider the Charity's annual report and accounts prior to approval by Trust Board

3.3 **Policies**

To consider and approve all policies relevant to the Committee's remit including the Investment Policy, the Fundraising Policy and the Ethical Donations Policy.

3.4 **Risk**

The Committee will 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 e.g reputational risks, fraud, business continuity.

4.0 MEMBERSHIP AND ATTENDANCE

4.1 The Committee will be appointed by the Board of Directors and shall comprise the following membership:

Voting members

- 2 Non-Executive Directors (one of who will chair the committee)
- Director of Finance and IT
- Director of Nursing and Governance

Core members

- Director of Workforce and Innovation
- Consultant Neurosurgeon or nominated Deputy
- Consultant Neurologist or nominated Deputy
- Named Consultant or nominated Deputy
- Head of Fundraising or Deputy

4.3 Both voting and core members are expected to attend a minimum 75% of Committee meetings during each financial year.

4.4 In the event the Chair of the Committee is unable to attend a meeting, the Non-Executive Director members shall appoint another Non-Executive to be Chair for that meeting.

4.5 Other Officers of the Trust shall attend at the request of the Committee if it is considered appropriate due to the nature of the business being discussed.

4.6 An open invitation exists for all members of the Board of Directors to attend the Committee.

Quoracy

4.7 The Committee will be deemed quorate provided ~~three~~ ***two*** members ***(one Non-Executive Director and one Executive Director)*** are in attendance. ~~one of whom must be a Non-Executive Director.~~

5.0 RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & MANAGEMENT GROUPS

5.1 The Committee will report in writing to the Board of Directors following each meeting and include a summary of the business that has been transacted and basis for any recommendations made.

5.3 The Committee may establish management groups to support it in fulfilling its duties.

5.4 The Committee will approve the terms of reference and annual work programme of any management groups on an annual basis and keep their effectiveness under review.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings.** The Committee will normally meet on a quarterly basis.

6.2 Additional meetings may be held on an exceptional basis at the request of the Chair or any three members of the Committee.

6.3 **Minutes.**
The minutes of meetings shall be formally recorded, checked by the Chair and submitted for agreement at the next meeting.

6.4 **Annual Work Programme**
The Committee will agree an Annual Work Programme/Cycle of Business, which will be reviewed at each meeting to ensure the Committee, is meeting its duties.

6.5 **Administration**
The Committee shall be supported administratively by the Corporate Secretariat, whose duties shall include: agreement of the agenda with the Chair and collation of papers; producing the minutes of the meeting for checking by the Chair, circulating draft minutes promptly to members once checked and advising the Committee on pertinent areas.

7.0 EQUALITY ACT (2010)

7.1 The Committee will ensure the Trust meets its obligations under the Equality Act 2010 in relation to the remit of the Committee.

8.0 REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 02/09/21		**Report of:** Quality Committee
Date of last meeting: 22/07/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Violence & Aggression Presentation • Medical Director's update • Integrated Performance Report • Governance and Risk Management Report Q1 • Mortality & Morbidity Q1 Report • Infection, Prevention & Control Q1 Report • Tissue Viability Q1 Report • Ward Accreditation (CARES) • Controlled Drug Accountable Officer Report • Equality, Diversity & Inclusion staffing trajectories and action plan • Quarterly Pharmacy KPI report • Organ Donation Terms of Reference • Sub-committee Chairs' Reports
2.	**Alert**	• Dr Nicolson provided an update of a radiology incident noted for w/c 12/07/21. A visit from the company representative resulted in changes being made to the system which meant a very small amount of extra radiation was given to 30 patients. The incident has been reported to CQC and NHSE. The risk to patients is negligible. Letters are being sent to patients to inform them so Trust is open and honest. Internal investigations are underway to ensure this cannot happen again. The Radiology Dept. has been extremely thorough in managing this incident. • IPC Q1 report, Ms Oulton drew attention to the increase in the number of SSI infections and noted that a review of themes/trends is underway. The team will be reducing the threshold of 6%. Ms Oulton also noted that uptake for staff lamp testing is low and all is being done to encourage participation. The 1st positive lamp test result for a staff member was received 22/07/21. Staffing for the next 6 weeks for the IPC team will be challenging due to recruitment changes – x 2 band 6 to start in the autumn and x 1 band 5 is out to advert.
	Assurance	• Mr. Fitzpatrick delivered a presentation to demonstrate how Violence & Aggression (V & A) is being managed within the Trust. Work related to this will be incorporated into the People Strategy. There is enhanced engagement with between Mental Health, Psychology Teams, Safeguarding and the Governance Team to manage V&A. Of the staff being assaulted at the current time, it has been recognised that they have not yet received the updated V& A training. It was noted that there is a

		need for a V & A Reduction Strategy. The team are currently risk profiling which conditions of patients (from past incidents) that have had V&A outbursts so that proactive work can be delivered to prevent harm. V&A to be added to the Quality Committee work plan for quarterly updates.
	Assurance	• Dr Nicolson provided an update with regards to the Thrombectomy Service, noting nursing staff competencies were updated and that 4 nurses have fully passed these with 2 more to be trained. Dr Wilson advised that extended hours (to 11pm) will commence 02/08/21 with a view to the 24 hour/7day service starting at the end of September or early October. • Ms Duffy provided a summary of the Rapid Access Neurology Assessment (RANA) service provided, noting that 6 patients are seen daily at the WCFT (transferred from other Trusts). The patients are assessed and diagnosed on the same day. A total of 96 patients have been assessed from February to the end of June. This has resulted in 192 bed days saved in other Trusts and positive outcomes for the patients who did not require a hospital admission. A further review is required to determine full benefits and the service needs to be promoted further. • The IPR was presented and key points noted. Complaints are in line with national KPI. The process was recently reviewed by MiAA who awarded the highest assurances. The IPR for Quality Committee is to be reviewed to ensure all elements are captured and that the data is appropriate. Some complaints related to lack of visiting but this was imposed following national and regional guidelines due to an increase in Covid-19. Nursing turnover is around 8% with many staff leaving ITU for non-ITU roles following Covid-19. This is being reviewed but is similar to other Trusts. Neurosurgery is awaiting Ribotyping for CDT cases to denote any links between cases. The Divisions provided a comprehensive review of their departments together with an update on how they are managing and mitigating the risks. ITU has had their peer review with only 3 areas identified as red or amber. The full report will be presented at QC in October. • The Mortality & Morbidity Q1 report was received with 2 cases noted for learning. The Mortality review of covid-19 nosocomial deaths were reviewed in line with KLOE. NHSI/E visited the Trust in February 2021 and provided positive feedback with no essential improvements. Some minor advice has been included in action plan which is reviewed at the IPPC meetings. • The IPC Q1 report was presented. No incidents of nosocomial infections, Klebsiella, Pseudomonas or CPE were reported. The training event with IPC link ambassadors evaluated well. • Ms King presented the TVN Q1 update, reporting on work completed and priorities for the next 3 months. An audit is to be undertaken to review moisture lesions. Incidents of pressure ulcers were noted. The new TVN is due to start early autumn once Ms King has left the Trust. • Ward Accreditation – the 12 month programme was delayed due to covid-19 but is due to recommence shortly. Once all CARES reviews are completed, these will be presented to Ms Salter and to Quality Committee via chairs' report. • CD Accountable Officer Annual Report was received. It was noted that only x 3 CD audits were performed instead of 4 due to Covid-19. The record keeping of

		patients' own CDs has improved since last year. WCFT was recognised as exemplar practise for managing incidents of liquid CDs at ward level. One high risk was noted pertaining to an intrathecal refill incident and related to human factors WCFT praised for the positive learning culture to prevent this happening again. • Equality, Diversity & Inclusion (E, D & I) update was presented by Mr. Lynch who presented 3 documents – the trajectories document which sets out the recruitment targets and the required additional BAME recruitment to 2028; the EDI actions for the WCFT document responds to the 6 specific recommendations the NSE/I requested from NHS Trusts and the Action Plan Template is a response to NHSE/I sending this template for Trust completion. The targets are ambitious which will support a change. Working with the system (C&M and ICP) is essential to target racial inequalities – this work is already underway.		
	Advise	• The Q1 Governance Risk Management was presented. The number of concerns has increased and these are to be given timescales for responses. CDT and MSSA are to be added to the GAF. E-Coli (Ref 309) is to be reviewed at the end of Q2. Rejection of pathology samples (ref 300) an order comms systems is required to make a difference. Theatre ventilation system (Ref 311) is being reviewed by Capital Group. Concerns were raised regarding incorrect filing of patient casenotes with Ms Salter noting that there is a need for clear guidance on how this is being managed. • In-patient Survey update – Ms Gurrell advised that the results are currently embargoed and update will be present to QC when these have been released (October) Mr Foy added that the Trust has been invited to join the survey again for this year. • Pharmacy KPI – it was noted that some of the KPIs (eg TTO verified on wards) were not met due to staffing issues. Ms Sparrow to work with Mr. Foy for presenting data in new Trust format.		
2.	Risks Identified			
3.	Report Compiled by	Seth Crofts Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
August 2021

Report Title	**Chair's Assurance Report – RIME Committee 07/07/21**
Sponsoring Director	Seth Crofts – Non-Executive Chair
Author (s)	Mike Gibney, Director of Workforce and Innovation
Purpose of Paper:	
The Research, Innovation and Medical Education Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Research, Innovation and Medical Education Committee held on 7 July 2021.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's Attention

- Key priorities for Research recovery
  It was highlighted that the single most important priority is the R&D administrative staff, led by Debbie Atkinson, to address the governance risks within the department.

  In working with Walton clinician scientists, a PI forum will be developed and is anticipated to run monthly/bi-monthly to dovetail with existing trust meetings.

  The NRC medical lead role, currently undertaken by Dr Heike Arndt, will be redefined due to her expertise in clinical trials, in a professional and safe manner, which will be central to the development of the NRC.

  Talented staff are sought to take on lead roles in research as clinicians. There will be a business plan submission for R&D staffing resource; there is some income in the budget to cover this. A change of role is indicated to the academic development manager which will make the best use of the skill set available. The PI forum is a non-cost option which will bring together PI's. Medical research co-ordination roles are to be delineated as they are currently unsustainable. It would mean two extra PAs but this would come from the additional income from the increased revenue associated with Medical Education.

- Research communications to raise the Trust's profile
  Work is ongoing within the Communications Department to increase the profile and brand of the Trust as a leader in Neuroscience Research. Publicising research is a positive way of demonstrating the Trust's strengths as a clinically leading trust and a specialist hospital. Advances in research show how the trust is changing the face of neurological and neurosurgical treatment and care for the benefit of all patients. This will broaden the Trust's reach nationally and potentially, internationally rather than just regionally and, supported by patient case studies, will demonstrate the human impact of research.

- Undergraduate University feedback
  Feedback confirmed the Trust has consistently been rated above the average score across all indicators. Highlights include a high quality learning environment; teaching was evaluated as

excellent and the willingness of doctors to engage with students and the responsiveness and supportive administrative team.

The areas which haven't been rated so well were supervisor accessibility, timely feedback and ability for e-portfolio sign off. There were difficulties with timetables/scheduling and limited exposure to patients and ward activity due to Covid which has led to gaps in the student's development of skill and knowledge of the patient journey. All areas identified for improvement will be addressed in a timely manner.

2.0 Items for the Board's Information and Assurance

- Research Key Priorities
- Research Communications
- Positive Undergraduate University feedback

3.0 Progress Against the Committee's Annual Work Plan

- Discussed and currently on track.

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 2/9/21		**Report of:** Remuneration Committee
Date of last meeting: 13/8/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Interim Director of Operations & Strategy • Changes to Executive Portfolios • Committee Terms of Reference
2.	**Alert**	• There were no matters on which to alert the Board.
	Assurance	• The Committee completed a periodic review of its Terms of Reference and can assure the Board that the content is consistent with best practice guidance. While the content remains largely unchanged, the Committee has proposed amendments in order to define quorum requirements and clarify Committee scope. With regard to scope, previous references to the Committee's role in relation to remuneration of *Senior Managers on Agenda for Change Band 8D and above* have been amended to *Any other Senior Managers who are not subject to Agenda for Change terms and conditions.* It is recommended that the Board of Directors approve the revised draft Terms of Reference included at Annex A to this report.
	Advise	• The Committee reviewed a report from the Chief Executive proposing changes to Executive Director portfolios and job titles. The Committee noted that the proposals had resulted from Executive Director planning days held on 4-5 August 2021, with the realignment of portfolios intended to address changes in the health and social care landscape whilst maximising individual Director skill sets. The Committee noted the Chief Executive's intention to trial / test the arrangements over the next 2-3 months and report final outcomes to the Committee in November 2021. The Committee endorsed the proposed changes to Executive Director portfolios and job titles. The report also detailed the Chief Executive's intention to appoint the Medical Director as Deputy Chief Executive. The Committee considered the rationale for this appointment and supported the decision of the Chief Executive. The Committee noted that, at present, there were no remuneration implications

		associated with either the Deputy Chief Executive appointment or the changes in Executive Director portfolios. It was noted that the Committee had deferred consideration of an Executive Pay Review earlier in the year, pending appointment of a substantive Chief Executive, and it was agreed that the Committee would revisit this review in context of finalised changes to portfolios in November 2021. • The Committee considered a report seeking approval for the re-appointment of Mr M Woods as Interim Director of Operations & Strategy on a fixed term contract. The Committee noted the requirement to recruit a substantive post holder, to fill the vacancy created by the appointment of Ms J Ross as Chief Executive, and the consequent requirement to ensure continuity of cover for the duration of the recruitment process. The Committee acknowledged Mr Woods' performance in the interim role to date and the benefits to the Trust of transition to fixed term contract arrangements. The Committee approved the appointment of Mr M Woods as Interim Director of Operations & Strategy on a full time, fixed term contract for a period of six months commencing on 9 August 2021. The Committee noted that the title of this particular post would change to *Chief Operating Officer* as part of the changes to Executive Director portfolios and job titles. The Committee endorsed plans for recruitment of a substantive post holder and approved a job description for the Chief Operating Officer role as the basis for the recruitment process. It is anticipated that a substantive post holder will be in place in January / February 2022.		
2.	Risks Identified	Nil		
3.	Report Compiled by	Seth Crofts Deputy Chair	Minutes available from:	Corporate Secretary

The Walton Centre
NHS Foundation Trust

REMUNERATION COMMITTEE

DRAFT TERMS OF REFERENCE

1. CONSTITUTION

1.1 The Remuneration Committee *(hereinafter referred to as 'the Committee')* is constituted as a standing Committee of the Trust's Board of Directors. The Committee's constitution and terms of reference shall be as set out below, subject to amendment at future Board of Directors meetings.

1.2 The Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Committee.

1.3 The Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for or expedient to the exercise of its functions.

1.4 The Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions.

2. MAIN PURPOSE

2.1 The Committee is responsible for identifying and appointing candidates to fill all Executive Director positions on the Board of Directors and for determining their remuneration and other conditions of service.

2.2 When appointing the Chief Executive, the Committee shall be the committee described in Schedule 7, 17(3) of the National Health Service Act 2006: '*It is for the Non-Executives to appoint or remove the Chief Executive'.*

2.3 When appointing the other Executive Directors, the Committee shall bethe committee described in Schedule 7, 17(4) of the National Health Service Act 2006: *'It is for a committee of the Chairman, Chief Executive and other Non-Executive Directors to appoint or remove the Executive Directors'.*

2.4 To determine the remuneration and conditions of service for any other Senior Managers who are not subject to Agenda for Change terms and conditions.

3. NOMINATIONS AND APPOINTMENTS ROLE

The Committee will:

3.1 Regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) of the Board of Directors, making use of outputs from any Board evaluation process as appropriate, and make recommendations to the Board of Directors and Council of Governors, as applicable, with regard to any changes.

3.2 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.

3.3 Keep the leadership needs of the Trust under review at Executive Director level to ensure the continued ability of the Trust to operate effectively in the local and regional health economy.

3.4 Be responsible for identifying and appointing candidates to fill posts within its remit as and when they arise. An Appointments Panel, comprised of members of the Committee, will be established to conduct interviews for relevant posts and will make recommendations to the Committee for subsequent approval of appointments. The Committee will determine the need for other internal / external stakeholders to participate in the Appointments process.

3.5 When a vacancy is identified in respect of those posts within its remit, evaluate the balance of skills, knowledge, experience and diversity on the Board of Directors, and in the light of this evaluation prepare a description of the role and capabilities required for the particular appointment. In identifying suitable candidates the Committee shall use open advertising or the services of external advisors to facilitate the search, will consider candidates from a wide range of backgrounds and will consider candidates on merit against objective criteria.

3.6 Ensure that a proposed Executive Director is a 'fit and proper person' in accordance with the Trust's Fit and Proper Persons Policy.

3.7 Ensure that a proposed Executive Director's other significant commitments (if applicable) are disclosed before appointment and that any changes to their commitments are reported to the Board of Directors as they arise.

3.8 Ensure that proposed Executive Directors disclose any interests that may result in a conflict of interest, whether actual or potential, prior to appointment.

3.9 Consider any matter relating to the continuation in office of any Executive Director, including the suspension or termination of service of an individual as an employee of the Trust, subject to provisions of the law and their service contract.

4. REMUNERATION ROLE

The Committee will:

4.1 Establish and keep under review a remuneration policy in respect of Executive Directors (and any senior managers on locally-determined pay).

4.2 Consult the Chief Executive about proposals relating to the remuneration of the other Executive Directors (and any senior managers on locally-determined pay).

4.3 In accordance with all relevant laws, regulations and Trust policies, decide and keep under review the terms and conditions of office of the Executive Directors (and any senior managers on locally-determined pay) including:

- salary, including any performance-related pay or bonus or earn-back arrangements
- provisions for other benefits, including pensions and cars
- allowances
- payable expenses; and
- compensation payments

4.4 Establish levels of remuneration which are sufficient to attract, retain and motivate Executive Directors of the quality and 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.

4.5 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.

4.6 Review and assess the output of evaluation of the performance of individual Executive Directors and consider this output when reviewing remuneration levels.

4.7 Advise upon and oversee contractual arrangements for Executive Directors, including but not limited to termination payments, to avoid rewarding poor performance.

4.8 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.

5. MEMBERSHIP AND MEETINGS

5.1 Membership of the Committee shall consist of:

- The Trust Chair (Chair);
- the other Non-Executive Directors;
- and, in addition, when appointing Executive Directors (other than the Chief Executive), the Chief Executive.

There is an expectation that members will attend all Committee meetings during each financial year. On any occasion when a member is unable to attend a meeting in person, it shall be acceptable for them to submit their comments / views on agenda items by electronic means such as e-mail.

5.2 Other Officers of the Trust shall attend at the request of the Chair of the Committee and other persons such as external advisors may also attend meetings to assist he Committee in its deliberations. However, only members of the Committee are permitted to vote and any non-members will be asked to leave the meeting should their own conditions of employment be the subject of discussion.

5.3 ***Quorum***. No business shall be transacted unless at least four members, including either the Chair or the Deputy Chair, are present.

5.3 ***Notice of meeting***. Before each meeting, a notice of the meeting specifying the business proposed to be transacted shall be sent by post or electronic mail to the usual place of business or residence of each member, so as to be available at least three clear days before the meeting.

5.4 ***Frequency of meetings***. The Committee will meet as required but will meet at least annually when these Terms of Reference should be reviewed. The Chair may, however, call a meeting at any time provided that notice of the meeting is given as specified in s. 5.3 above.

5.5 ***Minutes***. The minutes of meetings shall be formally recorded by the Corporate Secretary, will be checked by the Chair and will then be submitted for agreement at the next meeting of the Committee.

5.6 ***Administration***. The Committee shall be supported administratively by the Corporate Secretary whose duties shall include: agreement of the agenda with the Chair, collation and distribution of papers, producing minutes of Committee meetings and maintaining the Committee's action log.

6. RELATIONSHIP WITH THE BOARD OF DIRECTORS

6.1 The Committee will report to the Board of Directors by means of a Key Issues Report summarising business conducted by the Committee together with key actions and/or risks. A Key Issues Report will be forwarded to the Board of Directors following each Committee meeting.

7. RELATIONSHIP WITH OTHER COMMITTEES / GROUPS

7.1 The Committee will also report to the Council of Governors on matters relating to appointment of a Chief Executive and/or any proposed changes to Board composition involving Non-Executive Directors.

8. REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. Outcomes of the annual effectiveness review will be reported to the Board of Directors.

8.2 The Committee must review its terms of reference annually and recommend any changes to the Board of Directors for approval.

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 2/9/21		**Report of:** Business Performance Committee
Date of last meeting: 27/7/21		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report (IPR) • Capital Update / 5 Year Capital Plan • Transformation and QIP Quarterly Update • Digital Strategy and Digital Aspirant NHSX Programme Update • Freedom of Information Annual Report • Flow Chart / Revised Documentation for Investment Cases • Chair's Reports from 5 Sub committees
2.	**Alert**	• On 9 July 2021 guidance was produced stating that Elective Recovery Fund (ERF) thresholds had been reviewed and adjusted to 95% of 2019/20 activity levels from 1 July 2021. This information was received by the Trust on 14 July 2021. The Trust was currently reviewing the impact this would have from an income perspective and daily operational huddles implemented to review activity performance against the revised thresholds set for the remainder of H1. This would mean for the next 3 months there would need to be an additional 97 elective cases and 925 outpatient cases to achieve the new threshold. The work taking place by the divisions to work towards achieving the increase to a 95% trajectory was detailed.
3.	**Assurance**	• Assurance was provided to the Committee that the Trust had exceeded all elective targets including the Wales RTT target with performance above the 95% target in June 2021. Nursing vacancy levels would be monitored carefully between September 2021 and December 2021 although the recruitment of 8 international nurses who were now in post would go some way to bridging the gap until April 2022 when the newly qualified nurses would come into the local labour market. At M3 the Trust reported an in-month £192k surplus against a planned surplus of £178k (so £14k better than plan). • The Committee received an update on the capital priorities process noting that the original capital prioritisation of £8.4m had been reduced to £6.6m which was £0.4m above the capital allocation of £6.2m from the HCP and did not meet the capital demand of the Trust (although the capital allocation was 50% higher than the standard depreciation funded method). The process for prioritisation of the

		capital schemes was detailed and the group established to monitor this would meet on a quarterly basis in addition to the monthly meeting of the Capital Management Group. Assurance was provided around risk assessments carried out in the prioritisation process. • The Committee was presented with a monthly reporting update on the Digital Transformation Programme covering achievements; planned activity and spend against the Digital Aspirant NHSX Programme. It was noted that the Trust had been assessed as achieving HiMSS level 5 of digital maturity which placed it in the top 20% of trusts. Key updates were provided, particularly around the Digital Aspirant Support Team now in place and the reporting structure going forward. It was noted from the Funding Evidence Report that Q1 was underspent but this was due to implementing the correct staffing levels in order to move forward on projects in Q2 and Q3. • The Committee noted that QIP delivery was in accordance with plan in Q1. At M3 the Trust achieved the QIP YTD target of 1.54% for H1 2021-22. The biggest challenge would be H2 which was expected to be a 3% efficiency target. World Cafes were taking place and the message was being given to different areas and staff groups to think about ideas as to how they could be more efficient. Currently 50 suggestions were being worked through with the help of the Finance Team and monthly meetings were taking place to monitor schemes and feedback on performance. • The Freedom of Information (FOI) Annual Report was presented by the Responsible Officer, Ms L Blyth, to provide assurance on the effectiveness of the process in responding to the 366 FOI requests received from April 2020 to March 2021. There had been a significant decrease in FOI requests compared to 520 in the same time period last year. The decrease was believed to be due to Covid 19 with many businesses and universities that normally requested information being temporarily closed during the pandemic. The Committee noted the implementation of a new internally developed FOI system used to log new requests and record the time taken to collate the responses. The Committee was assured by the strong process in place and noted that the Trust had never had a FOI breach by failing to respond in the requisite time. The Committee acknowledged a good informative annual report.
4.	**Advise**	• It remained uncertain as to whether the proposed pay increase of 3% for NHS staff would need to be funded by the Trust. The Committee noted the considerable impact this would have if extra funds were not made available. • A flow chart detailing the process for submission, challenge and approval of all cases requiring investment or a case for change was presented to the Committee together with a simplified investment case proforma. The flow chart and documentation had been approved by the Executive Team. The Committee welcomed the revised process and cleaner documentation noting that a more detailed financial spreadsheet to accompany the proforma was still under development. Discussion took place around business cases requiring Trust Board approval and whether they needed to be presented at sub-committee level prior to Board. It was considered that this was a decision to be made by Trust Board but had the support of the members of the Committee that any investment case over

		£500k should be taken directly to Trust Board for approval. • The Committee discussed the current attendees and would make a recommendation to Trust Board for the Deputy Director of Operations and Deputy Director Workforce and Innovation to be core attendees of the Committee going forward. The Interim Director Operations would give more thought to operational representation for a more balanced approach and this would be considered at a future meeting. • A Trust General and Offensive Waste Contract award to B&M Waste Services was approved by the Committee. The contract ensured the Trust had a compliant contract in place for a maximum of 7 years following a formal tender process undertaken as part of a Cheshire and Merseyside collaborative scheme to align contracts to ensure value for money was achieved. The collaboration however required individual Trust approval to progress with the contract award. • Progress on the transformation work taking place was detailed highlighting what had been achieved in Q1 and brief updates provided on each of the schemes. Matron, Ms C Moore, had been recruited to the team and her experience would help progress some of the clinical projects. The Committee were advised that the Service Improvement Team did not have a budget and the role of the team was to work with the divisions in a supportive way to help make the schemes happen.		
5.	Risks Identified	• None.		
6.	Report Compiled by	David Topliffe Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date: 2nd September 2021

Title	**Governance Annual (Quarter 1) Report 2021/22**
Sponsoring Director	**Name:** Lisa Salter **Title:** Director of Nursing and Governance
Author (s)	**Name:** Lisa Gurrell **Title:** Head of Patient Experience **Name:** Tom Fitzpatrick **Title:** Head of Risk **Name:** Kate Bailey **Title:** Clinical Governance Lead
Previously considered by:	• Quality Committee

Executive Summary:

The purpose of the report is to:

1. A review of governance activity in Quarter 1 (Q1) 2021/22.
2. Assurances that robust actions are in place to mitigate risk, reduce harm and ensure that learning is embedded.
3. Assurance to the Board that issues are being identified and managed effectively.

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

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

Governance, Risk and Patient Experience

Quarter 1 Report

(April - June 2021)

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

1. Introduction

This Quarter 1 report (April – June 2021) provides an overview of activity for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health and safety.

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

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

- a summary of governance activity in Q1 (2021/22) compared to Q4 (2020/2021)
- assurances that actions are in place to mitigate identified risks, in order to reduce harm and ensure that learning is embedded
- assurance to the Trust Board that issues are being identified, escalated and managed effectively

2. Executive Summary

2.1. Throughout Q1, the Risk Team has placed a particular emphasis on:

- the management of violent and aggressive (V&A) patients:
  - supporting staff to ensure that timely interventions are put in place to reduce harm to staff and patients from V&A e.g. introduction of safe pods in Chavasse Ward
  - providing post incident debriefing sessions for staff
- the delivery of additional mandatory training (including evening sessions)
- supporting the vaccination programme for in-patients, including the development of training and competencies for vaccinators

2.2. Throughout Q1, the Patient Experience Team has:

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

3. Governance Assurance Framework (GAF)

There were no new GAF entries identified in Q1. The entry relating to E.coli Bacteraemia incidents (Ref 309) is requested to be closed and monitored via the Integrated Performance Report (IPR).

4. Incident Management

4.1. <u>Serious Incidents (SI):</u>

1 serious incident was reported in Q1 compared with 1 in Q4.

4.2. <u>Moderate (& above incidents):</u>

12 moderate harm incidents were reported in Q1 compared 25 in Q4.

4.3. Duty of Candour:

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

4.4. Incident theme by category:

4.4.1 Infection control Incidents:

- 29 incidents were reported in Q1 compared with 59 in Q4

4.4.2 Communication incidents (GAF entry 304):

- 90 incidents were reported in Q1 compared with 75 in Q4

4.4.3 Information Governance incidents:

- 15 incidents were reported in Q1 compared with 17 in Q4

4.4.4 Medication incidents:

- 80 incidents were reported in Q1 compared with 80 in Q4

4.4.5 Safeguarding incidents and concerns:

- 41 incidents were reported in Q1 compared with 72 in Q4

4.4.6 RIDDOR:

There were 6 RIDDOR incidents reported in Q1:

- 2 incidents involved fractures (staff members)
- 3 incidents resulted in more than 7 day absence from work (staff members)
- 1 incident was due to a fall in the car park (member of the public)

4.4.7 Violence & Aggression:

- 108 incidents were reported in Q1 compared with 90 in Q4

5. Risks

A capital monitoring risk register has recently been developed, to support the Trusts capital spend priority.

6. Complaints & Concerns

- 100% of formal complaints received in Q1 were acknowledged within 3 working days and responded to within the negotiated timeframe
- 16 new complaints were received in Q1 compared to 12 in Q4 of 2020/21
- 19 complaints closed in Q1; 1 upheld, 6 partially upheld and 12 not upheld
- in Q1 the overall average response time was 20 working days for formal complaint responses, this is an over achievement in line with the policy, as we aim is to respond within 25 working days and improvement from Q4 average response time of 22 working days
- by Division, the average response time for Neurology was 18 working days and 31 working days for Neurosurgery
- the number of concerns increased slightly from Q4 to Q1 with 140 received in Q4 and 159 received in Q1
- Communication is the highest theme in Q1 and remains a theme on the GAF (entry 304), this is followed by appointment arrangements and numbers remain higher than previous quarters
- 65 enquiries were received in Q1, in comparison to 85 received in Q4; themes relate to the referral process and general hospital enquiries

6.1. Complaints:

- 42 compliments were reported in Q1 compared with 58 in Q4

6.2. Patient Experience:

- **Outpatients** - **93% of patients were Extremely Likely/Likely** to recommend based on a total of 636 responses (4.1% response rate)
- **Inpatients** – **99% of patients are Extremely Likely/Likely** to recommend based on a 32% response rate compared to the number of discharges (1,900) in Q1

7. Claims

There were 4 new claims reported in Q1 compared with 4 in Q4. 1 claim was reopened.

8. Recommendation

Quality Committee is asked to receive and note this report.

9. Governance Assurance Framework (GAF) Log – Q1 2021/22

9.1. Items for closure:

Theme	Context	Analysis	Action	Recommendation
Ref 309 – E.coli Bacteraemia Incidents 7th January 2021	Healthcare associated infections can cause substantial patient morbidity, complicate treatment and increase cost to the NHS. A number of these infections are preventable through better application of good practice. The thematic review of 2019/20 investigations, identified that there has been 15 E-coli bacteraemia, against an internal trajectory of 9. This represents an increase of 5 since 18/19. Review of the subsequent investigations has shown 13 cases were related to urosepsis, a further 2 were as a result of abdominal sepsis. The presence of a urinary catheter in situ was identified in all cases. This increase reflects the national position; the government have set a goal to reduce healthcare associated gram negative blood stream infections by 50% by 2020/21. **Lead:** Lead Nurse Infection Control and Prevention	The Trust's infection control policies and procedures reflect the NICE Quality standard (QS 61). Quality Standard 4 states people who need a urinary catheter should have their risk of infection minimised by the completion of specific procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. This is important in terms of both infection prevention and patient comfort and experience. Previous reviews of catheter care (2017) have resulted in improvements in practice and education. The increase in E. Coli bacteraemia suggests it is necessary to raise the profile of catheter care and ensure the guidance and education is relevant and robust.	1. Infection Control/Service Improvement & MDT to undertake an A3 Quality Improvement Project (QIP) monitored via the Executive Team to reduce the complications associated with indwelling urinary catheters with the aim of reducing the incidence of E Coli bacteraemia. 2. The QIP measures are: • avoid unnecessary urinary catheters • all insertions to be undertaken with aseptic technique and managed in line with guidelines • all catheters to be reviewed daily and removed promptly in line with clinical requirements • theatre / recovery - review the criteria for the need for insertion, together with technique and commence the removal plan • acute ward team - ongoing care, daily review (plan for removal) • IPC / Specialist nurses - review of specialist needs (neurogenic bladder) including review of policy / education	Reduction in incidents reported continued throughout Q1, as expected, monitor via the IPR. **Recommendation:** Close.

9.2. Items for continued monitoring:

Theme	Context	Analysis	Action	Recommendation
Ref 287 Violence & Aggression 9th October 2017	The Trust is part of the Mersey Major Trauma & Critical Care and Cheshire and Merseyside Rehabilitation Network. The Trust now treats more complex and challenging patients. Feedback from incidents, staff and staff surveys highlight a higher risk of injury to staff whilst caring for challenging patients who lack capacity. There are often difficulties and delays experienced whilst trying to discharge or transfer complex patients. **Lead:** LSMS (Health Safety & Security Group).	There were 108 incidents in Q1 compared with 90 in Q4. 6 patients were responsible for 28 physical assaults (patient on staff). In the majority of incidents, the patient was deemed medically fit for discharge. These delays in discharge usually result in further incidence of violence or aggression.	1. Develop a Strategy to implement the National Violence & Reduction standards (Q3). 2. Undertake a risk profiling exercise and review of risk control measures (Q2). 3. Review of Trust TNA in regards to personal safety training (Q3). 4. Continue to provide support for staff. 5. Violence & Aggression working group (group to meet bi-monthly). 6. Recommendations and actions from MIAA audit of complex discharges to be implemented.	It is recommended that this remains on the GAF for further monitoring. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 286 Appointments Cancellations/Delays 16th January 2018	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in Do Not Attends (DNAs), complaints and this will affect staff/patient experience and patient outcomes going forward. **Lead:** Patient Access and Performance Director.	There has been an increase in concerns received in 2020/21, regarding appointment arrangements. Increase in issues in 2020/21, relating to patients unable to get through via telephone or to cancel appointments 28/06/2021. Review of call recordings since being provided access has enabled managers to provide timely feedback to staff. It has also allowed us to distinguish between genuinely abusive calls and patients who express frustration due to ineffective communication of the process from staff.	1. MITEL IT/telephony in-depth management training planned for 30/03/21 (complete). 2. The cancellation and delays with patient's appointments and the overall backlog for follow up review has increased further due to the Covid-19 pandemic. However, Covid-19 recovery and restoration plans are being devised and been submitted. 3. Recruitment of 2 additional Band 2 permanent staff members has taken place as opposed to continuous use of Admin Bank and overtime (complete). 4. Continuous review of patient concerns and complaints. 24 concerns were due to patients unable to get through to PAC 01/03/20 - 16/03/2021 compared to 51 from 01/03/19 - 28/02/20, this will continue to be monitored. 5. 28/6/21 the introduction of Synertec became live since end of May. Some teething problems with some letters not being processed. Currently working with Synertec and IT colleagues to resolve and monitoring DNA rates closely. 6. Data Quality report set up to highlight potential incorrect letters.	It is recommended that this remain on the GAF to monitor improvements in patient and staff experience to ensure that both are sustained. **Recommendation:** Continue to monitor for a further quarter (Q2) with a view to closing if improvement trend continues.

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

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

Theme	Context	Analysis	Action	Recommendation
Ref 311 Theatre Ventilation System – 05th May 2021	Theatres 1 – 5 do not meet the required level of air changes per minute as required by Health Technical Memorandum (HTM) 2025 guidance. **Lead:** Estates Manager (BPC).	During the annual validations of Theatre ventilation system (1 - 5) it has been identified there are not sufficient air change rates. Recent intervention work has taken place which has provided improvements, but fails to meet HTM standards. The National Infection Rate for Theatres does not indicate a high prevalence of infection which is an indicator of a clean environment. Additionally, it is known that the air cascade, as prescribed in HTM 2025 is correct.	1. Provide options to neurosurgical division, Infection Prevention & Control Team and consultant microbiologist to agree most appropriate way forward. 2. Engage with design consultants to evaluate preferred options. 3. Prepare paper with detail from above for discussion and capital investment.	**Recommendation:** Continue to monitor and work through all actions. Review at end of Q2. **Recommendation:** Continue to monitor.

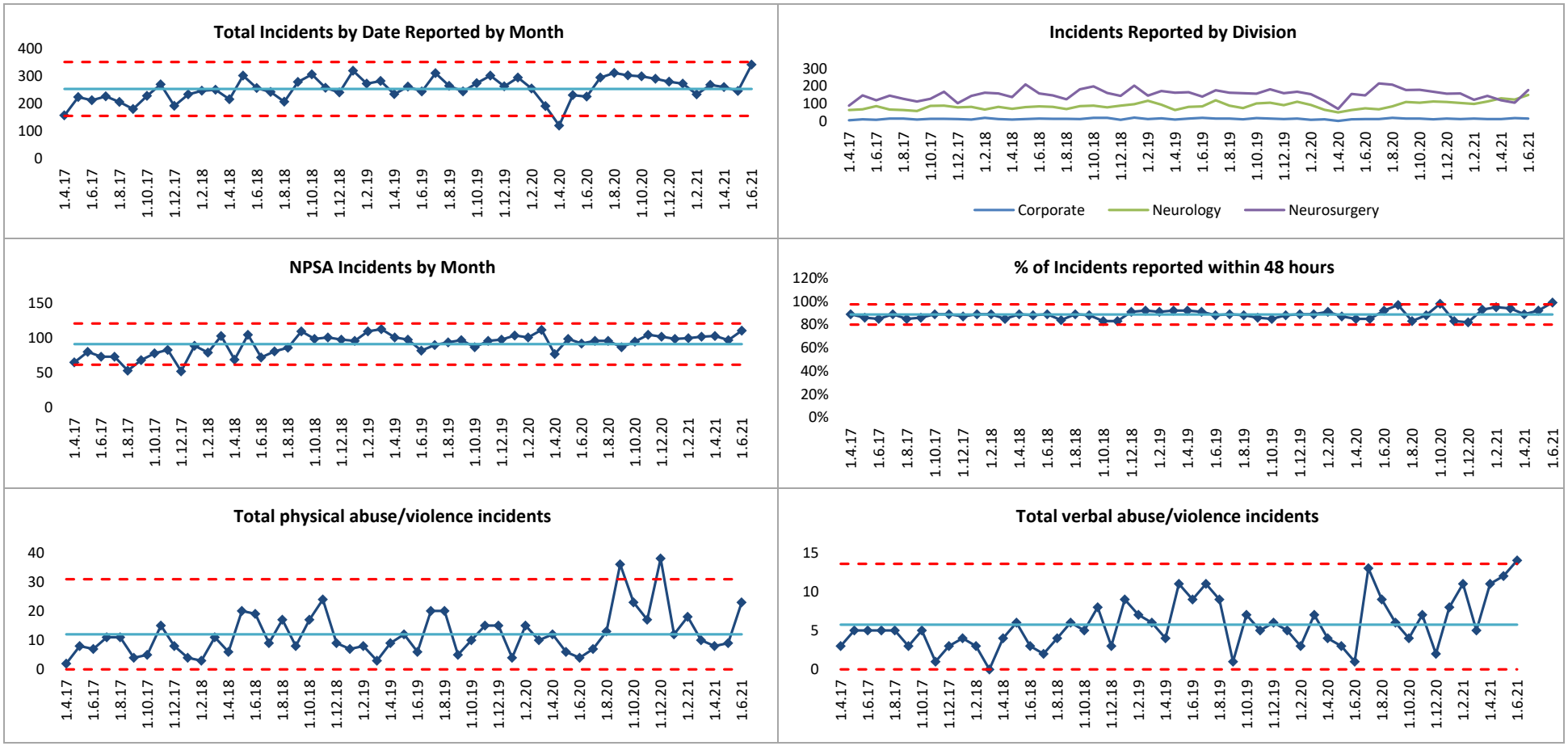
Theme	Context	Analysis	Action	Recommendation
Ref 301 Fire Safety Compliance 17th January 2018	Following the Outpatient Department fire in 2018, and Merseyside Fire Service investigation and inspection of the Trust, legislative breaches were identified. **Lead:** Estates Manager (BPC).	1. The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. 2. These gaps were as a result of the original building works not being inspected and signed off as being compliant. 3. The registered fire compartmentation contractor has now completed the works.	1. Undertake a validation audit of completed works to establish efficacy of contractual works. (Complete). 2. The minor works identified by the survey to be repaired by the contractor (End of July 2021). 3. Continue to update the Trust's passive fire register with photographic evidence. 4. Estates to manage staff & contractors (particularly network cable installers) works that affect compartment lines. 5. Head of Risk to provide regular update reports to Executive Team.	**Recommendation:** Continue to monitor with a view to closing in Q2 2021/22.

Theme	Context	Analysis	Action	Recommendation
Ref 305 – Legionella 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. **Lead:** Estates Manager (BPC).	There has been an improvement over recent months of the circulation of hot water temperatures which are now in line with HSE Guidance.	1. Undertake meeting with Estates Manager, Head of Risk, Consultant Microbiologist, Infection Prevention & Control Team (IPCC), Director of Nursing and Trust's external water treatment chemist to establish options for future chlorination and treatment of the water pipework. 2. Establish a process for re-balancing, treatment and testing that will lead towards the future removal of all point of use filters. 3. Continue programme of temperature testing to ensure stability of circulation. 4. Maintain flushing and regime via Compass water management system. 5. Water Safety Group / IPCC to monitor results of above. 6. Prepare a paper with options and potential capital implications for a system wide chemical treatment of the water system.	**Recommendation:** Continue to monitor and work through all actions. Review at end of Q2 2021/22 with view to closing.

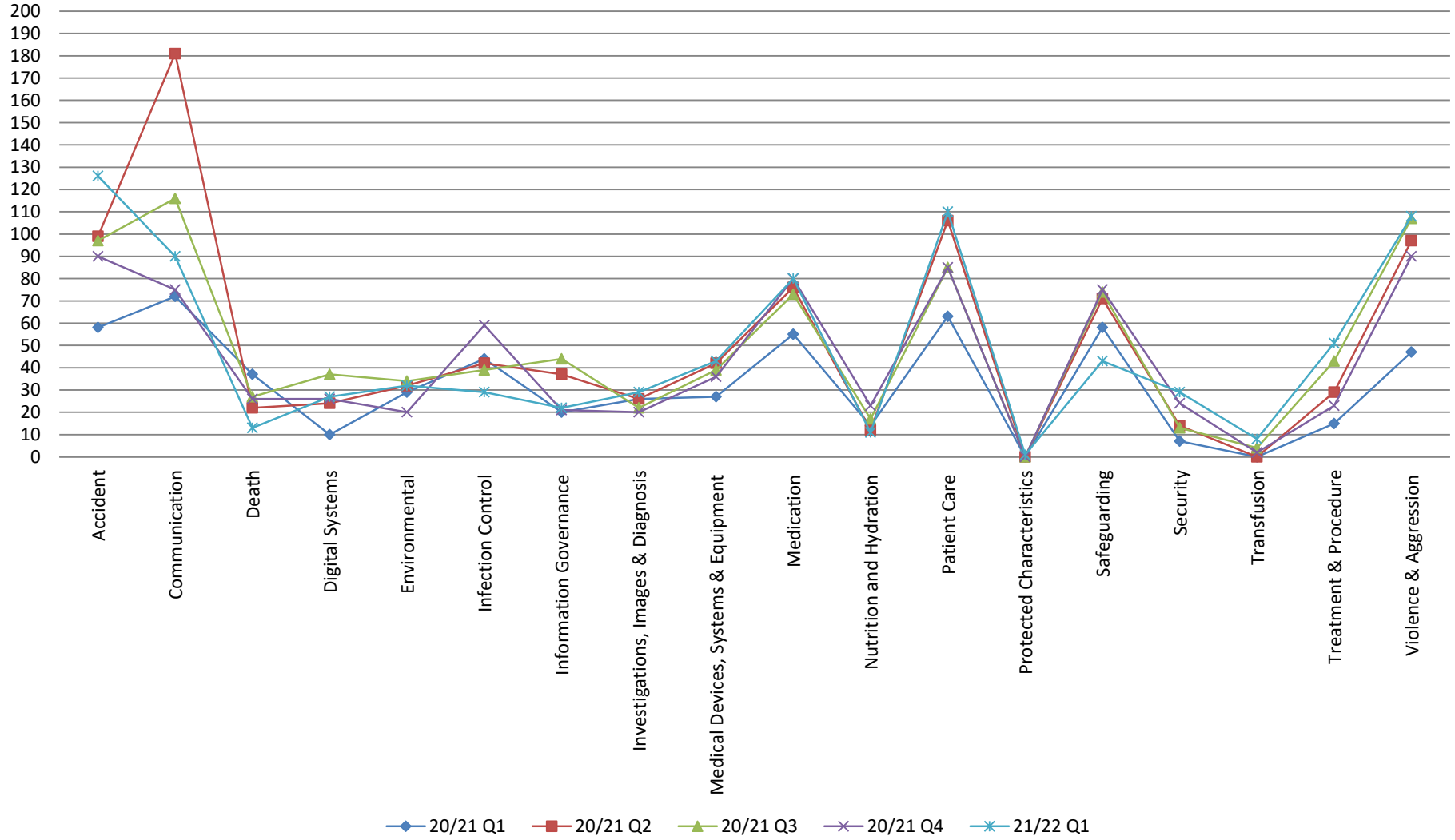
10. Safety and Risk

This section provides an analysis of the number and type of incidents reported during Q1 2021/22, the SPC charts below reflect reporting trends from the previous 5 years. The Trust is committed to maintaining a high standard of health, safety and welfare of patients, their families, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

10.1. Incident Management Overview



10.2. Incidents by Category & Quarter



10.2.1 Moderate & above incidents:

- 1 serious incident was reported in Q1 compared with 1 in Q4
- 12 moderate incidents were reported in Q1 compared with 25 in Q4
- all incidents complied with the Duty of Candour Regulations

10.2.2 Communication incidents (GAF Entry 304):

- 90 incidents were reported in Q1 compared with 75 in Q4

10.2.3 Infection control incidents:

- 29 incidents were reported in Q1 compared with 59 in Q4

10.2.4 Safeguarding incidents and concerns:

- 41 incidents were reported in Q1 compared with 72 in Q4

10.2.5 Information Governance incidents:

- 15 incidents were reported in Q1 compared with 17 in Q4
- 1 incident was externally reported to the Information Commissioners Office (ICO) in Q1 compared with 2 in Q4
- No breaches of Subject Access or Freedom of Information requests in Q1

10.2.6 Medication incidents:

- 80 incidents were reported in Q1 compared with 80 in Q4

10.2.7 RIDDOR (staff more than 7 day absence):

- member of staff - whilst walking to Liverpool University Hospitals (Aintree) to collect samples, tripped and fell on the floor resulting in a fracture and other bruising (fracture)
- member of staff - was assisting a patient to use the ward shower facilities and slipped on water resulting in a fracture (fracture)
- member of staff - was transferring a patient with high BMI from ward to theatres, while pushing the patient they developed pain to their lower back (>7 days)
- member of staff - was injured whilst attending to a confused patient who grabbed them by their thumb causing pain and discomfort (>7 days)
- member of staff - was assisting with the transfer of a patient with poor mobility, who unexpectedly grabbed staff member, resulting in a sprained wrist (>7 days)
- member of public - tripped whilst stepping up onto a foot path causing him to stumble and fall (no environmental causes could be identified as causing the fall)

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

- increase in violent or aggressive incidents from 90 in Q4 to 108 in Q1
- physical assault incidents against staff remain the same, 40 in Q4 and 40 in Q1 (all incidents in Q1 patients lacked capacity)
- 6 patients were responsible for 28 of the physical assaults (patient on staff), with 1 patient responsible for 9 of those incidents
- GAP analysis completed for the new ‘Violence prevention and reduction standards'. Presented at the Health, Safety and Security Group and Quality Committee.
- a violence reduction strategy is currently under development
- the Personal safety trainer/LSMS continues to support ward staff with challenging patients
- the Neuropsychiatry Team can:
  - review patients who present with agitation and violent and aggressive behaviour
  - provide advice regarding the management of patients who pose a risk towards themselves or others

- consider environmental and pharmacological changes to patient's treatment to reduce agitation

10.4. Fire safety:

- 7 unwanted fire signals were reported in Q1
- a new risk has been added to the Trust Risk Register regarding response to Fire Alarms
- fire evacuation drills are planned for Q2/3 across the Trust
- an audit of fire compartmentation works has been completed, a report is currently being prepared for BPC
  - a number of minor compartmentation breaches have been identified by the audit, the contractor will remedy these issues by end of July
- mandatory training compliance currently stands at 86%
- fire risk assessments are frequently reviewed with any findings discussed with all relevant parties

10.5. Moving and Handling (M&H):

- mandatory education and training sessions continue (as per Covid-19 guidance) in classroom settings
- planned additional sessions during Q1 have been provided via the Key Mover programme and on site training to Therapies, Radiology, Estates and NRC
- moving and handling assessments for staff and complex patient presentations provided on request
- teaching observations and reports provided to support the Trust Personal Safety Trainer towards achievement of a teaching qualification
- joint working to support staff with patients presenting with aggression and violence

10.6. DATIX:

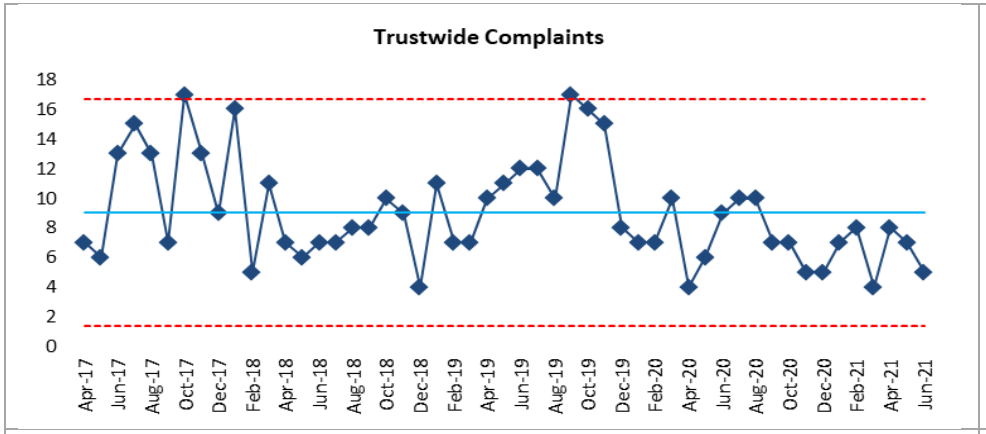
- Datix training has been provided throughout Q1 via both MS teams and face to face sessions for incident and risk management
- the bimonthly governance feedback poster was shared via the Safety Huddle and Walton Weekly during Q1
- the feedback poster will continue to be circulated to ward and departments

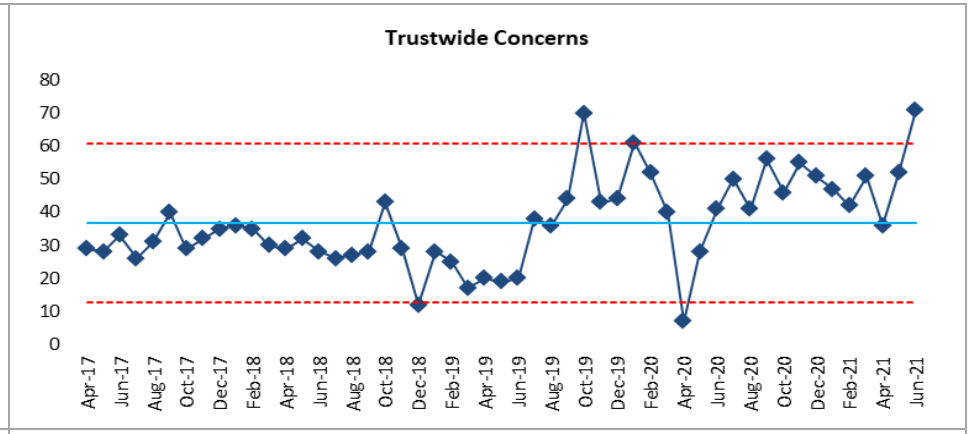
10.7. Health and Safety:

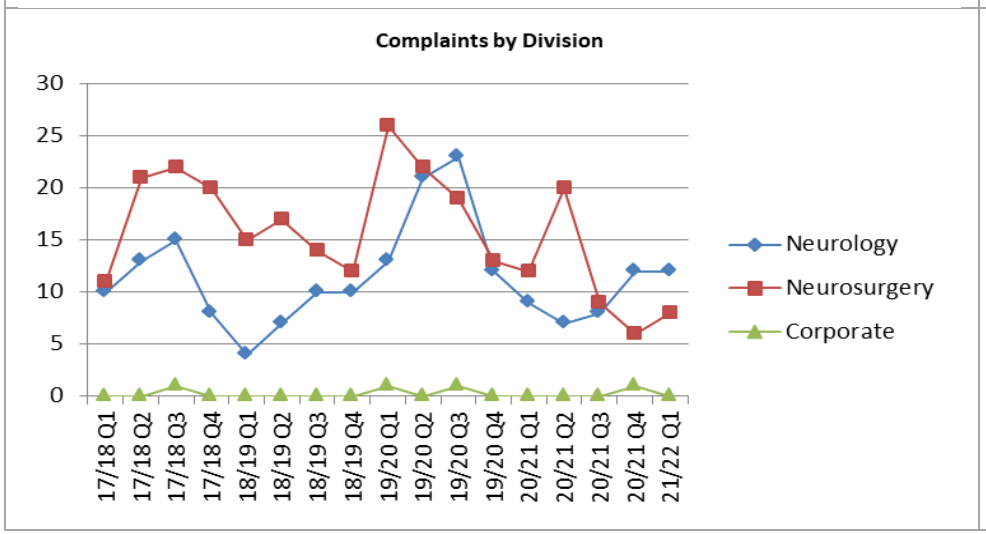
- the online health and safety audit has now been completed, the Deputy Head of Risk is now:
  - following up on any identified gaps with ward and departmental leads
  - ensuring risk assessments are in place
  - ensuring display screen equipment (DSE) arrangements are in place
  - developing COSHH training for identified services
- the fit testing programme continues in accordance with plan

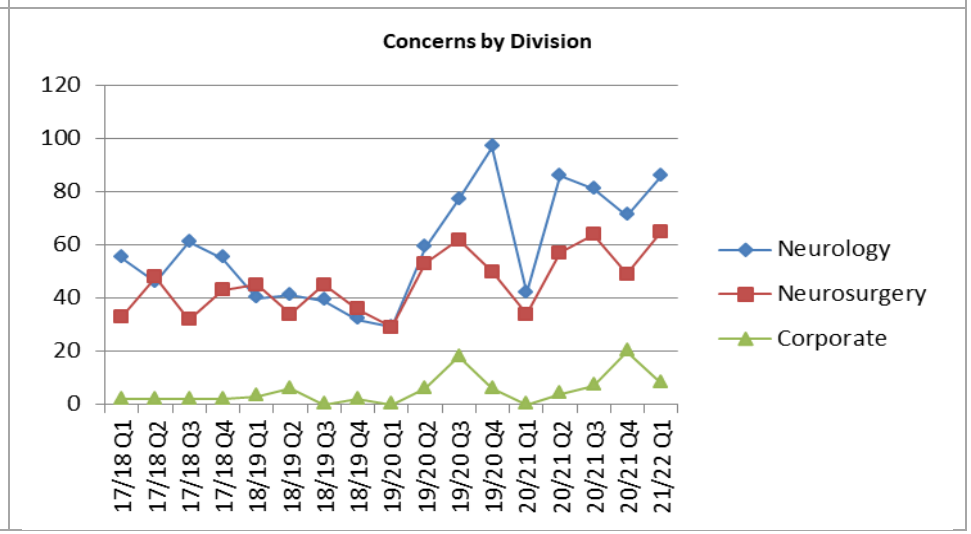
11. Complaints & Concerns

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







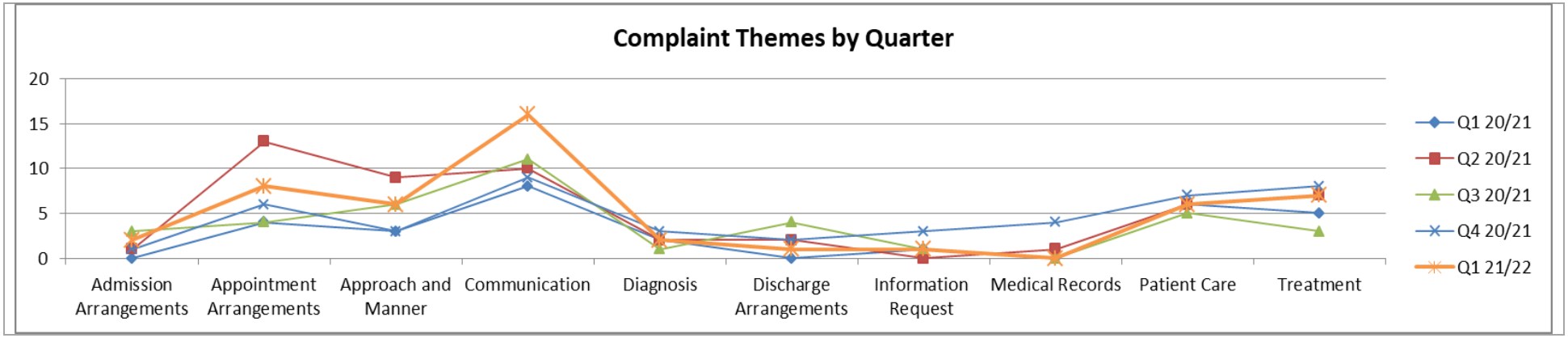


11.1. Concerns and Complaints:

11.1.1 Quarter 1:

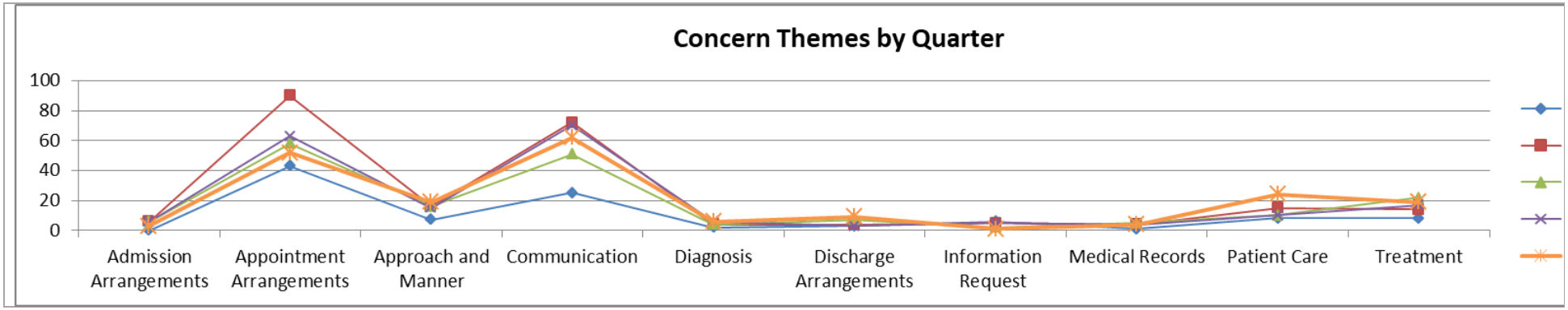
- 100% of complaints received in Q1 were acknowledged within 3 working days and responded to within the negotiated timeframe in line with Trust targets
- 16 new complaints were received in Q1 compared to 12 in Q4 of 2020/21
- 4 complaints were re-opened in Q1 as further clarity was sought. A deep-dive review into this concludes that this is not as a result of the quality of the investigation and response but a difference of opinion in relation to the factual/clinical information provided, this compares to 7 re-opened in Q4 of 2020/21
- 19 complaints were closed in Q1; 1 upheld, 6 partially upheld and 12 not upheld
- the average response time was 20 working days for formal complaint response, this is an over achievement in line with the policy, as we aim is to respond within 25 working days and improvement from Q4 average response time of 22 working days
- the average working day response time by divisions is Neurology is 15 days in Q1 compared to 18 working days in Q4 and Neurosurgery 30 working days in Q4 compared to 31 working days in Q4. This indicates Neurology is high achiving in terms of response times
- the divisional split of complaints remains fairly static with Neurology receiving 12 (including 2 re-opened) in Q1, compared to 12 (3 re-opened) in Q4, Neurosurgery 8 (including 2 re-opened) in Q1 compared to 6 (4 re-opened) in Q4 and Corporate 0 in Q1 compared to 1 in Q4
- the number of concerns increased slightly in Q1 to 159 from 140 in Q4. It is noted that a higher number of multifactoral concerns were received in Q1 requiring more indepth review and investigation
- in addition to concerns, 65 enquiries were received in Q1, in comparison to 85 received in Q4; themes relate to the referral process and general hospital enquiries

11.1.2 Key themes for formal complaints:



- Communication is the highest theme in Q1 and numbers remain higher than previous quarters
- Appointment arrangement complaints remain as the second highest theme; with the majority being raised in Q2 following the first National Lockdown for Covid-19, but these have been steadily increasing again over the past 2 quarters
- Approach and Manner as a subject of complaints has remained reduced in comparison to previous years
- Communication is the highest theme in Q1, with appointment arrangements as a close second. Communication themes remain multifactorial

11.2. Key themes for concerns:



10.1. Protected Characteristics:

There was 1 concern raised in Q1 in relation to:

- Disabilities – Hearing impairment – patient raised a concern as the Attend Anywhere platform did not have a text captions function which meant the patient was unable to attend their planned virtual appointment due to their disability. This was immediately actioned. Closed - *alert added to PAS to identify patient as deaf and patient to be offered face to face appointment in future with a BSL interpreter which was the patient's preferred appointment format.*

10.2. Compliments:

- 42 compliments were reported in Q1 compared with 58 in Q4

10.3. Police/Coronial Requests:

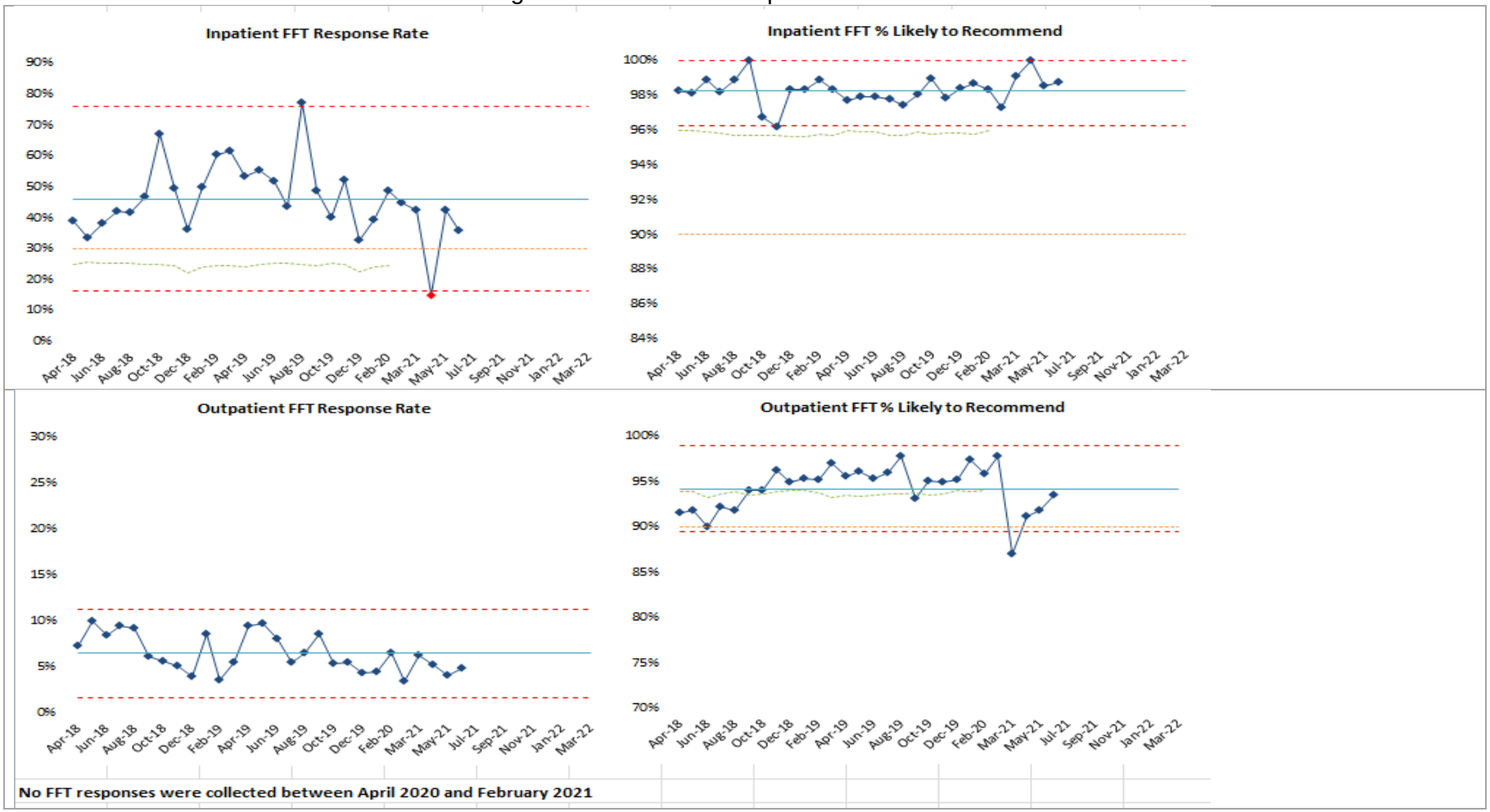
- 9 police requests for statements/copies of health records received in Q1 compared to 11 in Q4
- 6 Coroner's requests were received in Q1 compared to 5 in Q4

10.4. Volunteers:

All volunteers are required to undergo induction to ensure they have the training and support required prior to recommencing in roles. In Q1, two inductions were held and volunteers are being re-introduced in line with the Trust's Roadmap.

10.5. Friends & Family

- **Outpatients** - **93% of patients were Extremely Likely/Likely** to recommend based on a total of 636 responses (4.1% response rate)
- **Inpatients - 99% of patients are Extremely Likely/Likely** to recommend based on a 32% response rate compared to the number of discharges (1,900) in Q1
- Full details contained within Trusts Integrated Performance Report



10.6. Summary:

In Q1 there were 19 formal complaints closed, 142 concerns resolved and 64 enquiries successfully responded to in a timely manner. It is very encouraging to note that the average response times for formal complaints continue to improve and working days reduce. The PET and Divisional teams continue to work collaboratively to ensure we are rapidly responding and resolving enquiries and concerns to prevent them escalating to formal complaints which is reflected in the number of each received.

In June 2021, Mersey Internal Audit carried out an audit on the Trust's complaints procedure and process. The approach to the audit included:

- discussions with key members of staff to ascertain the nature of the systems in operation
- a desktop review of a sample of complaints records against the criteria of effectiveness, timeliness, communication, compliance with the complaints policy and legislation
- a walkthrough of the process from initial reporting to Board
- a desktop review of existing policies, procedures, local guidelines to confirm that they are up to date and communication across the Trust

This resulted in the Trust being awarded **High Assurance** demonstrating there is a strong system of internal control which has been effectively designed to meet the system objectives, and controls were consistently applied in all areas. There were two minor recommendations which were immediately actioned.

12. Claims / Legal

Trust Wide	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	Q1 21/22
Total new claims received	5	9	9	4	4
Neurosurgery claims	5	6	5	1	1
Neurology claims	0	1	2	3	1
Corporate claims	0	2	2	1	2
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	13	7	7	7	16
Number of closed claims in quarter	4	5	3	3	10
Value of closed claims - Public liability	£0	£0.00	£0.00	£5,000	£3,920.40
Value of closed claims - Employer liability	£0	£0.00	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£2,715,964.73	£3,203,388.52	£209,929.13	£128,261.21	£374,658.02

- All staff involved in claims/coronial reviews or inquests receive full support throughout the process
- 4 New claims

- 1 Re-opened claim in Q1

12.1. Lessons Learnt:

The following lessons have been learned from on-going claims. Please note that lessons have been learned following an RCA at the time of the incident over the last 5 years and not only following receipt of a formal Letter of Claim.

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

12.2. Thematic Review:

Poor documentation and allegations relating to informed consent remains an ongoing theme which runs through many of the claims that the Trust receives. This trend continues to be highlighted to medical staff during induction and to junior doctors at mandatory training sessions to raise awareness.

12.3. Clinical Negligence Trials:

The Trust had 4 clinical negligence trials scheduled to take place from January 2021 through to May 2021; 2 of the trials have been re-scheduled to 2022 due to Covid-19 related issues, 1 case was settled before the trial start date and 1 trial went ahead where judgement was made in favour of the claimant.

13. HM Coroners Inquests updates:

Current status: 4 Closed – 1 Open.

13.1. Neurology:

A patient with a long standing history of seizures was admitted on 19/02/18 for monitoring of epilepsy with an aim to adjust treatment in order to improve seizure control. The patient's condition deteriorated despite maximal efforts and, following admission to ITU, the patient suffered a cardiac arrest on 08/04/18. Despite input from a consultant cardiologist, which was futile, the patient suffered a further cardiac arrest and sadly died at 20:03 hours.

Following a formal complaint from the family regarding care, treatment and the cause of death, the family have met with the Trust on two occasions and referred their concerns to the CQC and HM Coroner. As part of the complaint an independent review was undertaken by the Royal College of Physicians (RCP). Recommendations have been included in an action plan managed by the Neurology Division and this was reviewed by the CQC. The CQC have now completed their investigation and found no failings with the treatment provided by the Trust. Directions were received from HM Coroner and the Trust attended a first pre-inquest review (PIR) on 28/07/20. Both Trust and family have legal representation. The PIR was scheduled for 11/11/20 but this was re-scheduled and now planned for 04/08/2021. This will be attended by the Claims Manager and Deputy Medical Director. **OPEN.**

13.2. Neurology

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

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

13.3. Neurosurgery (Pain)

Patient was referred to the Trust in 2016 due to abdominal pain and opioid dependency. They were reviewed regularly in follow up clinic and admitted into the Trust in 2018 in an attempt to wean the patient off opioids. The management plan was that the patient would be followed up with a plan to continue tapering Methadone and Buprenorphine with the aim to tail off and discontinue the latter. Consultant wrote to GP on 05/02/2019 detailing the plan. This was followed up by a nurse led telephone appointment on 07/03/2019 when patient was provided with a 4 week prescription for Methadone and was noted to be on a low dose of Buprenorphine which would be finished by the following week with no further plan for this to be continued by either GP or the Trust. The GP had provided post-dated prescriptions for both drugs.

The Coroner concluded death by Misadventure, as an intentional act had resulted in an unintentional outcome and that the cause of death was recorded as intoxication by multiple opioid drugs. The Coroner confirmed that there was some learning for the Trust and would hold back issuing a Regulation 28 report and would write to the Trust. This was because there was a delay in the letter from the nurse led clinic from 07/03/2019 not being received by the GP until 22/04/2019. This imposed a possible risk that the patient may have had the opportunity to dispense two prescriptions for Methadone, one from the GP prescribed on 04/03/2019 (in conjunction Buprenorphine) and the other which was received and dispensed from the hospital. As the doses prescribed were low, whilst this would not have attributed to the patient's death, this demonstrates that communications between the hospital and GP should have been more robust. The letter from the Coroner will give the Trust the opportunity to provide assurance regarding processes or inform of what they will do to improve this in the future. The response will then be reviewed to consider if a Regulation 28 will need to be issued. On the balance of probabilities, the Coroner was of the opinion the patient accidentally took more medication than prescribed perhaps to support with breakthrough pain or symptoms.

The Trust's response to the Coroner (1/7/21) offers assurance that robust systems are now in place to ensure that information is accurately communicated to GPs in a timely manner and process is audited. **CLOSED.**

13.4. Neurosurgery

A patient with a previous history of heart failure, osteoarthritis, spinal stenosis, obesity and cirrhosis was referred from Arrow Park Hospital (APH) on 18/11/2020. Advice was given to APH and they further referred back to the Trust 20/11/2020 when further advice was provided. The patient presented with further symptoms and was transferred to WCFT as an emergency admission on 30/11/2020. A L4/5 decompression was performed. The patient was discharged to Leighton Court for rehabilitation on 08/12/2020. They were admitted again on 29/12/2020 for wound debridement and further extension of the decompression. The patient tested positive for Covid-19 on 14/01/2021 and continued to be cared for at the Trust until transfer to Clatterbridge Rehabilitation Centre on 26/02/2021. The patient sadly died on 11/03/2021.

The Coroner opened an investigation and requested a statement and response to concerns raised by family from the consultant in charge of the patient's care. The statement and response to concerns raised were sent to the Coroner. On receipt of post mortem report, as this does not highlight any concerns regarding the treatment provided by the Trust and the Coroner has now discontinued this investigation and the planned was PIR cancelled. **CLOSED.**

13.5. Neurosurgery

The patient who was known to the Trust had a first posterior fossa decompression on 23/06/2017; post-operatively the patient suffered a cardiac arrest due to a build-up of CSF (hydrocephalus) which required insertion of an external ventricular drain (EVD). As the patient's symptoms had deteriorated, the patient was admitted in July 2020, for re-exploration of the post-fossa. The patient was discharged 5 days later but developed problems with the wound shortly after discharge. The patient was readmitted on the 25/7/2020 with CSF leak and hydrocephalus. Between July 2020 and January 2021, the patient remained an inpatient in the Trust and had ongoing problems with EVD failure CSF infection leading to two periods in ITU. Following the first admission to ITU, the patient was transferred back to the ward where they had a witnessed cardiac arrest. CPR was successfully given and post arrest the patient was transferred to ITU. On 15/1/2021 the patient had a further deterioration and her pupils were fixed and dilated. CT showed brain swelling and no hydrocephalus. Brain stem testing was carried out with consent from family and the patient sadly died on 16/01/2021.

The Coroner has discontinued this investigation following receipt of the post mortem report in June 2021. The deceased's next of kin has been updated and provided with copies of the reports received during the coronial investigation. The family have been advised that should they have any remaining questions and concerns they should take them forward with the Trust. To date the Trust has not received any correspondence way of complaint and/or clinical negligence claim. **CLOSED.**

The Walton Centre NHS Foundation Trust

The Walton Centre
NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date: 2nd September 2021

Title	**Nurse Revalidation Update Report – 2020/21**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Joseph Towell/Julie McEnerney Title: Revalidation & Nursing
Previously considered by:	• Committee None • Group None • Other None
Executive Summary The report provides an update on the progress of nurse revalidation during 2020/21 and provides an update for 2021/22.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	None
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	No
Any associated legal implications / regulatory requirements?	Revalidation is the process which all nurses, midwives and nursing associates within the UK are required to maintain their registration with the Nursing & Midwifery Council (NMC)
Action required by the Board	Delete as Appropriate • To consider and note

The Walton Centre
NHS Foundation Trust

Nurse Revalidation Update Report – 2020/21

Introduction

All registered nurses/midwives/nursing associates in the UK are required to maintain their registration with the Nursing & Midwifery Council (NMC) and must fulfil a range of requirements to show they are continuing to be able to practice safely and effectively by way of revalidation every three years.

The Trust uses an e-portfolio system (HeART) which has been in place since 2016. This system provides a repository for nursing staff to collate/store evidence and manage their registration through an NMC online account.

The NMC requirements for revalidation are:

- 450 Practice Hours over 3 years since last registration
- 35 hours of Continuing Professional Development (CPD) since last registration, of which 20 hours must be participatory
- 5 pieces of practice related feedback
- 5 written reflective accounts
- Evidence of a reflective discussion
- Health and Character Declaration
- Professional Indemnity arrangement
- Confirmation by a third party that the registrant has complied with the revalidation requirements

Update 2020/21

During 2020/21 a total of 127 staff were required to revalidate. Of these, 120 staff successfully revalidated in accordance with the NMC Guidelines. Due to NMC deadline extensions, detailed below, 7 had delayed submissions.

No issues with the completion process were identified during 2020/21 and the Revalidation and Nursing Administrator either completed the NMC submission with the nurse or obtained confirmation that the process had been undertaken.

The Trust has maintained a 100% success rate for staff undergoing revalidation during 2020/21 as per below:

	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Submitted	22	3	5	2	6	50	6	6	4	13	2	1
To Submit	0	0	0	0	0	0	0	0	0	0	0	7
Exemption	0	0	0	0	0	0	0	0	0	0	0	0
Total Number of staff members revalidated during 2020/21 – 120												

A proportion of nurses required support with their revalidation submission during 2020/21. The main reasons for the additional support were due to lack of computer skills, confidence or lack of Continuing Professional Development (CPD) hours. Additional information is always available on both intranet and internet to assist with this process.

Nursing Associates

As per previous guidance, qualifying NA's are added to Revalidation database to ensure successful submission of details.

COVID-19

Due to COVID-19 a number of automatic and optional deadline extensions were put in place by the NMC. A 12 week deadline extension was applied to staff due to revalidate between Apr 2020 and Oct 2020.

A 12 week deadline extension was automatically applied to staff due to revalidate

- November 2020 through March 2021 (resulting in 7 staff members still to submit although their original deadline has passed)

Staff could also apply for additional 12 week extensions to create a deferment of 24 weeks total.

The various extensions to revalidation dates created issues for the Revalidation and Nursing Administrator however ongoing communication with staff members has ensured that 120 have successfully completed this. The further 7 staff worked with the administrator to ensure they too were successful and the Director of Nursing and Governance was informed and appraised of this once complete.

2021/22

We do not anticipate there will be any issues/concerns with any cohort completing the revalidation during 2021/22.

COVID 19

At the time of writing the only deadline changes in place are for the Apr 2021 cohort and onwards. They may request an 8 week extension with the NMC at their discretion.

During 2021/22, 121 staff members are required to revalidate as per below*:

	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022
To Submit	0	0	0	0	0	42	8	8	2	6	2	7
Submitted	28	5	4	7	2	0	0	0	0	0	0	0
Total Number of staff members to submit during 2021/22 – 121												

*figures accurate as of 12th Aug 2021

Next Steps

The Trust recognises the importance of having a robust and systematic approach to nurse revalidation and will undertake the following:

- Review the level of support required by staff to complete the revalidation process
- Ensure updated guidance and templates are accessible via the intranet site
- Ensure accurate dissemination of changing NMC guidance to staff members

Recommendation

Trust Board is asked to:

- receive and note report and be assured that staff are monitored through revalidation and have active registration with the NMC.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
2nd September 2021

Title	**Medical Education Annual Report 2020-21**
Sponsoring Director	Name: Mr Michael Gibney / Dr Rhys Davies Title: Director of Workforce and Innovation / Director of Medical Education
Author (s)	Name: Liz Doherty Title: Medical Education Development Manager
Previously considered by:	• Considered as part of RIME Annual Report 2020/21 by Trust Board 1st July • RIME Committee – 1st September
Executive Summary The Medical Education Annual Report covers the academic year 2020-2021. Part of the report was previously included with the RIME Annual Report presented to Board on 1st July 2021. The report has been refreshed and updated to include the findings of the 2021 postgraduate training GMC survey and the UG end of year summary.	
Related Trust Ambitions	• Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	Numerous – associated with Trust reputation and profile; staff recruitment, retention, development, competence and motivation. There is also a financial risk in ensuring the programme is viable.
Related Assurance Framework entries	Risk 014 Ensuring the ongoing quality, capacity and capability of Medical Education for the Trust that is sustainable over the longer term.
Equality Impact Assessment completed	
Any associated legal implications / regulatory requirements?	• Yes – regulatory requirements as a local education placement providers as set out in the DoH/HEE Education Contract
Action required by the Board	The Board is requested to: • Consider and note

THE WALTON CENTRE NHS FOUNDATION TRUST

Medical Education Annual Report 2020-21

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FOREWORD

The Walton Centre NHS Foundation Trust is the only specialist trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services.

We provide Neurological undergraduate clinical placements to the University of Liverpool as part of the MBChB qualification in addition to elective placements for UK and international undergraduate students. The Trust is proud of its strong links with the medical school and continues its work to influence the trajectory of Neuroscience within the curriculum. Our consultants are break downing barriers to facilitate understanding of Neuroscience, mitigate 'neurophobia' within the student body. We are proud to support and collaborate with a number of interest groups within universities at local, national and international level.

We are recognised as an exemplar in postgraduate education. We have consultants in principal education roles within external regulatory organisations, such as HEE, this is in addition to prominent academic and research positions, all of which embodies the deeply embedded ethos of continuous education and personal development at the trust. Having representation at the top level in HEENW… Leaders in Neurology, Neurosurgery… In the context of system evolution as medical training responds to changing health population needs we strive to promote Neuroscience to

We have a purpose built Education Centre which facilitates medical teaching. We are working closely with colleagues to develop simulation offerings and grow the opportunity technology enhanced learning brings to health education.

2020 was an unprecedented year for medical education and the trust. Business as usual was suspended in March 2020 although most education and training programmes resumed, albeit in a modified fashion, in September 2020. We look forward to returning to on site teaching and training as the pandemic eases and continue to facilitate access to medical education that provides tangible benefits for patients.

Dr Rhys Davies
Director of Medical Education

Michael Gibney
Director of Workforce and Innovation

OUR YEAR IN NUMBERS

The Medical Education Annual Report covers the 2020-21 academic year.

Period covered - Academic Year 2020-2021

Doctors in Training	Core - 7	GP - 1	Specialty - 41
Medical Students	Year 4 - 180	Year 5 - 35	Elective N/A
# Consultants who are GMC Approved Educational / Clinical Supervisors	92 (/140 65%)		
#GoSW Education exception reports made by Doctors in Training	0		
UG Placement RAG Report: I would recommend this placement to another student Score & ranking against all other sites	Year 4 1.98 - Green outlier Ranking - 2nd / 12 sites	Year 5 1.81 – Green Outlier Ranking – 3rd / 11 sites	
WCFT GMC NTS Outliers	Green (positive) Anaesthetics - 2 CST - 1 IMT - 5 Neurology – 2 Neurosurgery - 4 Radiology - 2	Red (Negative) Anaesthetics - 2 CST - 4	
*GMC Enhanced Monitoring	No		
*GMC NTS Overall Satisfaction	Within national average		

*CQC monitored indicator

INTRODUCTION

This report on Medical Education covers the academic year August 2020- August 2021. The effects of the pandemic have been wide ranging upon the delivery of education with undergraduate clinical placements suspended in April 2020. Many postgraduate training programmes were interrupted with the redeployment of some doctors in training and changes to service delivery more generally in the spring/summer of 2020. Fortunately education and training of undergraduate and postgraduate medics at Walton has continued largely without disruption, albeit adapted with socially distanced MS Teams facilitated delivery replacing onsite face to face activity.

Responsibility for medical education and training at The Walton Centre sits with the Director of Medical Education and the faculty of Lead Educators, Clinical Tutors and Educational Supervisors. In April 2021 Dr Charlotte Dougan stepped down as DME and was succeeded by Dr Rhys Davies. The faculty has grown with the introduction of two new Education Clinical Fellows to support undergraduate education; we look forward to welcoming them from August 2021.

Managerial support to the faculty is provided by the Medical Education Development Manager Liz Doherty, with operational services administered by Medical Education Officers, Judith Dennis and Yasmin Harris, and Medical Education Administrator Amy Chapple.

Commissioning of medical education is by Health Education England via Health Education North West local office. Nationally, there has been a system wide review of health education finance and a new contract including both undergraduate and postgraduate training implemented from April 2021.

Quality assurance of Medical Education is overseen by the GMC as the regulator and Health Education England via the North West office. The HEE Quality Framework which sets the standards for health education is currently being refreshed as is the reporting tool for education; we look forward to being updated about this in the near future.

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FOCUS ON MEDICAL EDUCATION DEPARTMENT

2020-21 was essentially a test year for the medical education team as the impact of changes to education programmes, and associated delivery, on the Trusts' infrastructure played out. For Undergraduate education the core placement doubled in length from 2 weeks to 4 weeks. Due in part to COVID and students intercalating, undergraduate numbers were temporarily lower. The table below outlines student numbers for 20/21 compared to previous years and projected for next year:

Type of Placement	Number of Students Attending Placement Area		
	18/19	20/21	21/22
Core Neuro	289	192	380

The reduced numbers for 20/21 eased the transition to the new 4 week programme however despite this for the administration team and faculty there was still significant issues regarding capacity experienced. Adapting to new university led timetabling processes, as well as the complete redesign and implementation of a longer clinical placement programme, saw an exponential rise in the administration of activities and demand on medical staff. With the available resource at the time this was marginally achievable.

It was evident to prepare the trust to host increasing student numbers and comply with the requirements of the UGME Tripartite Agreement (DoH Education Contract) infrastructure investment was needed. At the close of the academic year (Aug 21) the medical education department and faculty has been consolidated with an administration role made permanent as well as financial investment in medical undergraduate supervision and new educator roles.

It is hoped the new roles will mitigate the human resource challenges faced in 20/21 and provide resilience across the faculty as well as demonstrating to our external stakeholder's evidence of the Trust commitment to education. In addition to ring-fenced funding for Consultant SPA undergraduate activity there have been two Education Clinical Fellow posts created. These are aimed at junior doctors with an interest in medical education to develop their educational leadership capabilities. The post holders will support the delivery and development of undergraduate education working closely with the undergraduate administration team and the clinical sub dean / DME.

The Postgraduate lead educator faculty has seen a couple of changes notably new leads in Anaesthetics and Neurology. Dr Sue Griffiths stepped down in April 2021 as RCoA College Tutor for Anaesthetics and was succeeded by Dr Elaine Anderson. In Neurology, Dr Michael Bonello was appointed HEENW regional Training Programme

Director for Neurology replacing Dr Rhys Davies who became WCFT Director of Medical Education.

FOCUS ON UNDERGRADUATE

Year 4

University of Liverpool resumed the undergraduate medical MBCHB programme in September 2020 and Walton welcomed the first undergraduate cohort to experience the new 4th year Neuroscience programme. Despite the challenges posed by COVID restrictions to actual time spent on site and experiential learning, student feedback has been excellent. The university collects formal evaluation data for each rotation which feeds into a placement RAG report and tracks student experience through the year. Walton has consistently received excellent results through the year for the standard of teaching available and the enthusiasm and engagement of the staff both medical and administrative. Below is a quote from the Medical School's Deputy Director of Quality, Dr Clare O'Leary, responding to WCFT end of year summary report:

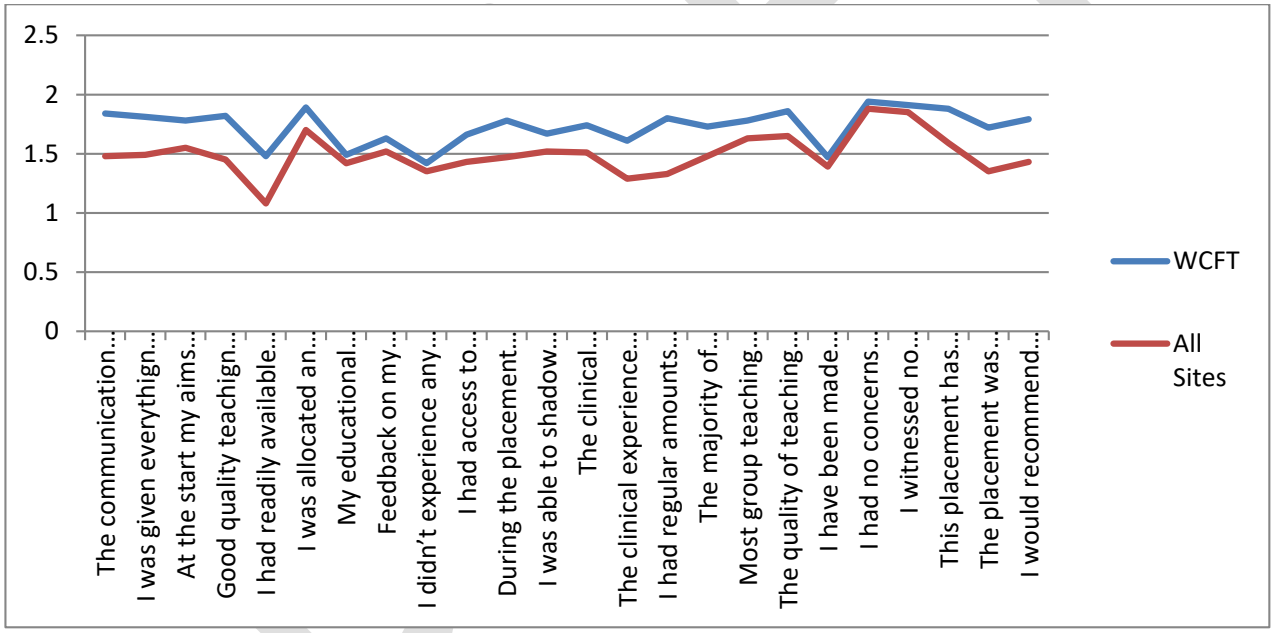
'It is clear from evaluation that the work of Undergraduate administration team underpins a good student experience.

Placement sites scoring more highly across the region had multiple comments about the support they received from the UG administration team. Comments included: "Supportive" "went above and beyond" "kind" "accessible" "respond to emails really quickly" "nothing too much trouble" "always listened to concerns" "approachable" "welcoming" "supportive"
This was apparent at Walton so thank you for your hard work.'

The table below compares Walton's annual average scores compared with the all site average for the period:

Year 4 Placement RAG Report 20-21 WCFT / All Site average scores		
	WC FT	All Sites
The communication from the site staff before my induction was clear and effective	1.84	1.48
I was given everything I needed to know to start this placement from the induction I received	1.81	1.49
At the start my aims and how the placement would support these were discussed	1.78	1.55
Good quality teaching space was available	1.82	1.45
I had readily available access to study facilities including IT	1.48	1.08
I was allocated an educational supervisor	1.89	1.7
My educational supervisor has been accessible and has been regularly engaged in enabling my development	1.49	1.42
Feedback on my progress was timely and appropriate	1.63	1.52
I didn't experience any issues getting my e-portfolio signed off	1.42	1.35
I had access to personal support and advice	1.66	1.43
During the placement admin staff were accessible and supportive	1.78	1.47

I was able to shadow different members of the clinical team as appropriate	1.67	1.52
The clinical experiences available to me were relevant to the placement portfolio requirements	1.74	1.51
The clinical experience timetable I was given was well planned and things generally took place as planned	1.61	1.29
I had regular amounts of group teaching, e.g. CBLs, 'bedside' style teaching	1.8	1.33
The majority of scheduled group teaching took place as planned or were delivered at another suitable time.	1.73	1.48
Most group teaching was delivered by experienced staff e.g. consultants and ST trainees	1.78	1.63
The quality of teaching was high	1.86	1.65
I have been made aware of how to report incidents and near misses	1.47	1.39
I had no concerns about the safety of the clinical care of patients I witnessed during this placement	1.94	1.88
I witnessed no examples of harassment or discrimination during this placement	1.91	1.85
This placement has been valuable to my education	1.88	1.59
The placement was well organised and ran smoothly	1.72	1.35
I would recommend this placement to another student	1.79	1.43



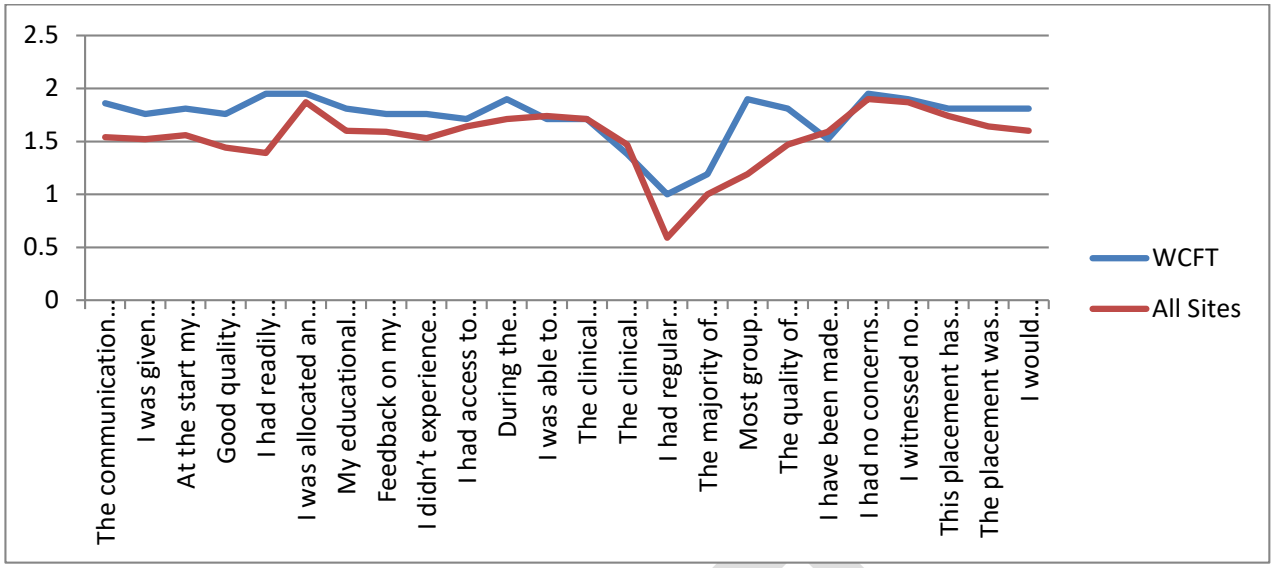
Source: University of Liverpool Year 4 Placement RAG Report, 2020-21

Students reported timetabling problems early on in the academic year with clinics clashing and supervisor availability however the administration team and education leads where able to mitigate with additional measures to address the problems and this lessened as the year progressed. A common theme that remained was the impact of not being on site for prolonged periods and lack of access to direct patient interaction creating gaps in student skills and knowledge however we expect this is ease as the restrictions lift.

Year 5

Final year students complete an elective type placement known as a SAMP; this is an 8 week placement which focuses on a project or piece of work that the students participate in. Feedback from the 2020-21 cohort has been very positive, the impact of covid generating the only 'negative' - a call for more on-site teaching, which was otherwise evaluated as excellent.

Year 5 SAMP RAG Report 20-21 - WCFT / All Site average scores		
	WC FT	All Sites
The communication from the site staff before my induction was clear and effective	1.86	1.54
I was given everything I needed to know to start this placement from the induction I received	1.76	1.52
At the start my aims and how the placement would support these were discussed	1.81	1.56
Good quality teaching space was available	1.76	1.44
I had readily available access to study facilities including IT	1.95	1.39
I was allocated an educational supervisor	1.95	1.87
My educational supervisor has been accessible and has been regularly engaged in enabling my development	1.81	1.6
Feedback on my progress was timely and appropriate	1.76	1.59
I didn't experience any issues getting my e-portfolio signed off	1.76	1.53
I had access to personal support and advice	1.71	1.64
During the placement admin staff were accessible and supportive	1.9	1.71
I was able to shadow different members of the clinical team as appropriate	1.71	1.74
The clinical experiences available to me were relevant to the placement portfolio requirements	1.71	1.71
The clinical experience timetable I was given was well planned and things generally took place as planned	1.38	1.47
I had regular amounts of group teaching	1	0.59
The majority of scheduled group teaching took place as planned or were delivered at another suitable time.	1.19	1
Most group teaching was delivered by experienced staff e.g. consultants and ST trainees	1.9	1.19
The quality of teaching was high	1.81	1.47
I have been made aware of how to report incidents and near misses	1.52	1.59
I had no concerns about the safety of the clinical care of patients I witnessed during this placement	1.95	1.9
I witnessed no examples of harassment or discrimination during this placement	1.9	1.87
This placement has been valuable to my education	1.81	1.74
The placement was well organised and ran smoothly	1.81	1.64
I would recommend this placement to another student	1.81	1.6



Source: University of Liverpool Year 4 SAMP RAG Report, 2020-21

FOCUS ON POSTGRADUATE -

Impact of Covid and the pandemic

Covid had minor effect on Walton's medical postgraduate training programmes, redeployment, for example, was not commonly needed. If this happened trainees were relocated within programme and not to another clinical specialty (Helen Banks, HEENW TPD Rehabilitation Medicine). The exception was in Anaesthetics where progression was affected by changes in service demands. In the autumn wave of the pandemic the need to manage COVID patients through ITU drew trainees away from other areas of work leading to difficulties achieving learning outcomes within the placement timeframe. In mitigation Walton placements where extended to 6 months and no similar requirements appear to have been needed as the year has progressed.

The GMC ran a survey in late summer 2020 focusing on the spring period of the pandemic. The COVID survey was an abridged version of the usual National Training Survey and had additional questions around health and wellbeing and organisational support. The results of this were made available in October 2020, hence the inclusion in this report.

Neurosurgery trainees reported via the COVID survey issues regarding out of hours supervision. The DME held discussions with the trust neurosurgery lead educators; they advised the current trainee group had not reported any similar problems and were confident any perceived issue from that time was no longer a concern.

Survey feedback from both Medicine and Anaesthetics cohorts was incredibly positive, with high levels of satisfaction in the level of health and wellbeing provision available through the trust and did not report significant negative impact to their working lives during this time. Inevitably there was a negative impact reported on

their access to curriculum development which the trust education leads have sought to remedy over subsequent months.

Training Programmes

National changes to postgraduate training are now filtering down to trust level. Curriculum reviews for Rehabilitation Medicine and Anaesthetics training programmes have been completed and are currently being implemented by the Trust education leads

RCP led Shape of Training (SHoT) is impacting medical training with the introduction of the 3 year Internal Medicine Training programme. Neurology was one of the specialities to be affected by reconfiguration of junior training and entry is now at year 4, to accommodate the 3rd year of IMT acute medicine. The TPD has been an advocate in discussion at a regional and national level to ensure Neurology is part of the IMT3 offering. To that end we have developed an innovative Neurology post with Aintree to commence this August.

IMT replaces Core Medicine training and builds on SHoT objectives for modernisation. Despite what could have been a challenging time with the ongoing effects of the pandemic, IMT experience this year appears to have been good. Trainees have engaged well with the junior doctor forum, exit surveys (internal placement evaluation) indicated high levels of placement satisfaction. RCP College Tutor Dr Damodaran described a series of 'small changes' which incrementally have contributed to this positive outcome, (the GMC section below expands further on this). A change to the higher training rota with the introduction of hot and cold blocks has meant a greater registrar presence on the ward which the junior doctors have benefitted from, in terms of informal pastoral and professional support from their near peers. Access to general neurology clinics has been facilitated by Attend Anywhere. With the creation of RANA – Rapid Access to Neurology Assessment – IMT trainees lead the clinic and oversee the initial consultation with patients before a follow-up review with the consultant supervisor. This empowers trainees and encourages active engagement rather than passive observation, mitigating longstanding perceptions by junior doctors regarding autonomy.

All Neurology registrars successfully passed ARCP with four doctors completing training and gaining their CCT. Neurology registrars have contributed significantly to undergraduate education this year and paved the way for the education fellow role. Dr Rhys Davies introduced a Neurology Registrar education rotation to support ward-based education. This was been extremely well received with the undergraduate students noting via the RAG reports the valued pastoral as well as academic support from the registrars this has brought over this year.

Rehabilitation Medicine had three Mersey trainees successfully achieve their CCT and have since been appointed to consultant posts in Salford. Trainees responded well to change resulting from the pandemic and training was able to continue via remote working and use of MS teams, to mitigate the loss of face to face activity. As

noted previously, there is a new curriculum being introduced for Rehabilitation Medicine and a key change to entry to the programme. Entry to training at ST3 will extend beyond doctors from medicine and surgery to include a far broader range of specialties e.g. ophthalmology.

Neuroradiology continues to host 18 core radiology trainees each year as well as placements for further two core neuroradiology subspecialty (one diagnostic and one interventional neuroradiology subspecialty trainees for 2 and 3 years respectively). As a tertiary centre, core trainees are supranumery with no clinical commitments; work is allocated as appropriate to their level, to ensure trainees meet portfolio outcomes and always with oversight by a senior colleague. The pandemic saw the working patterns of consultants change with increased off site working. To mitigate any negative impact the department developed a process via MS Teams to facilitate indirect supervision. This was subsequently adopted by neighbouring trusts to ensure training continuity during the pandemic. TSTL Dr Bhojak and colleagues contribute to the regional Radiology Academy teaching programme and are actively involved with lecturing on a national and international basis.

Neurosurgery has several trainees out of programme but the team are buoyed by a number of trust employed junior doctor and clinical fellow posts. The lead for junior grades is Mr Nick Carleton Bland and higher specialty training Mr Ajay Sharma. Junior doctors in surgery have a bespoke surgical departmental induction and recieve 2 surgical teaching sessions each week. Recently, the team were successful in sourcing funds from WCFT charity to support a new VR simulator which will enhance education and training provision for surgical trainees.

There have been several good news stories to come out of 2020-21. A Neurology Registrar led initiative, NeuroPodCasts, was successful with a bid for HEE NW funding in December 2020. The bid was put together by Dr Sarah Healy and has enabled the team to purchase kit to enhance the production quality of the resource. The online podcast discussion series focuses on Neurological conditions and has been accessed by users internationally.
Complete renovation and redesign of the Junior Doctors Mess is nearing completion after around 2 years development. This project has been funded by the BMA Fatigue and Facilities Charter monies and the Trusts own charity and ensure the trust's support of the principles of the HEE Enhancing Junior Doctors Working Lives work programme.
Lastly, the Neurology registrar's office has been relocated and adapted into an open plan space with a breakout area and TV screen to facilitate remote teaching and other online activity.

FOCUS ON MEDICAL EDUCATION FUNDING -

In April 2021 a new Education Contract was entered into between the Trust and HEE replacing the old Learning Development Agreement.

For undergraduate education a new tripartite agreement has been established within the contract. The three parties are HEE, Trusts as placement providers and HEI and the tripartite agreement sets out specific expectations for each, notably around LEP responsibilities in regard to educational supervision.

For postgraduate training there is a distinct alignment with the Academy of Medical Educators professional standards in regard to outcomes for placement providers.

Trusts are required to provide an annual finance return in respect of Undergraduate activity. Medical Education supported the Finance team completing the inaugural UGME return this summer. Going forwards, along with a bi-annual SAR report, the UGME Finance Return will form part of HEE contract performance monitoring, as described in the next section (External Monitoring).

FOCUS ON EXTERNAL MONITORING

Health Education England

The trust as the Local Education Provider facilitates clinical placements for healthcare learners. The quality of the education we provide is monitored by HEE. One of the mechanisms used is an annual report. In 2018 a Self-Assessment Report (SAR) multidisciplinary format was introduced. There is ongoing work at a national level to develop this report and produce a single UK wide annual quality report for health education.
This is to be rolled out following the release of the revised Health Education Quality Framework, due to be shared later this year. It is anticipated the aforementioned bi-annual education SAR report will be aligned the refreshed Quality Outcomes Framework and be part of HEE reporting cycle.
We have been advised Trusts will not receive a written response for the 2020 SAR report and instead feedback will be discussed between the DME and HEE Associate Dean. As the 2021 report format is under review we await and will update in due course.

GMC National Training Survey

The 2021 GMC survey returned to its usual format and set of questions, a written summary and survey data is available at the end of this document (appendix 1). The trust overall fared well with no negative outliers and two positive outliers for clinical supervision out of hours and handover. Most specialties were well evaluated by the trainees. Internal Medicine Training (junior trainees working in Neurology) feedback

was excellent with six green outliers notably in supportive environment and educational governance. As described before, there has been much work by the Royal College Tutor Dr Damodaran and Neurology TPD Dr Davies to facilitate the implementation of IMT and protect trainee experience. In comparison, year on year Neurology registrar training hasn't been as positive as previously however the effects of the pandemic on experience and the transition to IMT can go some way to explain the dip and is expected to be an anomaly as the medical workforce and working patterns settle down.

Neurosurgery registrar feedback was also excellent with five green outliers indicating trainee satisfaction has risen since 2019. In comparison the report for core surgical training had several pink outliers, suggesting experience hasn't been as good. There is a caveat which should be acknowledged; the reporting group consisted of 3 trainees and question analysis showed generally a 3 way split in response ranging from good, neutral to poor.

UoL MSAR

To date, the main tools for quality assessing placement providers have been the quality site visits and the ongoing data collection via the student feedback RAG reports. Moving forwards however trusts will be required to complete an annual self-assessment report to the medical school which will then be used in their quality reporting to the GMC

MEDICAL EDUCATION COLLABORATIONS AND PARTNERSHIPS

WCFT Research, Innovation and Medical Education Committee – RIME

In 2020 the RD&I committee was refreshed and became the Research, Innovation and Medical Education Committee. WCFT as a specialist centre has a real depth and breadth in excellence in each of these instinctively creative and progressive functions; the RIME committee underlines and reinforces inherent synergies between the functions, consolidating trust strategic aim to lead in research education and innovation.

University of Liverpool

Medical Education has developed a robust and reciprocal working relationship within the Medical School and the university beyond the formal relationship as clinical placement provider. NeuroSoc, the undergraduate medical society and the Medical Education Team have worked closely in recent years in facilitating and hosting the annual undergraduate conference as well as other undergraduate training events.

LUHFT

The Trust has agreed a new SLA with LUHFT as Library and Knowledge Service provider. Trust staff and affiliated students can access libraries at both sites as well as the full range of physical and online knowledge and information resources. The Knowledge Centre at Aintree was recently completely renovated and has an extensive suite of desk top computers, quiet study areas with access point for laptops and an education seminar room. With LUHFT, we negotiated a new contract with UpToDate, the online point of care decision tool, taking advantage of economies of scale afforded to the joint contract. We hope the collaboration with LUHFT Library and Knowledge Services will open up access to our educationalists, students and staff to specialist support and resources to aid education, personal, and professional development.

LOOKING AHEAD TO ACADEMIC YEAR 2021/22

After a period of unprecedented challenge, and transformation to established ways of working, we look forward to positively harnessing change for the benefit of medical education learners and educators.

We will support the emergence from COVID and look forward to inviting overseas electives back to the trust.

We will continue to develop the Undergraduate programmes and review the impact of the new UG roles.

We will work to consolidate our internal relationships and encourage engagement from all specialties within the trust.

We will support the development of Trust educationalists, identifying and facilitating a pathway for those with an interest in Medical Education

We will ensure there is clear alignment between trust ambitions and education outcomes and support the development of a workforce that support trust strategic direction

We will continue to work with Finance to develop transparency in education income.

We will build on the work from 2020, reinforcing Medical Education position within the RIME group and be an advocate for students and trainee doctors that wish to develop research and academic experience.

We will continue to be responsive to external changes affecting medical education and training and continue to build effective networks with stakeholders from across the health education system.

APPENDICES

1. GMC National Training Summary

WCFT 2021 GMC National Training Surv

References

GMC NTS https://reports.gmc-uk.org/analytics/saw.dll?Dashboard accessed 14th August 2021