NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 7th September 2023

Agenda and Papers

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

PUBLIC TRUST BOARD MEETING

Thursday 7 September 2023

Boardroom

09:30 – 13.00

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Staff Story (v)	Chief Nurse	N/A
2	09.50	Welcome and Apologies (v)	Chair	N/A
3	09.55	Declaration of Interests (v)	Chair	Note
4	10.00	Minutes and actions of meetings held on: • 6 July 2023 (d)	Chair	Approve
STRATEGIC CONTEXT				
5	10.05	Chair and Chief Executive's Update (d)	Chief Executive	Note
6	10.20	Digital Substrategy Update (d)	Chief People Officer	Assurance
7	10.30	Estates, Facilities and Sustainability Substrategy Update (d)	Chief Operating Officer	Assurance
8	10.40	Trust Anti-Racism Statement (d)	Chief People Officer	Approval
COLLABORATION				
9	10.45	Cheshire and Merseyside NHS Joint Forward Plan 2023/28 (d)	Chief Executive Officer	Assurance
10	10.55	Liverpool Trusts Joint Committee (d) • Key Issues Report – 16 June 2023	Chief Executive Officer	Assurance
11	11.00	Joint Site Sub-Committee (d) • Key Issues Report – 22 August 2023 • Terms of Reference	Chair	Assurance
11.10 BREAK				
PERFORMANCE				
12	11.20	Integrated Performance Report (d)	Chief Executive Officer	Assurance
13	11.25	Business Performance Committee (d): • Chair's Assurance Report – 25 July 2023	Committee Chair	Assurance
14	11.40	Quality Committee (d): • Chair's Assurance Report – 20 July 2023	Committee Chair	Assurance
FINANCIAL				
15	11.55	Proposal for Updates to the Standing Financial Instructions (SFIs) and Scheme of Reservation and Declarations (SoRD) (d)	Chief Finance Officer	Approval
16	12.05	2023/24 National Expenditure Controls (d)	Chief Finance Officer	Approval
GOVERNANCE				

Item	Time	Item	Owner	Purpose
17	12.15	NHS England Revised Fit and Proper Persons Test Framework (d)	Corporate Secretary	Agree
18	12.25	External Well Led Recommendations Action Plan (d)	Chief Executive	Assurance
QUALITY & SAFETY				
19	12.35	Emergency Planning Resilience Response Core Assurance Self-Assessment (d)	Chief Operating Officer	Approve
COMMITTEE CHAIR'S ASSURANCE REPORTS/ TERMS OF REFERENCE				
20	12.45	Audit Committee – 18 July 2023 (d)	Committee Chair	Assurance
21	12.50	Charity Committee – 22 July 2023 (d)	Committee Chair	Assurance
22	12.55	Neuroscience Network Programmes Board – 11 July 2023 (d)	Committee Chair	Assurance
CONSENT AGENDA				
23. Subject to Board agreement, the recommendations in the following reports will be adopted without debate: • Charity Committee Terms of Reference (d)				
CONCLUDING BUSINESS				
24	13.00	Any Other Business (v)	Chair	
25	13.00	Review of Meeting (v)	Chair	Note

Date and Time of Next Meeting: 9.30am, 5 October 2023, Boardroom, The Walton Centre

UNCONFIRMED
Minutes of the Public Trust Board Meeting
Board Room
6 July 2023

Present:

Max Steinberg (MS)	Chair
Irene Afful (IA)	Non-Executive Director
Mike Burns (MB)	Chief Financial Officer
Mike Gibney (MG)	Chief People Officer
Karen Heslop (KH)	Non-Executive Director
Paul May (PM)	Non-Executive Director
Andy Nicolson (AN)	Medical Director
Morag Olsen (MO)	Interim Chief Nurse
Su Rai (SR)	Deputy Chair and Senior Independent Director
Jan Ross (JR)	Chief Executive Officer
David Topliffe (DT)	Non-Executive Director
Lindsey Vlasman (LV)	Chief Operating Officer
Ray Walker (RW)	Non-Executive Director

In attendance:

Katharine Dowson (KD)	Corporate Secretary
Jennifer Ezeogu (JE)	Deputy Corporate Secretary *(for minutes)*
Lisa Judge (LJ)	Head of patient Experience *(item 1 only)*
Elaine Vaile (EV)	Communications and Marketing Manager (*item 7 and observer*)

Observers

Barbara Strong	Public Governor: Merseyside
Melanie Worthington	Partnership Governor:
Belinda Shaw	Public Governor: Merseyside

Apologies:

Lisa Salter	Chief Nurse

1 Patient Story

1.1 LJ introduced the patient story which was about a patient who had been referred to the Trust after having several episodes of seizures. The patient had previously been seen by a private neurologist before being referred to the Trust to undergo surgery to remove a brain tumour. The patient stated that she was able to get an appointment and booked in for her surgery with the Trust within a short time. She was always kept informed about every procedure and expressed her appreciation towards the medical and clinical staff that had been involved with her treatment.

1.2 MS asked the patient what aspect of the treatment stood out the most and if there were any areas where the Trust could have done better. The patient stated that she felt she had not been properly prepared for the potential side effects of the surgery. She had been told that she may experience some weakness on her right-side post operation but upon waking up, she felt temporarily paralysed on her right side and had required intensive therapy. Since

her treatment, she had become involved with the Brain Charity and was grateful for the care and treatment provided by the Trust.

1.3 RW inquired about the discharge process. The patient stated that it was quite difficult as she had struggled in the past with her mental health. She did not immediately get referred to a psychologist or occupational therapist, but she was eventually referred to a psychologist by her GP.

The Board thanked the patient for sharing their story.

2 Welcome and apologies

2.1 Apologies were noted as above. The Chair welcomed everyone to the meeting.

3 Declarations of interest

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

4 Minutes of the meeting held on 1st June 2023

4.1 A few typos were noted for correction and the following changes were made:

4.2 SR asked that it was noted in paragraph 1.4 that the Board had thanked the patient for her effort towards the money she raised for the Walton Centre Charity.

4.3 First sentence paragraph 3.1 – Act to be added after Learning Disabilities.

4.4 Paragraph 7.1 and 7.2 – MF to be corrected to MB.

4.5 Paragraph 11.5 – the second sentence was amended to read "JR responded that the Executive Team had identified key focus areas with regard to behavioural issues and all complaints raised were followed up and investigated thoroughly. However, on some occasions it was found that complaints raised were against individuals who had rightfully challenged and questioned certain matters.

4.6 Paragraph 11.6 – the sentence was amended to read "AN stated that most often when concerns were raised and disciplinary actions *carried out*, the Trust was unable to give feedback to the staff who had raised the concerns due to the need for confidentiality."

4.7 Following the completion of these amendments, the minutes of the meeting held on 1st June 2023 were approved as an accurate record of the meeting.

Action tracker

4.8 The actions formed part of the meeting agenda.

5 Chair & Chief Executive's Report

5.1 MS informed the Board about the passing away of Ian Linford, Trust Public Governor for Cheshire and his contribution to the Trust was recognised.

5.2 MS had attended in month the Aintree Joint Site Sub-Committee meeting, the Cheshire and Merseyside Acute Specialist Trusts (CMAST) Leadership Board meeting, NHS Providers Northwest Chairs and Chief Executives regional meeting, Research, Innovation and

Medical Education (RIME) Committee meeting and the Council of Governors (CoG) meeting. MS noted that the attendance of the Non-Executive Directors (NEDs) at CoG meetings had been lower than normal due to a number of factors.

Action: JE to resend COG meeting dates for 2023/24 to NEDs

5.3 MS reported that the Trust had organised a barbeque to celebrate NHS at 75 on 5th July and it was well attended by staff and visitors. MS thanked the Rapid Response Team for providing the food, the Liverpool Philharmonic Orchestra, Anne Hodgson and the Fundraising Team, and Elaine Vaile and the Communications Team for their effort towards a successful celebration. MS also thanked the ACE choir for their performance, they had raised approximately £600 for the Trust which had been presented at the celebration. The Trust had also sponsored five nurses to attend the NHS at 75 celebration held at Westminster.

5.4 JR stated that industrial action remained a key issue nationally and for the Trust. Although the Trust had a robust contingency plan in place to manage the situation, some appointments had been cancelled or rescheduled. More industrial action was expected over the summer. JR added that Cheshire and Merseyside (C&M) had just published its Joint Forward Plan and a paper would be presented to the Board to update on this.

Action: JR to bring a paper to Board with regards the Cheshire and Merseyside Forward Plan.

5.5 PM asked if the Trust was allowed to enquire which consultants would be participating in the consultant's industrial action to enable robust planning. AN replied that the British Medical Association (BMA) had provided some useful guidance and had stated that organisations were allowed to enquire from their consultants if they would be participating in the strike. Although consultants were not required to respond, the BMA had recommended that consultants inform the Trust of their intentions. As senior doctors they were ultimately responsible for patient care, and there was a professional responsibility due to their Trust and patients to keep them informed to enable the Trust plan properly.

5.6 AN stated that discussions were ongoing with the Chair of the Medical Policy Board and that if consultants had decided not to strike, there would be discussions regarding retaining clinical activity where possible.

5.7 A letter had been sent by the Integrated Care Board (ICB) on 5th July with regard to expenditure controls and the Board's responsibility to manage expenditure. A copy of the letter would be circulated to Board members after the meeting and a response would be sent to the ICB on or before 31 August 2023.

Action: JR to circulate ICB letter and send a response letter on behalf of the Board to ICB.

5.8 JR advised that she had been appointed as the Senior Responsible Officer (SRO) for stroke in Cheshire and Merseyside and the Workforce SRO for CMAST.

5.9 RW asked if an analysis of the impact of the strike could be provided to show which groups had been disadvantaged as a result. JR stated that it was difficult to measure the impact,

as there was a disconnect between understanding the financial impact of the strike and the impact on patients particularly those on the waiting lists and complex patients that were not cancelled but would be delayed in receiving an appointment or had to be rescheduled as a result. LV noted that the time spent by the various divisions to have the right plans in place to mitigate the impact of the strike was significant.

5.10 RW noted that it was good to see the SWAN model was being implemented and asked if a business case had been developed. AN confirmed that a business case and been developed and approved for a SWAN nurse.

5.11 KH inquired about the purpose of the ICS independent options appraisal review following on from the Liverpool Clinical Services Review. JR stated that clarity was being sought with regards the review and that the Chair of the Liverpool Trusts Joint Committee would be writing to the ICB.

The Board noted the Chair and Chief Executive reports.

6 Trust Strategy Update

6.1 AN presented an update on the Trust Strategy and highlighted the three areas of focus for the next quarter and outcome of the focus areas from the last quarter. AN noted that going forward, LV would be the lead officer for the Trust Strategy and she would provide updates as the Trust moved into the next implementation phase of the strategy.

6.2 AN highlighted that plans were ongoing to develop more undergraduate training to support the University of Liverpool (UoL) expansion program and bringing onboard medical students from Edge Hill University.

6.3 AN noted that a 12-month progress update on the Trust Strategy would be presented at the Board Strategy Day in September. AN and LV had met with the Interim Head of Business Intelligence to discuss how Key Performance Indicators (KPIs) could be developed to track and demonstrate progress on the plan.

6.4 KH asked about the career escalation for nursing and if a framework had been developed. LV stated that the framework would be for nursing pathways; for example, how care support workers could progress to become registered nurses. The development of the framework was near completion and was being led by the Divisional Lead Nurse for Neurology who had been to other Trusts to review best practice and had been engaging with staff through a number of different forums.

6.5 DT asked about progress on the system-wide review of pain services given the increasing number of referrals into the Trust which was creating longer waits. AN replied that although the Trust was ideally positioned to lead on this, it was a challenging service to coordinate across the system. He was the medical lead for the system on pain services and was building on existing collaborations with other providers.

6.6 JR added that pain had always been a fragile service as it was difficult to recruit into and retain staff hence the increase in referrals because some services had closed. It was something that needed to be led at system-level and discussions had commenced.

6.7 PM thanked AN for updating the Board and the progress recorded against the Trust Strategy.

6.8 IA asked if targets had been set for some of the KPIs as some of the actions did not have completion dates. AN stated that target dates had been set for some actions and that some did not necessarily have targets set for them. Once the dashboard had been developed this should help identify more clearly what had been achieved.

The Board noted the update on the Trust Strategy.

7 Communications and Marketing Substrategy Update

7.1 EV presented an update of the Communications and Marketing Substrategy and highlighted the objectives achieved in quarter one and those planned for the next quarter.

7.2 EV advised that the branding work was ongoing, internal communications and staff engagement was proceeding as planned and good feedback had been received for external communications. The filming project was on schedule, the wall project had been completed with great response from patients and staff and screens had been mounted in staff areas to improve internal communications. Quantitative data would be included in the next report (including social media followings) which would be balanced against qualitative data.

7.3 MS asked when the Board would receive an update on the naming project. EV stated that progress report would be shared with the Board in September.

Action: EV to bring progress report on the naming project to the Board in September.

7.4 DT asked for an update on the stakeholder engagement list and if it had been brought forward as a priority. JR stated the Board development session with senior leaders in June on horizon scanning had helped put a focus on it. A paper would be presented to the Board in due course with a summary of findings. A meeting had been scheduled with MS, KD, EV and AN to discuss focus areas and the way forward.

Action: JR to present to the Board a summary of findings in December 2023.

The Board noted the Communications and Marketing Substrategy Update.

8 Board Assurance Framework Report (BAF) 2023/24

8.1 JR presented the BAF and highlighted that it was the first BAF report of the year since the strategic risks had been reviewed and approved in April. The BAF had been updated to reflect changes made to some of the strategic risks. It was proposed that MB was nominated as the lead officer for the system finance risk rather than JR.

8.2 RW stated that there had been a discussion at Quality Committee around the target risk rating and whether or not the target risk ratings were going to achieve what was expected. It was agreed that the target risk score was the desired risk ratings of what the Trust aimed to achieve. However, the Trust recognised that these were ambitious and stretching targets which the Trust was aspiring to rather than an expectation for achievement by the end of the year.

8.3 KH stated that if the Trust had set a risk target, the mitigations in place should be expected to help achieve the target. JR replied that this was the case, but for example for Quality of Care (001) there would always be a risk to patient safety that the Trust must focus on and be aware of to ensure it was an 'unlikely' occurrence.

8.4 DT agreed that it was acceptable for the Board to have ambitious targets so long as the Board had mitigations in place. As some of the risks were outside of the Board's control mitigations had to be developed.

8.5 SR noted that it was important that the Board had identified the risks and had mitigations in place to work towards achievement of the target risk scores.

8.6 IA suggested that the oversight committee for BAF 005 (Leadership Development) be expanded to include the Health Inequalities and Inclusion Committee (HIIC) because HIIC had a role to play in this risk as it related to staff development. KD replied that there would always be cross over between committees for most of the risks and that workforce was a good example of this. However, for the purpose of the BAF and reporting there was only one assigned Committee per BAF risk which in this case was Business Performance Committee (BPC) as it has the oversight for workforce. There would always be the opportunity to discuss all risks at Board. MG added that some of the work referenced under risk 005 would be discussed in HIIC and hence the committee would still have input into this risk.

8.7 MO commented that this was a good example of the BAF being reviewed continuously and highlighting the gaps in control and mitigations put in place. The Board would continue to review the BAF to ensure it met its objectives.

8.8 PM noted that the risk in BAF 008 (Medical Education Strategy) had been increased not because there was a material risk but had been done in response to the Trust's strategy of expanding its goal to align with the national agenda and reflected that the Board was ambitious and the Trust was a learning organisation.

The Board approved the Board Assurance Framework Report.

9 Liverpool Trusts Joint Committee Terms of Reference (TOR)

9.1 JR presented the TOR of the Liverpool Trusts Joint Committee (LTJC) and highlighted that this was a significant moment in terms of governance as the Board was being asked to approve the delegation of some of its powers to the LTJC. The purpose of the LTJC was to ensure that there was no variance in care and no duplication of services.

9.2 IA clarified that where decisions were not unanimous on an issue the individual Boards would have the opportunity to review the decision. JR confirmed that this was the case and added that the LTJC would be able to make decisions on behalf of Board where delegations were agreed by individual Boards. The Chair and CEO were members of the Joint Committee and would always aim to represent the interests of the Trust.

The Board approved the Liverpool Trusts Joint Committee Terms of Reference.

10 Aintree Site Joint Sub-Committee Key Issues Report – 20 June 2023

10.1 MS presented the key issues report for the Walton Centre and Aintree Joint Site Sub Committee meeting held on 20 June 2023 and noted that the Committee had endorsed the proposed workplan to be presented to the respective Boards for approval. The workplan was led by AN and Rebecca Hanlon, Aintree Site Medical Director respectively. The workplan includes areas of existing collaboration between both sites and highlights the clinical areas and recommendations from the Liverpool Clinical Services Review (LCSR).

The Board noted the Aintree Site Joint Sub-Committee Key Issues Report.

11 Aintree Site Joint Sub-Committee Proposed Workplan

11.1 AN presented the proposed workplan and highlighted the areas of focus, to include emergency clinical pathways, clinical support services (including pharmacy and radiology), elective care, corporate services (utilisation of estate for clinical activity) and some focus on Digital.

11.2 The operational work would be led by a Joint Partnership Committee (JPC) to be chaired jointly by AN and Rebecca Hanlon. Joint Senior Responsible Officers (SRO)s would be appointed from both sites for each focus areas and they would provide reports on the progress of each work stream to the JPC, and this would in turn be reported to the Site Sub-Committee The proposed workplan would focus on solutions and how to improve existing collaboration across both sites.

11.3 JR stated that most of the areas highlighted were areas that both sites had already worked on collaboratively and both sites had to be mindful that the governance did not hamper the already existing good working clinical engagement and collaborative working. AN confirmed that this had been raised in the last Aintree Site Sub-Committee meeting.

11.4 SR asked if more context on existing work between both sites could be included in the workplan and if the Trust had the resource to carry out the plan. AN stated that areas of existing collaboration were highlighted in the paper. Resources and infrastructural issues could potentially impact the delivery of the workplan, and this had been raised as a risk.

11.5 PM stated that he was confident with the plan and the SROs chosen by the Trust as they were relevant, informed and understood the collaborative network that already existed between both sites and the degree of collaboration and engagement expected on a regional basis. He was confident that the SROs with AN's leadership would be able to inform and support the collaboration and reinforce what was already been done.

The Board approved the Aintree Joint Site Sub-Committee Workplan.

12 Board Cycle of Business

12.1 KD presented the updated Board Cycle of Business following the Board approval of the revised Board and Committee meeting schedule in June.

The Board noted the Revised Board Cycle of Business

13 Integrated Performance Report

13.1 JR introduced the Integrated Performance Report (IPR) and noted that check and challenge of the IPR had been undertaken at Board Committees and the Chairs of the relevant Committee would present this as part of their assurance reports.

The Board noted the Integrated Performance Report.

14 Business Performance Committee Chair's Assurance Report

14.1 DT, as Chair of the Business Performance Quality (BPC) presented the key issues report and highlighted that there had been improvements in cancer waiting and diagnostics and there were now no 78+ week long waits. There had been a slight increase in the number of 52 weeks long waiters due to an increased number of referrals for pain management in conjunction with tight resources in that area. A review was underway seeking to deliver the service differently to reverse the trend. New mutual aid requests had been received from Trusts in Nottingham and Birmingham for spinal surgery which the Trust had accepted.

14.2 Sickness levels were slightly below target but the mandatory training overall target had been achieved and maintained for the first time in two years. Appraisal compliance and safeguarding training compliance had slipped. Public Digital were carrying out a Digital Maturity Assessment to review structures and governance with findings expected in August and a report would be brought to the Board in October. As part of the Trust's sustainability drive, the Trust had installed 10,000 bees on the third floor of the main building which would be managed by Estates and Facilities with the help of local community experts.

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

15 Quality Committee Chair's Assurance Report

15.1 RW, as Chair of the Quality Committee (QC) presented the report and highlighted that the surgical site infection rate for the Trust was much improved, the Trust had performed well in several areas, however issues remained regarding MSSA infections and focussed work was ongoing. The Trust was currently being considered for Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) accreditation and a site visit was due to be undertaken as part of this process.

15.2 SR enquired about progress of focused work to address MSSA infections. AN stated that there were still concerns as the Trust had an annual trajectory of 10 cases and had already recorded six cases in the year. An action plan had been put in place in the Intensive Therapy Unit (ITU) and the affected wards and there was evidence of some progress in ITU, but work was still ongoing to prevent further infections.

15.3 Slippage had been noted against a number of target completion dates for actions identified from the national inpatient survey; the committee had been informed that plans had been implemented to address this with a focus to complete all outstanding actions and report by September. Mandatory safeguarding training was currently non-compliant and individual non-compliant staff would be contacted with a request to complete training.

15.4 RW noted that the Trust was scheduled to roll out the Patient Safety Incident Response Framework (PSIRF) by 1 September 2023 and a draft policy and implementation plan was being developed. Approval was being sought from the Board for Quality Committee to

approve the implementation plan and policy as there would be no Board meeting in August to approve this before the deadline.

15.5 PM asked about the requirement to report the safeguarding training compliance and what the benchmark score to be reported to the ICS would be. MO stated that the Trust had set its general target for mandatory training at 80% but the expectation of the Safeguarding national body was 90%. This would be updated on the performance chart.

15.6 KD stated that work was underway with the training team to plan a session for level 3 safeguarding training for NEDs to ensure compliance across the Board.

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

16 Major Incident Plan

16.1 LV advised that there had been some small changes from when the plan was first published in April 2021.The plan was due for a full review by April 2024. The Trust had in February undertaken an external review of all its emergency response services and the major incident plan and positive feedback had been received from NHS England.

16.2 LV noted that the ICB was in the process of devising a major incident plan for Cheshire and Merseyside and the Trust was engaging with this. The plan would be released in October and the Trust would align its plan, as appropriate, in response.

The Board approved the Major Incident Plan.

17 NHS National External Reviews Update

17.1 MO highlighted potential areas of closed cultures and the importance of the Trust demonstrating how it responds to issues reported.

17.2 RW noted that he had spoken to MO with regards to the use of restraints. MO observed that training was underway, focused on when, how, and why restraints could be used. The training also covers the reporting procedure when restraints had been used although there was no requirement nationally for the Trust to report this. A further update would be provided at Quality Committee.

The Board noted the NHS National External Reviews Update.

18 Patient Safety Incident Response Framework (PSIRF) Policy and Plan

18.1 MO noted that this was to be signed off by the ICB by 31 August 2023 and rolled out by 1 September 2023 but as reported by RW, Quality Committee would be reviewing this in detail at their July meeting and therefore it was requested that the Board delegated the approval of these to Quality Committee.

The Board agreed delegation to the Quality Committee to approve the PSIRF Policy and Plan ahead of the deadline.

19 Audit Committee Key Issues Report

19.1 SR presented the Extra-ordinary Audit Committee key issues report from the meeting held on 19 June 2023 and highlighted that the Committee had received the findings of the external auditors and endorsed the Financial Statements and Annual Report. SR stated that

the external auditors had issued an unqualified opinion for the financial accounts and value for money. Two recommendations were given, and a management response had been provided.

19.2 KD noted that the Annual Report and Accounts 2022/23 had been submitted for laying before parliament before the summer recess.

The Board noted the Audit Committee Key Issues Report.

20 Research, Innovation and Medical Education (RIME) Committee Key Issues Report

20.1 PM highlighted that there had been a significant change in the Committee over the past year with stronger governance and focus. No alerts and risks had been identified. There was evidence of increased stability in the Neurosciences Research Centre (NRC) infrastructure resulting in improved quality of patient recruitment.

20.2 IA enquired if there were opportunities for the Trust as a University Hospital to access funding from the European Research Fund. PM stated that if any opportunities arose, the University would seek to explore it and that he would make more enquiries about how the funds could be accessed.

20.3 The Board thanked KD for her help in restructuring the RIME committee governance and ToR.

The Board noted the Research, Innovation and Medical Education (RIME) Committee Key Issues Report.

21 Health Inequalities and Inclusion Committee (HIIC) Key Issues Report

21.1 JR highlighted that the committee had been extensively reviewed and restructured and its brief widened and thanked KD for her work on this.

21.2 Plans were underway regarding the appointment of a NED Chair to bring it into line with other Board Committees.

The Board noted the Health Inequalities and Inclusion Committee Key Issues Report.

22 Remuneration Committee Key Issues Report

22.1 MS highlighted that Executive Director succession planning had been considered and the Committee had approved the Pension Recycling Policy for 2023-24.

The Board noted the Remuneration Committee Key Issues Report.

23 Consent Agenda

23.1 The Board noted the following papers submitted on the Consent Agenda which had been reviewed through the Board Committees:

- **Medical Education Annual Report 2022/23**
- **Controlled Drugs Accountable Officer Report 2022/23**.
- **Pharmacy and Medicines Management Annual Report 2022/23**
- **Research and Development Annual Report 2022/23**
- **Infection Prevention & Control Annual Report 2022/23**

- **Innovation Annual Report 2022/23**

24 **Any Other Business**

24.1 There was no other business to be discussed.

25 **Review of Meeting**

25.1 Those present agreed that the meeting had proper debate and assurance received.

There being no further business the meeting closed at 12.55

Date and time of next meeting – Thursday, 7 September 2023 at 09:30 Boardroom

Trust Board Attendance 2023-24

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

PUBLIC TRUST BOARD
Action Log
September 2023

	Complete & for removal
	In progress
	Overdue

Completed and for removal

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
04/05/2023	Item 10	**External Well Led Review Report** Develop an action plan in line with the recommendations from the report and report back to the Board.	KD	Agenda Item no 18	5 October 2023	
06/07/2023	Item 5	**Chair & Chief Executive's Report** JE to resend Council of Governor (CoG) meeting dates for 2023/24 to Non-Executive Directors	KD	COG meeting dates resent to all NEDs in August.	7 September 2023	
06/07/2023	Item 5.4	**Chair & Chief Executive's Report** Paper to Board on the Cheshire and Mersey Forward Plan.	JR	Agenda Item no 9	7 September 2023	
06/07/2023	Item 5.7	**Chair & Chief Executive's Report** JR to circulate Integrated Care Board (ICB) letter and send a response letter on behalf of the Board to ICB.	JR	Completed.	31 August 2023	
06/07/2023	Item 7.3	**Communications and Marketing Substrategy** Progress report on the naming project to the Board	JR	Progress report presented at the Board Strategy Day 4th September 2023	7 September 2023	

Actions for future meetings

06/07/2023	Item 7.4	**Communications and Marketing Substrategy** Update on stakeholder engagement to be provided to Board.	JR		7 December 2023	
01/06/2023	Item 6	**Charity Substrategy Update** Charity Committee impact statement report to be brought to the Board at the end of the 2023/24 financial year highlighting the achievements and projects approved by the Charity Committee within the year against the focus areas.	MG		4 April 2024	

01/06/2023	Item 12	**Board and Committee Reporting Schedule** Report on the effectiveness and impact of the revised Board and Committee reporting schedule.	KD		4 April 2024	

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

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

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

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

Key Messages

- Industrial action continues to impact on patient activity.
- Focus on process for speaking up and fit and proper person test increased following Lucy Letby trail conclusion.
- Positive news regarding awards both Health Service Journal (HSJ) and The Walton Centre staff awards

Next Steps

This paper is intended for information purposes

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

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

All Risks	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Chief Executive's Report

National Update

Industrial Action

1. There have been further periods of industrial action from junior doctors, radiographers and Consultants through July and August. The mandate for junior doctor industrial action lasted until August and so they have been re-balloting, with this closing on August 31 2023.

2. Further dates for Consultant industrial action have been announced for 19-20 September and 2-4 October 2023, with "Christmas Day cover" provided during these periods.

3. The Trust has maintained safe services throughout all periods of industrial action however this does have a financial impact as well as the ongoing impact on our patients.

NHS England Long Term Workforce Plan (LTWP)

4. The LTWP was published on 30 June 2023, with a focus on training, retention, and reform.

5. It outlined a need to expand medical school places by 60-100% by 2030/31 (12,000-15,000 more places), with a 50% increase in GP training places. The medical degree apprenticeship is being piloted from 2024. Nursing training places are to increase by 80% by 2031/32. There are projected increases in training also for Allied Health Professionals, Pharmacists, Dentists, Healthcare scientists and Psychologists.

6. There is an ambition to reduce leaver rates from 9.1% in 2022 to 7.4-8.2% by 2028. The focus areas for retention were recognition, development and reward, staff well-being and voice, and flexible working.

7. The LTWP recognises the need for the NHS to recruit and retain more people, but there is also a focus on working differently. This includes innovative approaches to training, career diversification and the utilisation of AI and other digital innovations.

Whistle Blowing and Fit and Proper Persons Test

8. Following the verdict on the Lucy Letby trial for murdering seven babies at the Countess of Chester NHS Foundation Trust between 2015 and 2016, NHS England issued a letter to all leaders on Friday 18 August 2023 to ensure that processes are in place to protect whistle-blowers and to block the appointment of directors who have been deemed unfit. Boards have been asked to ensure robust implementation and oversight of their whistleblowing processes and that all staff know how to raise concerns including through the Freedom to Speak up Guardian. All Trusts must adopt the updated national FSUG policy by January 2024 the Trust has already done this.

9. The Audit Committee review annually the raising concern processes with the next report due in October. It is proposed to share this report in full at the next Trust Board meeting as well as the Trust's response to all the recommendations in the letter from NHS England.

10. New guidance has also just been released on enhancements to the Fit and Proper Persons Test and there is a separate paper on the agenda at this meeting for the Board's consideration.

Cheshire & Merseyside (C&M) Integrated Care System

11. The Cheshire & Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative Leadership Board met on 7 July 2023 and considered a number of important issues which included an update on the progress being made through the Diagnostics Programme Board and a number of upcoming key infastructure decisions which relate to:
    - Prioritisation of multi-year system imaging capital allocations
    - Process for managing system bids for endoscopy hubs and prioritisation of funding
    - Pathology consolidation options appraisal and laboratory information management systems (LIMS) development

12. In addition the Leadership Board received an update on the Integrated Care System (ICS) and Integrated Care Board (ICB) Children and Young People's agendas and considered and supported proposals for the establishment of a CMAST Paediatric Network which will enhance the collaborative's focus and delivery of this agenda.

13. Finally the CMAST Board considered the dialogue taking place in different parts of the country in respect fo bank workers and pay awards and the preparation for and approach to managing industrial action.

14. The Board also received the following documents:
    - C&M ICS Activity Summary Report
    - C&M ICS Finance Report

15. The CMAST Leadership Board met again on 4 August 2023. Key decisions from the Board included recommendation of Endoscopy capital monies to two hubs and agreement to a way forward on Laboratory Information Management System (LIMS) procurement. The agreed approach was to implement network-wide LIMS solution for all pathology disciplines through a convergent plan over several years with sites coming on line at appropriate point in line with current contract. A draft business case is being developed which will be shared with all Trusts and approval will be sought using the agreed Memorandum of Understanding on collaborative decision-making approved in 2022.

16. It should be noted that the Trust does not provide this service directly and therefore would be kept informed but explicit decision-making delegation would not formally be required.

17. A visit took place to the region on August 7 from David Sloman (Chief Operating Officer) and Andrew Morris (Deputy Chair) from the NHSE national team, the purpose of the meeting was to follow up after the clinical services review. The meeting was with Liverpool CEOs and Chairs in addition to ICB and CMAST representatives. They were presented with updates on the work in the Liverpool joint committees with the focus on collaborative working and the future of Women's services in Liverpool. The feedback was positive, with recognition of the significant work which has taken place across the Liverpool Trusts, and support for this approach to continue to develop.

Trust Update

HSJ Awards

18. The Trust has been shortlisted for the HSJ Awards “Trust of the Year”. There will be a presentation to the judging panel on September 25th and the awards ceremony takes place in London on November 16th.

Staff Awards

19. There has been an excellent response to the request for nominations for staff awards, with over 230 nominations. The awards evening which takes place on September 22 2023 has been extremely popular and tickets have now all sold out.

Documentary

20. Filming is now complete for the 8-part documentary on the Trust. This is due to be aired on Channel 5 starting in October 2023.

Appointments

21. Mr Sash Ramdhay has been appointed to the role of Neurosurgery Assistant Chief Nurse, he will commence in post in December.

Trust Strategy

22. The Trust will celebrate the key achievements of year one Trust Strategy and the enabling strategies, there will be several events held in October and walkabouts from the Executive team planned. Year 2 objectives have now been set and a dashboard has been developed to be able to monitor the objectives and KPIs.

Estates & Facilities

23. The Air Handling Unit replacement work has now gone out to tender and the initial business case for the scoping exercise has been approved by the Executive team with the plan for next steps and approval to move forward with further plans. The divisions are working up the plans for activity during the period of reduced theatre capacity and are currently in discussion with Liverpool University Hospitals NHS Foundation Trust to understand what mutual aid can be given in relation to theatre capacity.

24. The Ponta beam work has commenced in ITU and a plan is in place to manage the bed occupancy during this period to ensure patient safety is maintained and there are no patient cancelations.

25. The Heating and Pipework project is now in the final phase and will be due to complete in March 2024.

26. The results for the mini PLACE (Patient-Led Assessments of the Care Environment) review have now been reported and much improvement has been made. The report will be shared with both Quality Committee and Business Performance Committee.

Business as Usual

Quality

27. Jefferson and Cairns wards have had ward accreditation visits and both areas maintained GOLD status.

28. The Trust performance against its Healthcare Acquired Infections continue to be positive with the exception of Methicillin-resistant Staphylococcus Aureus (MSSA) with a total of six cases against a threshold of 10; the last case was in June 2023. The Trust MSSA action plan has been reviewed and refreshed with several additional interventions aimed at proactive support including cross-divisional peer review audit.

29. There has been a significant decrease in Catheter Associated Urinary Tract Infections (CAUTIs), with two infections at the end of July 2023 compared to 13 at the same point in 2022.

30. The Trust has one of the lowest rates of E.coli bloodstream infections in the Northwest reducing from 42.5 per 100,00 bed days to 8.5 per 100,00 bed days.

Finance

31. Financial performance in July and year to date is in line with the plan. The Trust delivered a surplus in month of £496k. Year to date the Trust is showing a £2,013k surplus. The full year plan is a £4.1m surplus. There has been over performance in income mainly driven by Agenda for Change (AFC) pay award funding which is matched by the over performance in expenditure. There are still areas of cost pressure, notably in homecare drugs and utilities which is under review.

32. Capital is underspent in month, mainly due to a revision of IT capital expenditure to revenue. Year to date, capital is £0.4m below plan, driven by lower than anticipated spend on the heating and pipework scheme, IT as noted, neurosurgery equipment and the Ponta system now being slightly behind plan. The recurrent Cost Improvement Plan (CIP) and delivery of planned activity, given on-going Industrial Action, will continue to be key challenges to the delivery of the plan for the Trust.

33. At 31 July 2023 (Month 4), the ICS ‘System’ is reporting a year to date (YTD) deficit of £103.0m against a planned deficit of £64.9m resulting in an adverse variance of £38.0m. Adjusting for the non-recurrent CIP, the underlying System position is a YTD deficit of £136.8m. The ICB position is a YTD deficit of £1.8m against a planned surplus of £23.0m, resulting in an adverse variance of £24.7m. The Cheshire & Merseyside Providers position is YTD deficit of £101.2m against a planned deficit of £87.9m, resulting in an adverse variance of £13.3m.

Performance

34. The system is now preparing for Winter Planning and the Trust is working with the ICB to devise the Trust winter plan and the ICB joint winter plan.

35. The ICB have introduced new metrics for patients who are 'Discharge Ready' patients who are ready for discharge. This new system will enable the ICB to have an accurate number of patients who are classed as delayed discharges, and this will come into effect at the end of September 2023. The operational, nursing and IT teams are working together to plan how this will be undertaken and reported from a trust perspective.

36. There will be a number of changes to cancer waiting times standards from 1 October 2023. The 2 weeks wait cancer standard will be removed and replaced with a 28 day faster diagnosis standard with a KPI of 75%. The 3 core measures for cancers will include;

    - The 28-day Faster Diagnosis Standard (75%)
    - 62-day referral to treatment standard (85%)
    - 31-day decision to treat to treatment standard (96%)

37. Performance remains on track for cancers and diagnostics. All the long waiting patients have now been completed for 104 weeks and 78 weeks. The Trust is now focusing on patients who have waited 52 weeks.

38. Due to the Junior doctors, Radiologist and Consultant industrial action, there were a number of patient cancellations both inpatient and outpatient all appointments have been rearranged and patients have been informed.

39. Mutual aid requests continue via the Digital Mutual Aid Systems. Requests have been received for spinal support from Robert Jones and Agnes Hunt Hospital, University Hospital of North Midlands NHS Trust, Salford Royal Hospital and Nottingham University Hospitals NHS Trust; both the clinical and operational teams are working through these requests.

People

40. The national staff survey will be distributed across the Trust from late September to the end of November.

41. Investors in People re-assessment for both the general award and health and well-being will take place in November 2023.

Recommendation

To note

Author: Jan Ross, Chief Executive Officer

Date: 29 August 2023

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	Digital Sub Strategy Update 2023/24 (April to September)
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Justin Griffiths, Chief Digital Information Officer
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Network Upgrade Completed Phase 1
- New Datacentre commissioning on track
- New Digital Sub-Strategy Group launched.
- Clinical Engagement portal developed and
- Increased clinical engagement sessions.
- Digital engagement sessions held.
- Cyber Office 365 high severity completed

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

- Onboarding of RPA (Robotic Process Automation) Solution for organisational development September/October
- Paper light remaining paper list to be finalised.
- ISO9001 stage 1 external audit
- Cyber role development to help support annual Cyber plan.
- External Digital Review findings
- Multi Factor Authentication Policy workload planning once released by NHSE for June 24 deadline.

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

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

011 Digitalisation	012 Cyber Security	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Digital Sub Strategy Update 2023/24 (April to September)

Executive Summary

1. This is the updated plan for the Digital Sub Strategy for H1 (1st Half of Fiscal Year – April to September) 2023/24. It currently shows that the team is delivering the sub strategy on target and have ongoing planning sessions to ensure realistic deliverable dates to support the Trusts overall strategy working with internal stakeholders through engagement and Public Digital through their external Digital review.

Summary

2. Internal Digital Engagement Portal is now live and contains all engagement sessions, live action tracking and live Gannt charts linked to all Digital Programmes and projects.

3. Cyber Security remains a key priority and with increased cyber alerts and the recent Advance One attack in 22/23 has meant there are/will be additional securities being put in place at a national level that will have an impact on resources at a local level, which is currently being seen within the team.

Conclusion

4. The Digital sub-strategy launched 2023 is current in year one and is seeing planned deliveries and constraints showing no major issues that need to be escalate currently. It has been through Business Performance Committee (BPC) and Digital Strategy Group (DSG) in Q2 23/24 (BPC in July and DSG in August).

5. We await the outcomes of the external Digital review being carried out by Public Digital to see if this will impact any plans and deliverable delivery dates, in parallel to this there is also some internal replanning currently underway after review meetings with Public Digital which may realign some project delivery dates to reflect current resources and pressures. The Digital engagement portal will reflect any potential changes and will be taken to the Digital Strategy Group for ratification.

Recommendation

To Note

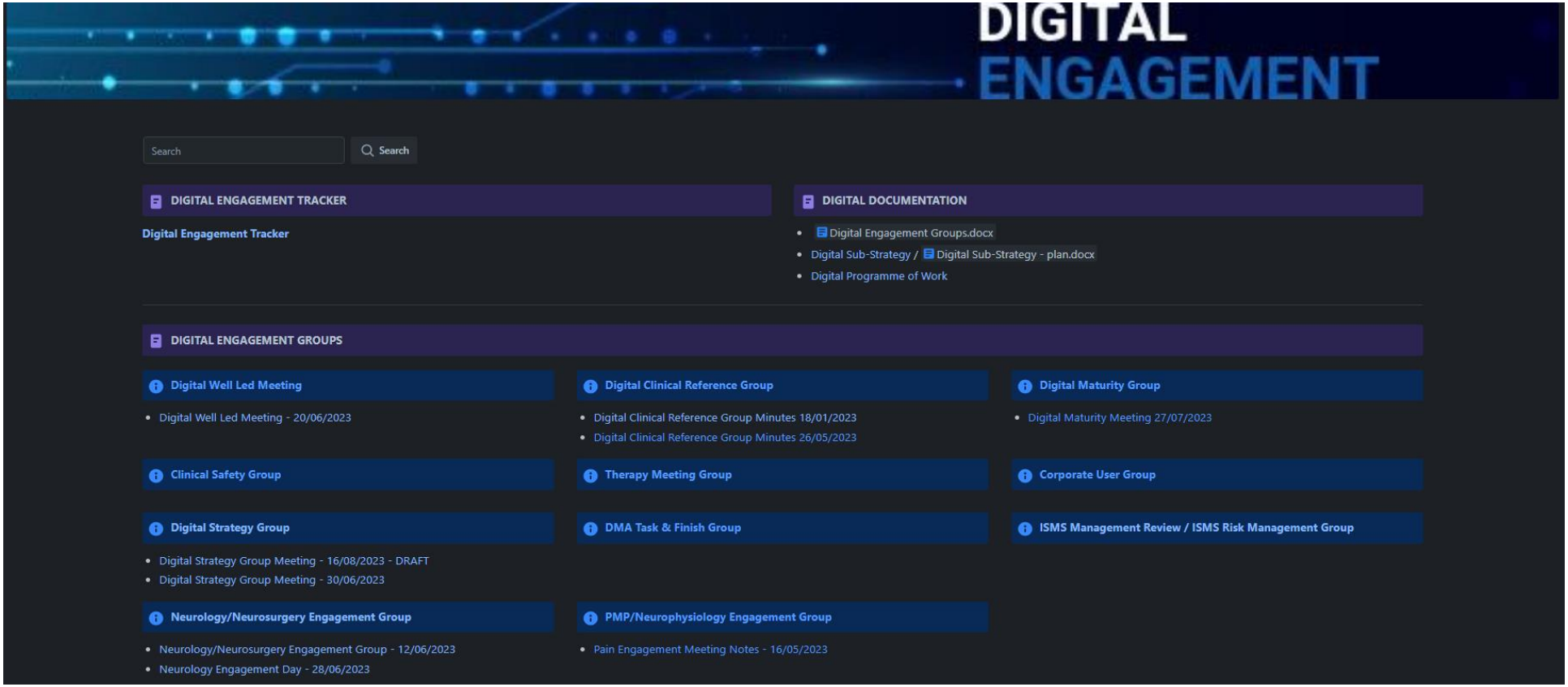
Author: **Justin Griffiths, Chief Digital Information Officer**
Date: **24/08/2023**

Appendix 1

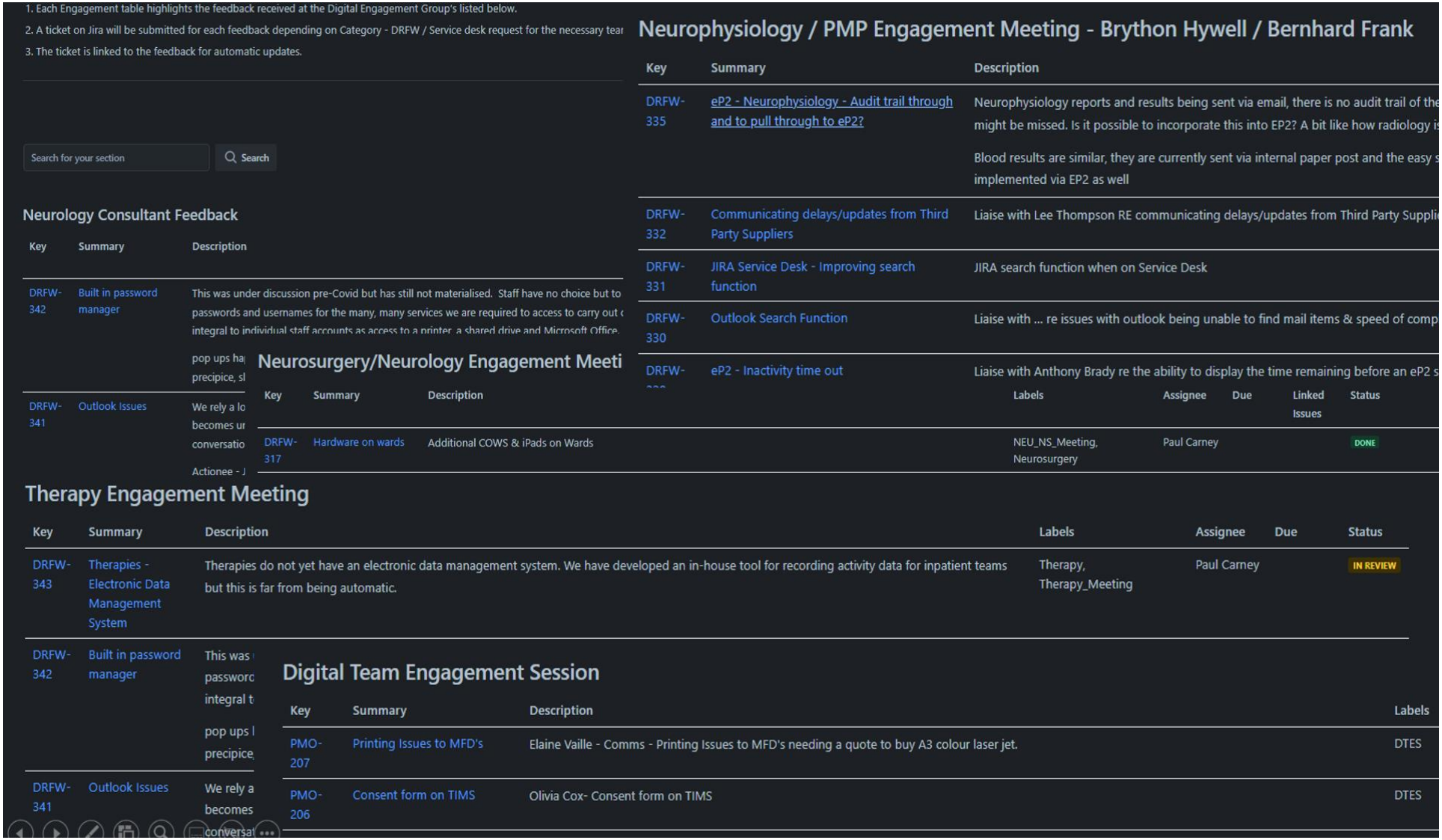
Digital Engagement Portal

Digital Engagement Portal which is now launched in pilot stage and shows all issues raised in sessions/meetings, as well as all meeting actions and timelines of all Digital projects and programmes.

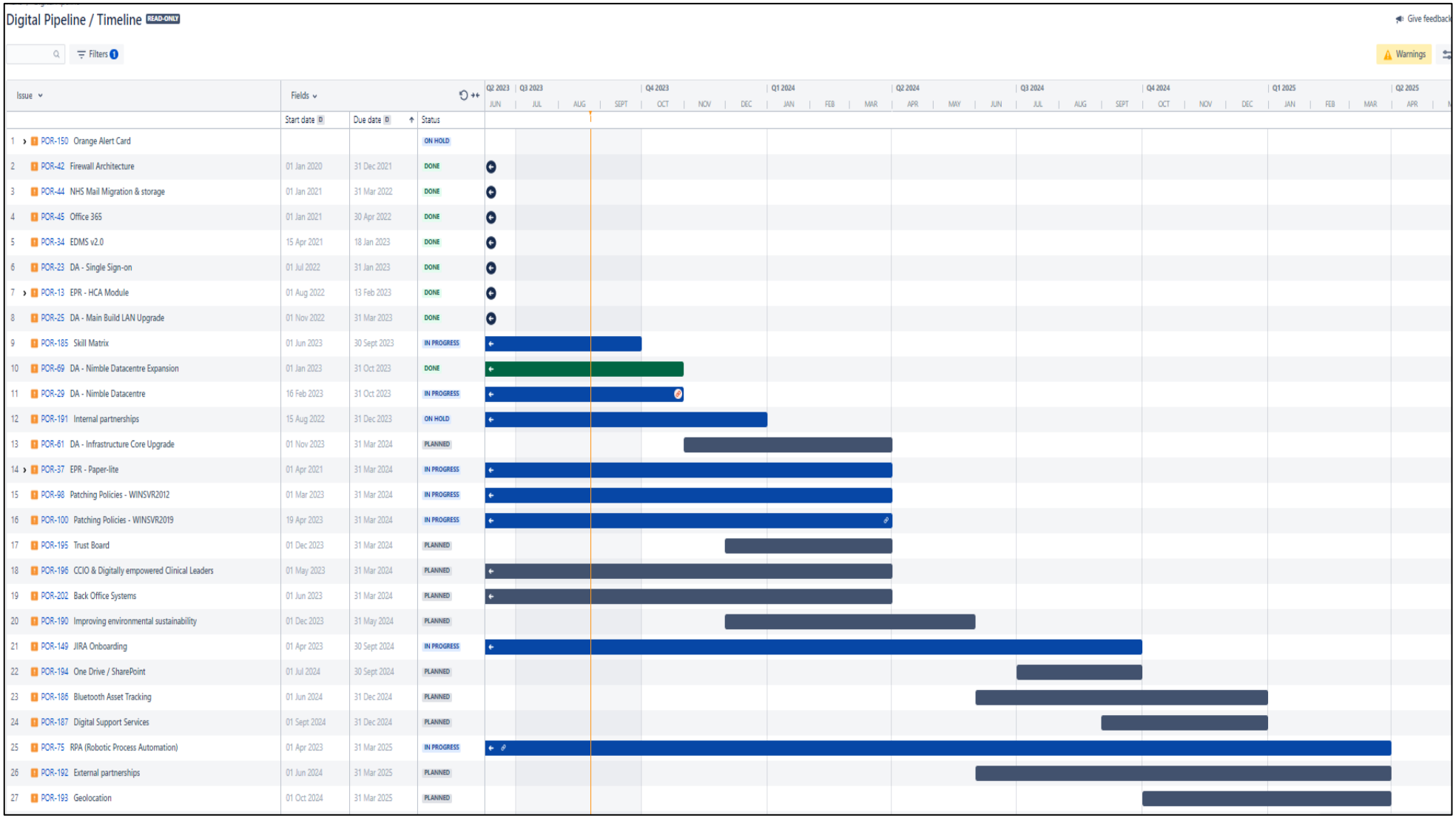
https://www.digitalatcore.com/ *(requires username and password)*



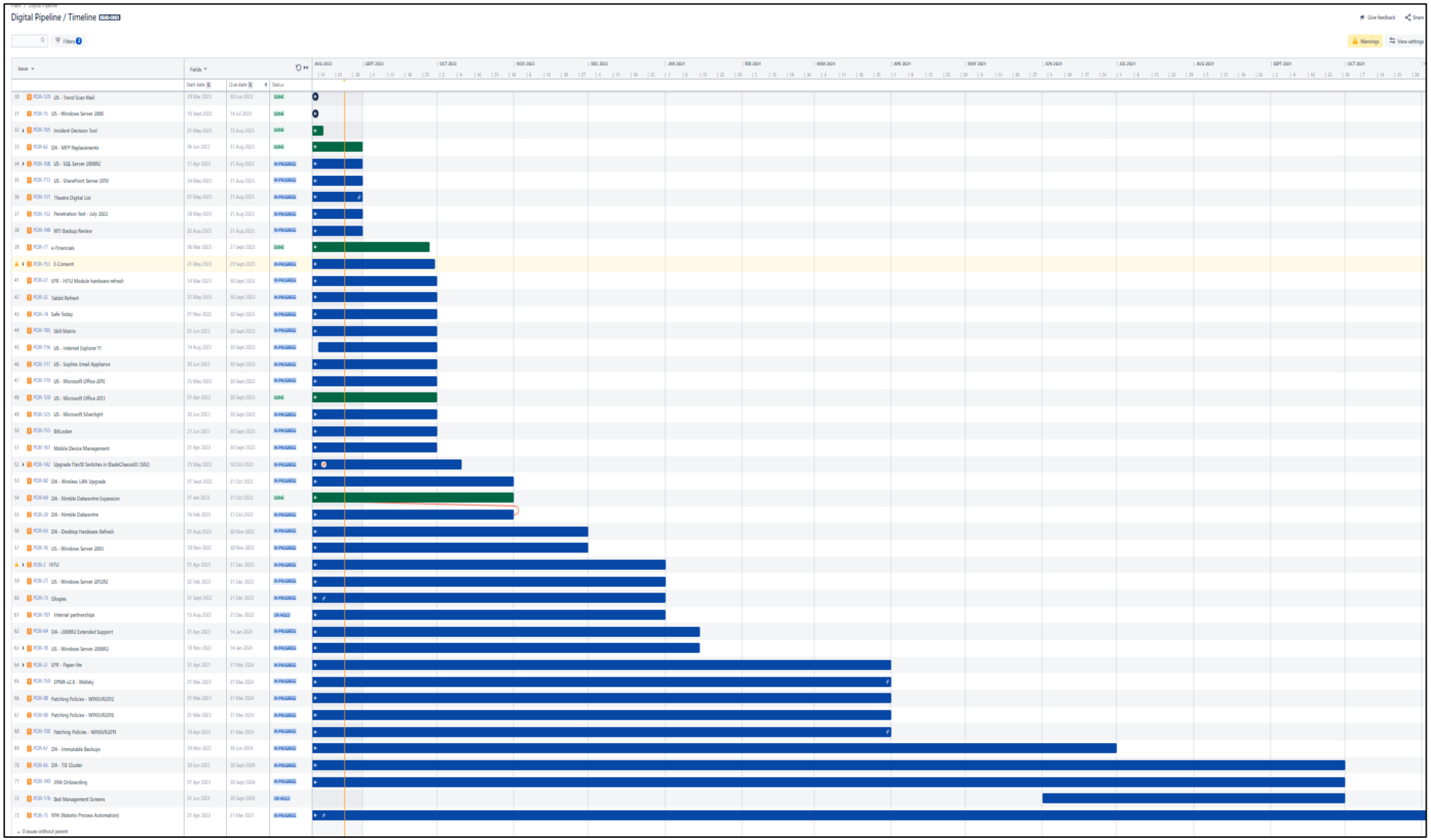
All Meetings/Sessions and common/linked actions accessible via Portal Homepage



All Issues in one place under specialty or linked if common issues, dashboard shows live changes, statuses and updates



Live Gannt of all Digital Sub Strategy programme



Live Gannt of all Digital Projects and Programmes

Appendix 2

The Walton Centre NHS Foundation Trust
Strategy 2022 to 2025

Digital Sub-Strategy H1 23/24 Update

Digital

Developing and implementing industry-leading digital solutions for our patients and our people

Strategy	Maps to	Where we want to be	How we will get there	Digital Enabler	Delivery Date	RAG Status
Digital Infrastructure	• Improve Care	• Existing digital infrastructure is optimised to its full potential. Our core infrastructure remains 'fit for purpose' and adheres to all relevant national and system wide standards and expectations. • Resilience and cybersecurity are keystones in the digital delivery of services as the move to a digital at core organisation.	• By continuing to horizon scan to identify how that infrastructure can be optimised to deliver faster, more reliable and resilient services to underpin patient care and back-office services. • We will put in place a rolling replacement programme for our digital infrastructure (including end user devices) to ensure it is standardised across the organisation and remains fit-for-purpose for supporting.	**POR-42 – Firewall Architecture**	**Q1 - 2023**	**DELIVERED**
				POR-98 – Patching Policies	**Q4 - 2024**	

			delivery of the Trust's strategic ambitions. • We will consolidate our on-site server infrastructure into the new Nimble architecture to improve resilience for core clinical systems and provide a greener architecture. • We will ensure that all new systems are deployed in 'the cloud' where possible to ensure we adopt a cloud first approach going forward (in line with national guidelines). • We will ensure that all future technical infrastructure designs adhere to the NHS Digital architecture principles and standards (including interoperability and data sharing standards)	**POR-61 – Infrastructure Core Upgrade**	**Q1 - 2024**	
				POR-29 – Nimble Datacentre	**Q4 – 2023**	
				POR-69 – Nimble Datacentre Expansion	**Q4 – 2023**	
				POR-25 – Main Build LAN Upgrade	**Q1 Q2 – 2023**	**DELIVERED**
Clinical Systems	• Safe Practice	• A paper light organisation before the end of this sub-strategy period with an ambition of achieving HIMSS. • Stage 6 and beyond as soon as is practical. Other Trusts as required. • Developing an EPR module specifically targeted at data capture for Health Care Assistants (HCAs)	• Further exploit our existing in-house Electronic Patient Record (EPR) system by ensuring that it integrates. • with other internal and external systems so that those systems are available in EPR in patient context • without having to open and login to those systems independently. • We will develop and deploy functionality to allow us to	**POR-37 – Paper-Lite**	**Q2 – 2024**	
				POR-23 – Single Sign On	**Q1 – 2023**	**DELIVERED**
				POR-13 – HCA Module	**Q1 – 2023**	**DELIVERED**

		• Implementing an e-consent module into EPR. • Create Orange Alert card system that integrates into EPR. Allow access to external systems in patient context. • To have a standalone Electronic Document Management System to view historic patient records whilst accessing live clinical systems. Digitise remaining forms that can be moved	achieve our paper-light ambition. This will include. but not limited to:Developing an Intensive Care Unit (ICU) system linked to EPR, but which can also be used stand-alone by	**POR-150 – Orange Alert Card** OPS team / Clinical to decide on how functionality is to be delivered		
				POR-34 – EDMS	**Q1 – 2023**	**DELIVERED**
Non-Clinical Systems	• Well-led	• Office 365 used and fully expanded to support collaborative working in all parts of the organisation.	• Further exploit our investment in Office 365 through increasing our in-house training provision and rolling • out a support programme to clinical and non-clinical services as resources become available from Cheshire and Merseyside wide initiatives.	**POR-45 – Office 365**	**Q1 – 2023**	**DELIVERED**
				POR-44 – NHS Mail Migration & Storage	**Q1 – 2023**	**DELIVERED**

PMO	• Ensure Smart Foundations	• Jira is used to support our staff (and potentially our patients and their carers in the future) to thoroughly engage with the digitisation of services as they develop.	• We will further exploit our existing Jira Programme Management tool by: Ensuring Jira is used for all IT service management workflows within the digital team. • Linking Jira with our service desk system so that requests for work (such as changes to the EPR system) have full visibility to the requester and can be easily audited. • Identifying opportunities for Jira to be used by the wider organisation, working with relevant clinical and non-clinical teams to support future up-take outside digital. • Adopting Information Technology Infrastructure Library (ITIL), which is a recognised set of detailed. practices for IT functions within an organisation. • Adopt ISO9001, which is the International Standard for Quality Management Systems to ensure management throughout the digital lifecycle of programmes, projects and delivery. • ServiceDesk will align with International ServiceDesk Institute standard.	**POR-149 – JIRA Onboarding**	**Q3 – 2024**	
Back Office Systems	• Well Led	• Our back-office systems meet current and future needs of our staff.	• We will work with corporate service teams to identify requirements and implement digital solutions that meet their current and future needs, providing technical support where appropriate. • We will expand into Robotic Process Automation (RPA) to help automate	**POR-202 – Back Office Systems**	**Q4 – 2024** **(To be delivered via SPMO)**	

			repetitive tasks and bring rich data into relevant data stores.			
Digital Support Services	• Well Led	• Providing industry standard, high quality digital support services to the whole organization Ensuring a catalogue of services is in place and updated to offer the organisation an OLA to manage expectations	• We will achieve Cyber Security Essentials Plus accreditation to align our existing ISO27001 international standard accreditation for information security with the cyber security requirements of NHS Digital. • We will ensure that all the applications and systems we develop in-house or bring in through a third party are DCB0129/DCB0160 and DTAC clinical risk management standard compliant moving forwards. • We will ensure that the implementation of new systems and upgrades to any existing systems are undertaken in line with 'best practice' clinical safety standards (as outlined in the DCB0160 clinical risk management standard). • We will achieve ISO9001 accreditation for our quality management systems associated with software development. • We will ensure all our digital staff are trained to ITIL Foundation standard as a minimum and we will implement ITIL principles in all areas of our IT service management process.	**POR-187 – Digital Support Services**	**Q3 - 2024**	

Social responsibility

Strategy	Maps to	Where we want to be	How we will get there	Digital Enabler	Delivery Date	RAG Status
Increasing digital inclusion - Digital access for patients	• Empower Citizens	• Digital inclusion will be prioritised in all our digital programmes and initiatives. • For our patients, we will ensure either help is provided (be that hardware, software or training), or will provide a non-digital equivalent (to enable equity across our population)	• We will utilise the Cheshire and Merseyside ICS Digital Inclusion Impact Assessment toolkit to ensure that our current and any future systems take into account all relevant digital inclusion issues when specified, deployed and supported. • We will access the ICS wide IT equipment recycling scheme to provide access to equipment for our most digitally excluded patients. • We will provide support to patients to develop skills for themselves and their carers through development, in conjunction with partners, of a 'digital buddies' support scheme and the establishment of digital carers hubs, as laid out in the People Sub strategy	**POR-188 – Increasing digital inclusion - Digital access for patients**	**Q3 - 2025**	
Digital solutions for patients	• Improve Care • Empower Citizens	• We will provide additional tools for our patients to enable them to be more empowered regarding their care. This will include: Electronic access to their patient record, including clinical correspondence. • The ability to book and change appointments electronically. • Access to relevant information, advice and guidance online.	• We will implement a Patient Engagement (Empowerment) Portal solution as an organisation that allows a patient to access their record and other relevant services through the NHS App as the front door. • We will support clinical services in the identification, implementation and integration of high-quality patient facing apps to support clinical pathway transformation.	**POR-189 – Digital solutions for patients**	**Q3 - 2025**	

		• Tools to allow for electronic input of patient reported outcome and experience measures (PROMs and PREMs). • Accredited mobile phone apps and remote monitoring solutions that integrate with pathways of care to help patients better manage their own health and well-being. • These developments will align with national and local digital patient empowerment initiatives, in particular the commitments made through the 'Plan for Digital Health and Social Care' for the NHS App to be the digital front door to NHS services in future.	• We will work with clinical teams to identify where remote monitoring solutions could potentially benefit patient care delivery and support those teams implement such solutions successfully, using approaches and systems already in use in Cheshire and Merseyside where possible.			
Improving environmental sustainability	• Smarter Foundations	• Continue to be one leading NHS organisations that uses digital innovation to support sustainability	• We will further expand the use of our print saving software across the whole Trust by introducing this into all remaining printers and on newer Multi-Functional Devices (MFDs), further reducing the amount of ink and paper used. • We will introduce enhanced power management software to reduce power usage by desktop and laptop computers without affecting user experience, completing the decommissioning of all standalone servers and complete the introduction of Virtual Machine (VM) architecture where possible to reduce the amount of hardware and air conditioning required in our data centres.	**POR-190 – Improving environmental sustainability**	**Q1 – 2024**	

			• We will develop and implement a 'green cloud first' approach to reduce our on-site data centre requirements even further. • We will develop digital tools to effectively monitor the organisation's true carbon footprint, including monitoring the impact of hybrid working. • We will proactively support the digital commitments in the ICS Green Plan through involvement in local, Place and ICS-wide activities. • We will continue to innovate to address sustainability challenges and support other organisations in rolling out solutions developed at our Trust where appropriate.			

Collaboration

Strategy	Maps to	Where we want to be	How we will get there	Digital Enabler	Delivery Date	RAG Status
Internal partnerships	• Support People • Smarter Foundation	• Standardised processes, tools and approaches to requirements gathering, business case development, procurement, implementation and benefits delivery from digital solutions. • Work towards a digital workforce plan further engage with the organisation via groups and	• Build on the PMO tool development through Jira and enhance with industry standard processes and approaches to support joined up internal partnership working and co-creation of fit-for-purpose clinical and back-office solutions. • Embed a service catalogue for the organisation that helps demonstrate the function and acts as OLA.	**POR-191 – Internal Partnerships**	**Q3 - 2023**	

		demonstrate digital is a critical business partner. • Create a catalogue of services and how we intend to deliver those services concisely to ensure clarity of the digital function to the organisation.	• Deliver monthly reports to key stakeholders showing ongoing digital performance and potential issues through JIRA dashboards. • Display the whole digital transformation programme through live JIRA dashboards			
External partnerships	• Healthy Populations	• Sending and receiving structured clinical information to and from relevant Place based and system-wide Shared Care Record systems to support both continuity of care and cross-organisational care pathways. • Continue to be an active partner in the region and nationally for digital health.	• We will share clinical data from our in-house EPR system with relevant shared care record solutions at Place and ICS level, in particular eXchange (ICS wide) and future shared care record developments at Liverpool Place. • We will ensure that information from external shared care record systems is available in EPR in patient context without having to open and login to those systems independently	**POR-192 – External Partnerships**	**Q1 -2025**	

Research and innovation

Strategy	Maps to	Where we want to be	How we will get there	Digital Enabler	Delivery Date	RAG Status
Robotic Process Automation (RPA)	• Ensure Smart Foundations	• Minimised use of repetitive, manual human involvement in our back office and clinical administration processes, particularly in relation to HR, finance and patient booking admin pathways.	• Based on the outcome of the discovery work, we are interested in implementing the RPA solution being supported through the ICS to help us to improve the efficiency of relevant back-office processes and other administration processes. Not reinventing the wheel but sharing bots between organisations to help	**POR-75 – Robotic Process Automation (RPA)**	**Q4 – 2025** **(To be delivered by SPMO)**	

			each other with common issues and learning			
Bluetooth asset tracking	• Improve Care	• We are interested in potential uses of this technology including undertaking automated data collection in process flow studies in theatres and the accurate identification of highly mobile equipment in the hospital setting, saving time in finding that equipment when needed.	• We will undertake some initial research to identify potential products for trial and evaluate in a number of different clinical settings	**POR-186 – Bluetooth Asset Tracking**	**Q3 – 2024**	
Geolocation	• Improve Care	• We are interested in using geolocation solutions to improve our patient experience, providing targeted information for our patients via a mobile phone app on arrival at site which updates whilst they are moving around The Walton Centre. Internal Device management.	• We will undertake some initial research to identify potential products for trial and evaluate in a number of different clinical and patient settings.	**POR-193 – Geolocation**	**Q3 - 2025**	
One Drive/SharePoint	• Support People	• We are looking into moving all shared drives to Onedrive and Sharepoint to allow data freedom of movement and also look at managing retention periods of documentation.	• We will undertake research with NHS Digital to look at how we can be involved within this programme and lessons learnt from other organisations.	**POR-194 – One Drive / SharePoint**	**Q2 - 2024**	

Leadership

Strategy	Maps to	Where we want to be	How we will get there	Digital Enabler	Delivery Date	RAG Status
Trust Board	• Support People	• Common, high level of understanding of the 'art-of- the-possible' through digitally-enabled change.	• We will ensure that our Trust Board has received the NHS Providers 'Digital Boards' training programme to support senior ownership of the digital transformation agenda in the Trust.	**POR-195 – Trust Board**	**Q3 - 2024**	
CCIO & Digitally empowered Clinical Leaders	• Well Led	• More devolved clinical leadership of the digital transformation agenda across the Trust.	• We will implement a 'digital champions' programme (in line with the Health Education England Digital Champions Programme) to ensure that all local teams have at least one person who is engaged, supported and has time to sup-port achievement of the digital priorities outlined in this strategy and support Digital Work-force/Inclusion.	**POR-196 – CCIO & Digitally empowered Clinical Leaders**	**Q3 - 2023**	
External partnerships	• Healthy Populations	• Sending and receiving structured clinical information and various formats of media content to and from relevant Place/ICS based and system-wide Shared Care Record systems to support both continuity of care and cross-organisational care pathways.	• Support and be active in the Digital Diagnostic Regional Programme to bring together a shared single vision of diagnostic care	**POR-192 – External Partnerships**	**Q3 - 2025**	

Education, training and learning

Strategy	Maps to	Where we want to be	How we will get there	Digital Enabler	Delivery Date	RAG Status
Skill Matrix	• Support People	• For our staff, we will provide training and support to individuals in the Trust in conjunction with our HR and training function. • To help support staff with digital literacy both using the tools within the organisation but also wider digital literacy to support digital inclusion, cyber awareness and to utilise digital tools effectively in their lives. • To help enable and support a future workforce with the right skills to support a Digital at Core organisation.	• We will ensure that all staff have the appropriate skills to undertake their role by implementing standardised digital literacy and digital confidence training that supports the Health Education England Health and Care Digital Capabilities Framework requirements. • To support digital Inclusion within the workforce by actively being involved with Health and Wellbeing Hub in offering digital support to the workforce and work with providers to recycle hardware to support workforce in work poverty	**POR – 185 – Skill Matrix**	**Q2 Q3 – 2023**	

Report to Board of Directors
7 September 2023

Report Title	Estates, Facilities and Sustainability Substrategy Update
Executive Lead	Lindsey Vlasman, Chief Operating Officer
Author (s)	Rebekah Phillips, Associate Director of Performance Stephen Holland, Head of Estates
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Estates, Facilities and Sustainability Substrategy update
- Q2, Q3 & Q4 delivery and ongoing workstreams

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

- Meet with divisions to understanding planned service improvements requiring Estates & Factilities (E&F) support
- Meet with various design professionals for capital scheme developments
- Establish plans for future capital & revenue expenditure

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Quality of Care	Estates & Facilities	Quality	Compliance

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

007 Capital Investment	006 Prevention & Inequalities	004 Operational Performance

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Estates, Facilities & Sustainability Substrategy Update

Executive Summary

1. This paper has been developed to provide the Board with an update as to the progress of the Estates, Facilities and Sustainability sub-strategy, (see Appendix 1), together with both an updated Sustainability Programme (Appendix 2) and an updated the Estates & Facilities 2023/24 work programme (see Appendix 3).

Background and Analysis

2. The Estates, Facilities and Sustainability sub-strategy was approved in March 2023 and subsequently designed, consistent with the Trust Strategy.

3. An update of the Substrategy, and associated documents, was presented to Business Performance Committee in July 2023

4. As outlined in the Substrategy, the Estates, Facilities & Sustainability Team have developed an implementation plan for year 1; however, this is based on the work schedule and maintenance backlog plan for the Estates, Facilities and Sustainability team only. These plans can be found in appendix 2 & 3.

5. Upon completion of individual departmental service developments, further planning will be aligned to the Estates, Facilities and Sustainability implementation plan.

6. The sub-strategy aims to meet, and deliver, Trust capital ambitions.

Conclusion

7. Divisional service strategies are expected to be completed in quarter 2, following which assessment and prioritisation will take place through the current governance process to determine those that most effectively meet the Trusts strategic ambitions.

8. Where applicable, the schemes will be identified on the Estates, Facilities and Sustainability implementation plans, providing a masterplan for the delivery of the sub-strategy.

Recommendation

To note

Author: Rebekah Phillips and Stephen Holland
Date: 29/08/2023

Appendix 1
Estates, Facilities and Sustainability Sub-strategy

Appendix 2
Sustainability Work Programme 2022/23

Appendix 3
Estates & Facilities Work Programme 2022/23

Estates & Facilities Strategy

2023 - 2028

The Walton Centre
NHS Foundation Trust
Excellence in Neuroscience

1 Version 3 – August 2023
Steve Holland
Rebekah Phillips

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1 Estates & Facilities Strategy Overview

The Estates and Facilities (E&F) Strategy is intended to provide an accessible explanation of the priorities the Trust has for the management and improvement of its property and buildings, as well as our “soft” facilities management, and the potential for both E&F to flex and develop to support the needs of the Trust.

It is one of the sub strategies supporting the Trusts overarching strategy. The information available in this strategy satisfies the requirements of the Department of Health and Social Care’s Estate Code in relation to its expectations of a good estate strategy.

3 Version 3 – August 2023
Steve Holland
Rebekah Phillips

2 Welcome

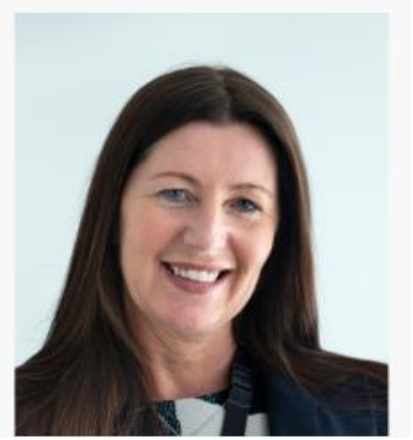
Our Estates and Facilities Strategy will guide improvements to the built environment across the Trusts property portfolio over the next five years. Implementation of our E&F strategy will demonstrate commitment to our organisations strategic vision of delivering *Excellence in Neuroscience*.

The Trust wants to ensure that all sites, where we provide a service for patients, and staff, are functional, and of a sufficient standard to ensure safety and a positive experience. An efficient, well designed, and well-maintained estate is at the heart of positive patient experience and ensuring our patients receive the best possible care. It is also a powerful motivator for staff, aiding recruitment and retention and a positive work experience.

Whilst the more modern, sustainable and energy efficient, Sid Watkins Building (SWB) is 7 years old, the main Walton Centre (WCFT) building is now 24 years old, signifying mandatory lifecycle works to be undertaken. This challenge is amplified by the rising demand for services and often high occupancy rates across the Trust as well as the effective management of available capital.

New and exciting ambitions for the future of our services have been set out, many of which require new or reconfigured space and continuous review of our encompassing facilities. Planning for these schemes requires careful consideration and coordination to ensure the limited resources available to the Trust are used effectively.

The E&F strategy provides a vision for the future and sets out key principles that will guide our priorities over the next five years and beyond. It is consistent with, and supports the ambitions set out in the overarching Trust Strategy.



Lindsey Vlasman,
Chief Operating Officer

The E&F Strategy will support our ongoing financial and environmental sustainability strategies and provide foundations for the delivery of our future clinical strategies.

The E&F Strategy supports our desire to maintain anchor institute recognition for Cheshire & Merseyside and the wider population, for which we serve. This sub-strategy is supported by a series of plans that depict how our estate may develop over the plan period.

3 Introduction

This Estates and Facilities (E&F) Strategy sets out our ambitions for the next five years to ensure that the Trust's estate meets the needs of patients as well as the needs of our staff. Our estate is a key enabler to the delivery of the Trust's future vision, and the objectives have therefore been aligned with the Trust strategic objectives for the next five years. The sub-strategy is an essential tool in ensuring The Walton Centre NHS Foundation Trust (WCFT) is providing value for money, high quality buildings, that maximise clinical efficiency and functionality and, in a condition, able to deliver modern patient-focused healthcare services in a safe and secure built environment.

Our aim is to be the number one standalone Trust across the UK for delivering "Excellence in Neuroscience" by ensuring we deliver the best quality care to our patients and their families.

An estates and facilities strategy cannot be developed in isolation. Rather, it is an integral part of service planning. It is produced from an evaluation of existing performance, guidance from key national and regional bodies and the objectives and service strategies of WCFT identified to deliver the Five Year Forward View (5YFV) and envisaged transformation agenda.

It aims to provide a detailed plan to enable the estate to be developed, setting out how the management and investment in WCFT facilities will be planned and prioritised.

The E&F strategy will be supported by an implementation plan and programme of service developments. The implementation plan will identify key projects, outcomes and milestones the Trust is committed to achieve over the next five years. The proposed programme relies on sufficient funding being identified and schemes being supported by robust business cases as they are developed.

4 Creating the context

The Walton Centre is a leader in the treatment and care of neurology and neurosurgery, placing the patient and their family at the heart of everything we do. We are the only specialist neurosciences Trust in the UK and we are proud to be rated as an 'outstanding' Trust by the Care Quality Commission (CQC). Originally formed in 1992, the Trust received Foundation Trust status in 2009. We serve a catchment area of 3.5 million people across Merseyside, Cheshire, Lancashire, Greater Manchester, The Isle of Man, North Wales and beyond. We are partnered with 18 NHS Hospitals as part of our satellite model and our commitment to providing care closer to home. Our 'Walton Clinics' model is now on 44 sites.

With approximately 1450 staff, The Walton Centre treats more than 127,000 outpatients and 18,000 inpatients each year. Our Neurosurgery Division is one of the biggest and busiest in the UK, performing around 3,000 elective surgical cases, 2,000 emergency surgical cases and 1,000 day-cases per year. The Division of Neurology delivers over 75,000 outpatient appointments and treats over 4,500 inpatients per year. We are also host to the regional complex rehabilitation service.

Our Neuroradiology service is the most comprehensive in the UK with five MRI scanners, including an iMRI; two biplane intervention rooms and two of the most advanced CT scanners available as well as a fluoroscopy scanner. We perform over 40,000 scans per year. We have 8 theatre suites, a dedicated recovery area and day-case facilities for both surgical and medical patients.

The main building was originally purpose-built in 1998. We have 119 acute beds, 30 complex rehabilitation beds, 10 acute rehabilitation beds and it is one of only a few centres in the UK with a dedicated, 20 bedded neurocritical care unit. The Sid Watkins building (SWB) opened in 2015 and houses the Cheshire and Merseyside Complex Rehabilitation Unit, together with outpatient facilities, the 'Home from Home' centre for use by patient's families, and a dedicated Medical Education Suite. In addition, SWB plays host to a 12 bedded Brain Injuries Unit, managed by the neighbouring mental health Trust, Mersey Care.

5 National Policy Landscape

Both national policy and local policy mandate will remain key drivers in helping to shape and deliver our ambitions over the next 5 years. Those most notable include:

- The Carter Review (2016) which resulted in more robust benchmarking to identify and tackle unwarranted variation in costs between comparable Trusts.
- The Naylor Review (2017) which established the foundation for a more strategic approach to the NHS Estate.
- The NHS Long Term Plan (2019) which requires the NHS to make better use of capital investment and its existing assets to drive transformation, and focus on improving safety, transforming the patient pathway and working environment, with resulting benefit of reducing future revenue operating costs.
- Health Building Note 008 (Estate Strategies) Department of Health and Social Care guidance on the preparation of Estate Strategies.
- The Sustainability and Transformation Partnership (STP) is the chosen means for delivering transformation and they are supported in the planning process jointly by NHS England and NHS Information (NHSEI).

As future strategies, policies and mandates develop the Trust will adapt and adopt the associated activity as part of this strategy.

In addition, the Trust continues to play an active role in the ICB & ICS, sharing good practice and identifying opportunities for closer working between organisations across the region, particularly neighbouring Trusts.

6 Where we are now?

The current performance of the estate is based on the analysis of a wide range of primary and secondary data including:

- Patient Led Assessments of the Care Environment (PLACE) surveys – this assessment is focussed on food, cleanliness, accessibility, condition, privacy and dementia.
- Care Quality Commission inspection reports
- Patient satisfaction surveys
- Premises Assurance Model (PAM) analysis of key data that compares the performance of the Trust
- Estates Returns Information Collection (ERIC)
- Greener NHS returns
- Fire inspections
- Internal reporting mechanisms i.e., helpdesk reports

Key headlines for The Walton Centre Estate

Patient experience

The Estates & Facilities department works closely with the Trust Patient Experience team to ensure both the patient journey and stay are positive experiences and ones that are representative of the Trust values.

Value for money

Detailed analysis is undertaken via Estates Return Information Collection (ERIC) data that provides a benchmark assessment of performance. These have been used to identify areas that are successful and where improvement can be made when compared against the 'best in class'. A summary of similar sized organisations within the C&M catchment area is detailed in table 1 below. This provides specific estates and facilities data in comparison to 2 other, similar Trusts, within the region. However, it can be seen from the data that certain inconsistencies appear to prevail during the collation and submission of information.

We continue to engage with the annual NHS Estates Return (known as ERIC) which informs the national Model Hospital benchmarks established following the Carter Review. The Trust is seeking to engage proactively in this process to help identify further areas for improvement.

In addition to the data within table 4, E&F work closely with Trust Procurement to ensure both purchasing and contracting is carried out within both Trust Standing Financial Instructions (SFI's) and procurement legislation.

Furthermore, E&F, together with Procurement, ensure that both sustainability and social value principles are constant themes through all our processes.

Table 1 – Comparative estates and facilities data for 21/22

Site Name	Estates and property maintenance (£)	Grounds and gardens maintenance (£)	Electro Bio Medical Equipment maintenance (£)	Other Hard FM (Estates) costs (£)	Other Soft FM (Hotel Services) costs (£)	Management (Hard and Soft FM) costs (£)	Total	Gross internal floor area (m²)	Cost / m2
LIVERPOOL HEART AND CHEST HOSPITAL	1,176,914	25,296	1,720,883	0	1,048,667	295,845	4,267,605	31,062	137.39
LIVERPOOL WOMENS HOSPITAL	1,039,000	26,000	227,894	3,000	688,136	276,223	2,260,253	32,135	70.34
WALTON CENTRE FOR NEUROLOGY & NEUROSURGERY	1,232,202	12,947	128,823	78,938	834,091	81,748	2,368,749	28,595	82.84

Although the above benchmarking data is available, and is a mandatory section within this sub-strategy, it should be noted that comparison for 'best in class' using this method does not take into account the huge variances evident as a result of the different requirements by specialty, equipment, in or outsourcing and geographical location. Specific, individualised benchmarking is carried out, as required, and based on the workflow requirements in any given moment in time.

Functional Suitability

All areas of the Trust, both main Walton Centre and Sid Watkins building achieve a high level of functional suitability with the whole estate being classed as A or B using NHS England guidance document "Land and Property Appraisal".

Space

The total size of the combined estate is 28,595m2 with a clinical and non-clinical split of 70.04% and 29.96% respectively, with a total occupied area of 95.26%. The remaining unoccupied space being 2 areas of fallow space within the Sid Watkins Building on the 1st and 2nd floors respectively.

The Trust is currently undertaking an exercise looking at the need to increase Outpatient Department (OPD) capacity within The Walton Centre. An exercise will be undertaken to look at current usage of the area to understand how much additional capacity is required, then a review of the fallow space on the 1st floor in Sid Watkins Building will be completed if further capacity is required, this may involve moving other areas as part of this exercise.

Office space allocation is another work stream currently underway with a full review of office accommodation and usage suitability ongoing.

Quality

As identified above, the estate is in good overall condition and requires a general level of maintenance to upkeep along with a robust planned preventative maintenance programme.

Additionally, maintenance activity needs to be supported by a programme of capital investment in line with the Trust's backlog maintenance plan.

Statutory compliance

The Trust is compliant with all statutory duties except for critical ventilation plant.

The Trust is aware that the ventilation plant to Theatres 1 to 5 is not compliant with HTM 03-01. The Trust has allocated funding for the affected ventilation plant to be replaced with works planned to commence in Q4 of financial year 23/24. Theatres will be refurbished, with the remaining planned for the following years.

Further to this, the backlog maintenance plan has a full replacement programme of air handling units greater than 20 years old, planned thereafter. This programme will be undertaken according to the risk-base, with more critical areas e.g. Radiology Intervention rooms, being categorised as priority.

Environmental

Table 2 identifies Trust energy performance in year 22-23, whilst table 3 identifies Trust waste data in year 23-24. The energy data, both gas and electric, is subject to robust scrutiny due to the rapidly increasing cost of each commodity, at present.

Car Parking - The Trust has a total of 106 spaces, 30 of which are disabled bays. This allocation is reserved for patients and visitors, with The Walton Centre staff able to park on the wider Aintree campus, for a monthly fee. The Trust continues to have challenges with both patient and staff car parking.

This problem is compounded by the wider Aintree site now being controlled via Automatic Number Plate Recognition (ANPR) which means people seen entering these zones will be obliged to pay. However, currently, the main Walton Centre car park is not ANPR and therefore, represents the largest area on the whole campus not to be so, presenting anyone the opportunity to park undetected.

A scheme is currently underway to install ANPR on main Walton Centre car park and this should be operational in Q3 2023.

Sustainability – The Trust, along with others, is tasked with meeting the Government's target of achieving net-zero by 2050. However, NHS England has set all Trusts a more challenging set of targets which are detailed below:

- For the emissions we control directly (the NHS Carbon Footprint), we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- For the emissions we can influence (our NHS Carbon Footprint Plus), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

In response to this the Trust is collaborating with all other Trusts within the region to produce a Green Plan. The Walton Centre's Green Plan was submitted to the Integrated Care Board (ICB) in January 2022, to be included within a wider ICB Green (Sustainability) Plan.

The Trust has also commissioned a Decarbonisation plan which is currently being undertaken by external consultancy, Mantis Energy. It is anticipated that the final plan will focus solely upon The Walton Centre, specifically in relation to airtightness, with recommendations of improving the thermal performance of the building fabric. The plan will also consider the potential for alternative energies, solar, wind, ground, and air source heat pumps, etc. Such outputs from the report will form the basis for future Salix funding application.

Furthermore, in order to capture the above, as well as many other elements, the Trust has now established its own Sustainability Group and are awaiting the recruitment of a sustainability lead who will be able to drive this agenda forward.

Table 2 – Trust Energy data 221/23

Energy	Value
Total Electric	5,609,948 kWh
Total Electric cost	£2,164,688
Total Gas	717,087 kWh
Total Gas cost	£71,564
Additional energy costs (Heat from CHP plant)	£135,807

Table 3 – Trust Waste data 21/22

Waste	Value
Total Clinical waste –	51.47 t
Total Clinical waste cost -	£27,995
Total Offensive waste –	115.9 t
Total Offensive waste cost -	£24,811
Total Domestic waste –	150.46 t
Total Domestic waste cost -	£6,364
Total Recycled waste –	31.76 t
Total Recycled waste cost -	£6,364
Total Confidential waste –	69.2 t
Total Confidential waste cost -	£5,005

Table 4 – 5 year capital planning for maintenance backlog and lifecycle replacement

Scheme	Estimated cost £m
Phase 6 of Walton Centre heating replacement scheme	1.5
Building Management System (BMS) replacement	0.4
Theatres Air Handling Unit replacement and Theatre Upgrade	8.2
HITU Ponta Beam Replacement	0.45
HITU nurse and emergency call replacement	0.07
Air Handling Units 5/3, 5/4, 5/5, 5/6 2/1, 1/1, 3/1, 3/2, 3/3 & 4/1	1
Walton Centre fire alarm system	1
Roof re-covering	0.7
Replacement nurse and emergency call systems	0.5
Medical gas alarm systems	0.15
BMS Controls replacement	0.1
Chiller plant replacement	0.5
Electrical switchgear upgrade	0.25
Passenger lift refurbishment	0.4
Replacement air conditioning systems to Dott, Cairns, Caton and Lipton Wards	0.2
OPD Expansion programme	1
Ward refurbishment programme	6
CAT 3 cabinet replacements	0.2
Wayfinding upgrade	0.08

Table 5 – E&F Trust risks

ID	Opened	Division	Risk	Risk Type	Location	Risk Subtype	Risk level (initial)	Risk level (current)	Review date
394	14/01/2020	Corporate	If the Trust continues with the gaps in the fire compartment protection, then there is a risk of a breach of fire regulation and smoke and fire spread from one area to another. 17.12.21 SH - All fire compartmentation works are now complete and an ongoing contractor management process is in place	Divisional Risk 6-12	Estates Department	Capital Monitoring	High 16	Mod 8	30/09/2023
393	14/01/2020	Corporate	If in the event of a fire and the fire dampers in certain areas do not operate, there is a risk of smoke and fire being able to spread from one area to another (breach of Fire Regulation)	Divisional Risk 6-12	Estates Department	Legal	High 16	Mod 8	30/09/2023
220	07/04/2022	Neurosurgery	If the AHU fail completely, the department would be unable to run a Theatre list. Aging Theatre air handling units (AHU) are performing at below the recommended level of air changes per hour (affected theatres 1-5) and therefore running at below the compliant level for theatre.	Divisional Risk 6-12		Capital Monitoring	High 16	Mod 12	30/09/2023
21	01/02/2022	Neurosurgery	If adherence is not made to the appropriate controls set out in relation to pseudomonas, then there is a risk to patient safety and reputation.	Divisional Risk 6-12	Horsley - HDU	Environment	High 16	Mod 9	31/05/2023
894	25/01/2022	Corporate	If the current access control system continues to be very limited in capacity due to age, there is a risk that in the event of total system failure, access to all areas, including critical would be compromised which could lead to a risk for patient safety and care. 30/03/23 (SH) - the old system is now in a stable condition with limited problem. Therefore, risk score is being reduced accordingly. This is dynamic and will be kept under review	Board Risk 15+		Capital Monitoring	High 15	Mod 8	01/09/2023
737	19/11/2020	Corporate	If high levels of legionella (serogroup 1) in the Trusts hot water systems continues then, there is a risk to patient and staff safety.	Divisional Risk 6-12		Environment	High 15	Mod 10	31/05/2023
416	24/03/2020	Neurology	If waste is inapproriately disposed of in toilets of SWB (i.e paper towels) then there is a risk to blocked drains and flooding in the Complex Rehab Unit.	Divisional Risk 6-12	NRU	Environment	Mod 12	Low 3	30/09/2023
414	23/03/2020	Corporate	If the water feature within the courtyard bistro is not effectively maintained, then there is a risk of bacterial contamination.	Department Risk 0-5	Estates Department	Environment	Mod 12	Low 4	30/09/2023
200	02/06/2020	Corporate	If the lack of/poor quality estates maintenance, then there is a risk of building failure or engineering failure.	Divisional Risk 6-12	Estates Department	Capital Monitoring	Mod 12	Mod 8	29/12/2023

Condition

The Walton Centre Trust estate is split across 2 sites, The Walton Centre and the Sid Watkins building. The estate condition varies between the buildings due to age and functional use, The Walton Centre being 25 years old and Sid Watkins building, only 8 years old.

The Trust has a current 6 Facet Survey which identifies the main assets for replacement over the next 5 years. These are summarised in Table 4: A formal update to the 6 Facet Survey is due to be completed prior to the year end.

Soft Services Contract

The Walton Centre operates with all its “soft services” being outsourced via a single, all encompassing, contract. This contract was re-tendered toward the end of 2021 with the new contract commencing April 2022.

The contract was re-awarded to ISS who were also the previous incumbent. The new contract places more emphasis on delivery with a number of Key Performance Indicators (KPI) in place to allow the Trust to financially penalise where failings occur. This is managed via regular reporting mechanisms alongside formal contract review meetings.

National Cleaning Standards

NHS England/Improvement (NHSE/I) released the new National Standards of Healthcare Cleanliness (NSoHC) 2021, which was mandated for all Trusts to implement in April 2022. The Walton Centre has developed a robust plan to respond to the changing standards and worked with soft services provider, ISS, to implement.

The requirements for cleaning are somewhat different than those previously in place and the Trust is working closely with ISS to ensure the new cleaning standards are ineffective.

E&F have recently recruited a new member of the team whose responsibility will be to undertake the regular audits and manage the audits outputs through to completion and to ensure all mandatory requirements are implemented, for all wards and departments, whilst also ensuring continual engagement to confirm implementation of the new standards, and that they continue to meet their needs and requirements.

Waste and Dangerous Goods

The Trust has a legal responsibility, via several legislative and guidance documents, to manage the disposal of any waste the Trust generates and to ensure that records and consignment notes are kept in accordance with the regulations.

E&F has appointed an external specialist to ensure its legal responsibilities are fully discharged.

Risk

Table 5 identifies all the Estates related risks currently sat on the Trust risk register. These risks are subject to ongoing scrutiny at various committees throughout the year and, as such, are regularly updated to reflect changes.

7 Where do we want to be?

7.1 Our vision

Our vision is aligned to the Trust's ambition for the organisation:

> Estates, Facilities and Sustainability
>
> Taking a multidisciplinary approach to keep our patients, staff and visitors safe and comfortable within the environment whilst building on sustainable pathways of care conducive to growing our services and supporting the Cheshire & Merseyside region

Delivery of the vision will require a Trust-wide approach to the use of space and assets. It will require close collaboration across organisations, services and individual departments to realise synergies, adopting a flexible approach to design and use, and encourage more sharing. It will require that sovereignty over space is relaxed and decisions over how space is used are based on objective judgements about current service requirements and not simply possession or occupation rooted to past decisions.

This sub-strategy recognises that quality of care is enhanced by good design, by ensuring staff and contractors have the things they need where they need them. By minimising transfers and planning efficient patient pathways productively can be improved to make more time available for patient care.

At the same time, it is important that facilities maintain privacy and dignity and provide space to support staff wellbeing. The vision will require a patient centred approach so that the experience of our patients, from the time they arrive on site is a positive one.

This sub-strategy seeks to deliver against the very many urgent and pressing demands consistent with a modern-day acute hospital whilst ensuring flexibility for the future. Maintaining and developing an estate that can be adapted to accommodate new technologies and deliver new treatments. To support the pressures of an aging population with more complex health needs and enable integration of service delivery across the healthcare system.

The Walton Centre collaborates closely with our neighbouring Trust, Liverpool University Hospital (LUHFT), for a number of hard and soft services, including planned and reactive maintenance, out of hours emergency response, water sampling, site infrastructure (car parks, roads, lighting, electrical and oxygen supplies, etc…), energy procurement and management, funeral and laundry services. As such, the Trust, makes a financial contribution to LUHFT for such a share of such services.

Additionally, both Trusts collaborate in a Combined Heat and Power Plant (CHP) scheme to deliver more cost effective and energy efficient heat and power across the whole of the Hospital campus and work together, as a site, on various energy and sustainability projects.

The Trusts also have a knowledge sharing stream and well as the sharing of specialist training courses, where appropriate.

7.1.2 Strategic Principles

To support our vision, we have adopted 5 key principles. Although the estate may appear to be a static feature, the way in which it is used needs to be increasingly flexible. The following principles will be used to help assess how new ideas fit with the overall strategy and vision.

- Optimise the use of the built resource to meet clinical need

Property and buildings are a significant financial burden to the Trust and it is therefore imperative that space usage is understood and monitored. The cost of space will continue to be managed centrally but will increasingly be allocated to individual departments through service line reporting to ensure a clear link and inform service strategies. The use of the Sid Watkins Building will be reviewed with every attempt to ensure the space is maximised for clinical use rather than non-clinical use. This principle will ensure that premium space is utilised in the best possible way.

- Improve the stakeholder experience in relation to the estate

The estates strategy must deliver tangible improvements to patient experience across the site, measured by the Patient-Led Assessments of the Care Environment (PLACE) survey. Initiatives focused on addressing these issues should be given priority and implemented quickly. While PLACE puts heavier emphasis on the services provided within buildings (cleaning, catering and patient care), rather than buildings themselves, it is recognised that the patient experience is core to the overall Trust strategy and can be relatively easily improved. The Trust will continue its ongoing audit programme of the patient environment which reviews catering, cleanliness and condition on a continuous basis.

- Drive improvements in the environmental sustainability of the estate

The Trust recognises that its activities have both direct and indirect environmental impacts and sees the protection of the environment as an integral part of good institutional practice. The estate strategy will seek to deliver tangible reduction in our carbon footprint, energy usage, water usage and waste production. Whilst these reductions are beneficial to the environment and sustainability, the Trust would naturally expect to see a reduction in the costs of these services. Through close collaboration with partners, the Trust will realise these benefits which will then be passed on to our staff, patients and wider community which we serve, while ensuring the long-term sustainability of the Trust. The strategy therefore aims to ensure efficient use of the estate whilst remaining in-line with the Trust values. By:

- Actively seek funding opportunities

The E&F team will continue to seek funding opportunities through Local Authority initiatives or national initiatives aimed at sustainability and fossil fuel reduction.

The Trust is acutely aware of its position within the local economy and its potential to influence various factors as well as its own responsibility to contribute toward the enabling of Government directives, specifically, its challenging net-zero carbon initiatives.

- Seeking out the most advantageous combination of cost, quality and sustainability

The E&F team will continue to work with regional and national colleagues to benchmark against those considered 'best-in-class' to ensure the Trust is receiving the right balance of economy, efficiency and effectiveness, demonstrating value for money throughout all active workflows and, following a method for improvement, planning for the future.

8. How do we get there?

The ability to deliver upon this strategy will require an effective departmental structure which comprises a dedicated and hard working team of individuals all of whom possess the necessary skill mix within their own area, to deliver both individually and as a team. Such a team requires, not only the support of its own management but also that of the Trust Executive and Board, especially in relation to adequate resource provision.

Delivering such a strategy, which, as previously noted, is an enabling strategy to the Trust strategy and cannot be achieved in isolation. It will require collaborative working across all divisions and departments, as E&F are embedded within the functioning of the whole estate and its activities. The E&F strategy will be supported by a robust implementation plan setting out short and long terms proposals, aligned to 5 key principles.

As the E&F strategy is one of several sub-strategies for the Trust, there is a significant amount of inter-dependency that needs to be recognised and considered in the development of the implementation plan. The following describes the major stakeholders in the sub-strategy, and they can support:

- NHS Commissioners

Commissioners are key to helping the Trust manage demand on its services and ensuring delivery of stretching targets, NHS providers work in partnership with the Trust, often sharing buildings and services to meet demands. The increased integration will rely on effective space planning and scheduling.

- Digital Team

The digital team (IT) is leading on the Trusts Digital Strategy which will support organisation-wide change to paper-light and paper-less service delivery, reducing demand for storage and transfer of paper records. Projects to roll out new software and hardware will also be key to modernising office environments and enabling new ways of working. IT is critical to the introduction of new communications systems across the Trust.

- Procurement

Health Procurement Liverpool (HPL) supports the purchase and supply of services and equipment. Delivery of a number of the ambitions in this strategy will rely on timely procurement and collaboration.

- Human Resources

The HR team are leading on workforce including recruitment and retention involving internal recruitment of nursing and medical staff. Close collaboration is needed to ensure that additional staff can be accommodated in both residential and office capacity. The E&F sub-strategy seeks a cultural shift in the way we work to support better use of space.

- Finance

The Finance department supports the Trust to manage its use of resources. The success of this strategy will be dependent on the availability of funding and ensuring Trust readiness to bid for additional funding when it becomes available.

- Service Development Priorities

As part of the development of the implementation plan, individual departments will be asked to present their service development aspirations. These will be assessed and prioritised through the current governance process to determine those that most effectively meet the Trusts strategic ambitions. The long list of potential developments will be ranked as short, medium and long term goals to support future bids for funding. The schemes will be identified on a series of development control plans which in combination with the sub strategy provides a masterplan for the site's future development.

The long list of service developments will be gathered through engagement during the development of the implementation plan. Engagement will include:

- A review of clinical service strategies
- Outputs from business planning
- Engagement sessions with individual departments / divisions
- Validation by individual departments / divisions
- Validation by the Trusts Capital Management Group.

The prioritised proposals will subsequently be used to inform the Trusts capital programme and establish an investment strategy for the Trust.
Each of the emerging priorities for the Trust will be subject to more detailed feasibility and viability and a subsequent business case for funding.

9. What Happens Next?

The sub-strategy will be reviewed after two years to ensure that it remains consistent with national standards and requirements. The Estates and Facilities team will develop the *Implementation Plan* and *Service Development Priorities* which will inform the detailed *Development Control Plans.*

SUSTAINBILITY WORK PROGRAMME 2023/24

Quarter 1

Category	Scheme / Project	Department	Current Environmental Impact	Anticipated Environmental Impact	Anticipated Annual CIP	Lead (s)	ECD	Comments
Plastics	Face masks	Theatres	28.4 EmPt	8.07 EmPt (72% pvc reduction)	£6,108.00	DP/JB	Jun-23	Awaiting EQIA sign off
Waste	Anaesthetic Circuits	Theatres	28.4 EmPt	8.07 EmPt (72% pvc reduction)	As above	DP/JB	Jul-23	Awaiting EQIA sign off
Waste	Theatre hats	Theatres	21.5k desposits to landfill	TBC	£1,576.80	DP/JB	Aug-23	See business case for environmental impact
Travel	Travel Survey collaboration	Sustainability	TBC	TBC	TBC	TD	Jun-23	Survey results received, actions from survery in Q2 (Annual tickets, Car Share database)
Medicines	Desflurane	Theatres	1,845,831Kg/CO2 PA	1,845,831Kg/CO2 PA	£1,500.00	JB/DP/RP	Nov-22	Complete
Waste	Scrubs vending machine	Theares	TBC	TBC	TBC	EB	N/A	Not viable project due to estate required
Environmental	Bees	Estates	Nil	Improved ecological footprint	N/A	SH	Apr-23	Complete
Buildings	Water flushing toilets	Estates	TBC	TBC	TBC	SH	N/A	Does not appear to be viable option but more work to be done
Waste	DrDoctor	QSIT	TBC	TBC	TBC	SH	Nov-23	
Recycling	Walking Aids amnesty	Therapies	TBC	TBC	TBC	EG	Sep-23	SOP approved June 23. Project to launch Sep-23 discussed at team brief in august
Waste	Synertec Hybrid Mail solution	Trustwide / QSIT	TBC	TBC	c£70k PA total	BD	TBC	PAC complete
Travel	Neurosphere	QSIT	TBC	TBC	TBC	RP	TBC	Onboarding required as phase 2. See Project mandate
Buildings	Feasibility study in current building / decarbonisation	Estates	N/A	N/A	N/A	SH/RP	Jun-23	Options may be available within buidings/site

Quarter 2

Category	Scheme / Project	Department	Current Environmental Impact	Anticipated Environmental Impact	Anticipated Annual CIP	Lead (s)	ECD	Comments
Waste	Laryngosopes	Theatres	TBC	TBC	TBC	DP/JB	Sep-23	Timesco provided laryngoscope demo - sustainbility group to discuss in sept
Transport	Annual Merseyrail/Merseytravel tickets	Sustainability	TBC	TBC	N/A	CS	Sep-23	Onboarding with merseyrail/travel to sign up to annual scheme
Transport	Car Sharing Database	Sustainability	TBC	TBC	TBC	CS	Sep-23	DPIA approved at August IGSF -sustainability group update to finalise database in sept
Waste	Reusable Gowns	Theatres	TBC	TBC	TBC	DP	Sep-23	Prototype awaited from supplier - sustainbility group update in Sept
Medicines	Nitrous Oxide	Theatres / ITU	TBC	TBC	TBC	JB/DP/RP/SH	Aug-23	Plant Decommissioning complete
Energy	Locked in AC unit temperatures	Estates	TBC	TBC	TBC	SH	Aug-23	Works to lock off A/C conrolleers underway
Waste / Environ	Meat free Monday campaign	ISS	TBC	TBC	TBC	CS/ISS	Aug-23	Campagin trial period complete, results to be shared at sustainability group in september
Waste / Quality	Gloves off Campaign	IPC	TBC	TBC	TBC	HO/CS	Oct-23	Task & Finish group to implement project to meet 31/08/2023
Recycling	Sharpsmart for metal consumables	All	TBC	TBC	TBC	BS/CS	Sep-23	Conversations ongoing with with Procurement and liaising with Sharpsmart and Theatres.
Buildings	Feasibility study deep dive & action plan	Estates	TBC	TBC	TBC	SH	Q4 23/24	appointing suppler
Buildings	Water flushing toilets	Estates	TBC	TBC	TBC	SH	Nov-23	Expensive solution and only suitable for non-clinical environments. Company now have a new business model which may prove worthy of trial
Buildings	Feasibility study in current building / decarbonisation	Estates	N/A	N/A	N/A	SH/RP	Oct-23	Initial high level cost being prepared to prevent heat loss at main site
Waste	Synertec Hybrid Mail solution	Trustwide / QSIT	TBC	TBC	c£70k PA total	BD	TBC	Neu/NS roll out - awaiting milestone plan from BD

Quarter 3

Category	Scheme / Project	Department	Current Environmental Impact	Anticipated Environmental Impact	Anticipated Annual CIP	Lead (s)	ECD	Comments
Waste	Synertec Hybrid Mail solution	Trustwide / QSIT	TBC	TBC	c£70k PA total	BD	TBC	Radiology roll out - awaiting milestone plan from BD
Medicines	Inhalers	Pharmacy	TBC	TBC	TBC	OC	TBC	Olivia joined sustainability group in July.
Medicines	TTO's	Pharmacy	TBC	TBC	TBC	OC/CS	TBC	
Environment	Free trees for planting on-site	Estates	TBC	TBC	N/A	SH	Nov-23	Awaiting deliver of trees

Quarter 4

Category	Scheme / Project	Department	Current Environmental Impact	Anticipated Environmental Impact	Anticipated Annual CIP	Lead (s)	ECD	Comments

Waste	Digital records	QSIT	TBC	TBC	TBC	SH/RP	Mar 23/24	Awaiting scoping work information
Waste	Clinical waste recycling (CURO)	E&F	TBC	TBC	TBC	CS	TBC	Curo demo received, ERIC data provided, procurment to look into current clinical waste contracts
Recycling	General recycling	Facilities	Recycling rate of 22%	TBC	TBC	BS	TBC	Report received from B and M, and shared with the sustainabilty and social value group on July 6th

ESTATES & FACILITIES WORK PROGRAMME 2023/24

Quarter 2

Category	Scheme / Project	Department	Capital / Revenue	Associated Costs of Scheme	Lead (s)	Start Date	ECD	Comments
Clinical	Ponta Beams Replacement	ITU	Capital	£450k	AS/SH	Sep-23		All materials on-site. Awaiting final structural engineer's report. Works due to commence in Sept23
Non-clinical	Phase 6 heating scheme	second floor	capital	£1.5m	SH	Apr-23		Works progressing well. On target for completion March24
Non-clinical	BMS system replacement	Trustwide	Capital	£400k	SH	Aug-23		Colloaborative tender with LUHFT due to commence Sept23
Non-clinical	Way-finding upgrade	Trustwide		£80k	SH	Aug-23		Exploring options with various providers
Non-clinical	Phase 1 office space review	Various	Revenue	£3k	SH/MC/RP	Jan-23		Complete
Non-clinical	PLACE review	Various			DC/SH	Nov-23		Complete
Non-clinical	contract tender process for Air Conditioning	All	Revenue		SH/HC	Feb-23		Collaborative working with LUHFT. Tender process complete. Formal award in progress
Non-clinical	Contract tender process for medical gases	Clinical	Revenue		SH/HC	Apr-23		Collaborative working with LUHFT. Tender in progress
Non-clinical	Contract tendering process for BMS	All	Revenue		SH/HC	Sep-23		Collaborative working with LUHFT. Tender works due to commence in Sept23
Clinical	Option to relocate NRC	WC/SWB	Capital	£1m	SH/RP	May-23		Works on hold
Corporate	Premises Assurance Model	Corporate			SH/DC	Jul-23		Due to complete Sept23
Corporate	Policy Development/Update	Corporate			SH/MC/RP	Oct-23		Approved at H&S Group

Quarter 3

Category	Scheme / Project	Department	Capital / Revenue	Associated Costs of Scheme	Lead (s)	Start Date	ECD	Comments
Clinical	Air handling units / lighting	Theatres	Capital	£1.5m phase 1a and 1b	SH/DP/AS	Oct-23		Invitation to tender complete. 4 no contractors applied. Tender documents now published via framework portal
Non-clinical	Phase 2 office space review	various	Revenue	£3k	SH/MC/RP	TBC		Commencing Sept23
non-clinical	Mini PLACE review	Various			Various	Nov-23		Mini PLACE complete. Report circulated. Main PLACE due Nov23
Non-clinical/ clinical	Review of clinical service strategies	Neurosurgery			SH/RP	TBC		Once main strategies reviews complete
Clinical	Contract tendering process for deceased patients	Clinical	Revenue		SH/DC/BB	Oct-23		E&F working with procurement to develop specification
Clinical	Additional Revenue Expenditure	Clinical	Revenue	£250k	SH/NM	Nov-23		Quotations being sought
Corporate	Backlog Maintenance Review	Corporate	Capital		SH	Nov-23		Quotation in place. Framework solution being discussed with procurement
Corporate	Wayfinding Review	Corporate	Revenue	TBC	SH/EV	Dec-23		develop plan for improved signage
Corporate	Options appraisal for Improved energy perfomance at WC	Corporate	Capital	TBC	SH	Oct-23		Develop plans for improved thermal efficiency
Clinical	Theatre Refurb Design Development	Clinical	Capital	TBC	SH/MC	Sept23 -Dec23		Complete tender process and award contract. Obtain guaranteed maximum price (GMP)
Clinical	Radiology estate review including fluoroscopy	Radiology	Capital	-	SH/SN/PR/RP	Sept23 -Dec23		Proposed redesign

Quarter 4

Category	Scheme / Project	Department	Capital / Revenue	Associated Costs of Scheme	Lead (s)	Start Date	ECD	Comments
	Phase 3 office space review				SH/RP	TBC		On completion of phase 2
	Review of clinical service strategies	Neurology			SH/RP	TBC		Ensure E&F link into other strategies
Clinic/Corporate	Revenue Expenditure	Clinical/corporate	Revenue	TBC	SH/MC	Oct 23 - Jan23		Develop plans for further revenue expenditure
Non-clinical	Digital records - med recs estate review	Medical records	Revenue	-	SH/RP	Jan-24		Redesign of med records provision and storage
	Phase 4 office space review				SH/RP	Jan-24		Review accomodations
All	Capital Works up to end FY23-24	Corporate	Capital / Revenue	TBC	SH/MC	Jan-24		Develop plans for further capital expenditure
Clinical	Theatre Refurb Works Commence	Clinical	Capital	TBC	SH/MC	Jan-24		Commence works

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	Trust Anti-Racism Statement
Executive Lead	Mike Gibney, Chief People Officer
Author (s)	Mike Gibney, Chief People Officer
Action Required	To approve

Level of Assurance Provided

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

Key Messages

- The Walton Centre is committed to being an anti-racist organisation.
- Anti-racism is an active and conscious effort to work against all aspects of overt and systemic racism.

Next Steps

- Publish on Trust website.

Related Trust Strategic Ambitions and Themes	**Impact**		
Health Inequalities	Equality	Legal	Workforce

Strategic Risks

006 Prevention & Inequalities	004 Leadership Development	001 Quality Patient Care

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

Report Development

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Health Inequalities and Inclusion Committee	26.06.23	Mike Gibney Chief People Officer	Approved without any changes.
Circulated to members of the Trusts @Race Network	24.07.23	Mike Gibney Chief People Officer	Circulated – no amendments received.

Anti-Racism Statement

Executive Summary

1. The Walton Centre is committed to being an anti-racist organisation.

2. Anti-racism is an active and conscious effort to work against all aspects of overt and systemic racism.

Background and Analysis

3. The statement combines narrative and some high-level commitments/actions that underpin the Trust's ambitions. The actions are drawn from NHS Providers six high impact actions, the recommendations to Trust Board from Clive Lewis (Globis) following his strategic review and the Trusts active membership of Liverpool Citizens.

4. It is important to note that the actions are not an exhaustive list as there is a detailed Equality, Diversity & Inclusion (ED&I) Action Plan for the Walton Centre and ED&I is currently a very dynamic agenda with further commitments likely.

Conclusion

5. This is the final draft of the statement seeking approval from Trust Board.

Recommendation

- To approve.

Author: Mike Gibney – Chief People Officer
Date: 29 August 2023

Appendix 1 – Draft Anti-Racism Statement

Anti-Racism Statement

The Walton Centre recognises that racism goes beyond conscious or open hostility towards individuals or communities because of their culture, colour, nationality, race or ethnic background. Racism can be subtle and unconscious. To truly tackle racism, we need to understand our personal contribution.

We are committed to a safe, healthy and productive workplace that promotes diversity of thought, heritage and social background. Our individual qualities and differences must be celebrated as we bring our whole self to work. We want our people to be productive, creative and innovative – this cannot be achieved for our colleagues who are oppressed by racism.

Although this Trust is committed to help establish a more open, equal and democratically accountable NHS, racism is still prevalent in our systems, processes and behaviours towards employees and patients. We cannot be complacent or adopt a position that is impartial. Anti-racism is an active and conscious effort to work against all aspects of overt and systemic racism.

The Walton Centre is genuinely committed to take urgent action rather than the hollow rhetoric of the past. It is no longer about wearing a badge or flying a flag, it is time to act!

We are committed to delivering the following actions:

- We will urgently define a set of ED&I objectives on race for the next 24-36 months.
- We will set measurable objectives on anti-racism for the Chair, Chief Executive and all Board members.
- Commit to understanding and then eliminating pay gaps between Black, Minority Ethnic (BME) staff and their white colleagues.
- We will work with, invest in and support our @Race Group to become an @Anti-Racism Group.
- We will review current recruitment and career progression policies to ensure they are inclusive and do not disadvantage those from a BME background.
- Ensure induction and appraisal systems enhance the experience of BME staff (and internationally recruited staff) and support those looking to develop their careers.
- Through the provision of outstanding Health & Wellbeing support, continue to address health inequalities within our workforce.
- Continue to deliver and embed the Cultural Competency training programme and promote Civility training across the trust. These must run alongside a clear policy framework on bullying and harassment.
- We will trailblaze working in partnership with the population of Liverpool (as part of our community) through *Liverpool Citizens. This will include extensive engagement, breaking down barriers and improving employment opportunities for residents in the areas with the highest levels of deprivation.

*Liverpool Citizens is a non-partisan alliance of Groups from across the city including faith, education, academia, housing, health, community, voluntary and charities.

The Walton Centre
NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	Cheshire & Merseyside NHS Joint Forward Plan 2023-28
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Five year forward plan for Cheshire & Merseyside has been published as required by statute
- The plan outlines how the Integrated Care Board for Cheshire & Merseyside will fulfil its statutory duties and deliver its vision and mission.

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

- All Cheshire & Merseyside Provider Boards to endorse the strategy
- Plan will be republished annually (by March 2024)

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Cheshire & Merseyside NHS Joint Forward Plan 2023-28

Background and Analysis

1. The Joint Forward Plan (JFP) is driven by the ambitions of the Cheshire and Merseyside (C&M) Interim Health and Care Partnership (HCP) Strategy, which is built around four core strategic objectives:

    - Tackling health inequalities in outcomes, experiences and access (the eight Marmot principles)[1]
    - Improving population health and healthcare
    - Enhancing productivity and value for money
    - Helping to support broader social and economic development

2. The plan will also help the HCP for C&M deliver their vision and mission.

3. This is the delivery plan for the Health and Wellbeing Board plans, NHS Universal Priorities and the HCP Strategy which will be finalised in the next few months. Once the HCP Strategy is published the priorities in the JFP will be refreshed and the JFP updated before March 2024. This process is outlined on page 7 of the JFP.

4. The plan is intended to describe, as a minimum, how the HCP and the provider trusts intend to arrange and/or provide NHS services to meet C&M's physical and mental health needs, including delivery of the universal NHS commitments set out in the NHS Long Term Plan.[2]

5. In addition to the statutory duties of an ICB the JCP also includes content on workforce, performance, digital, estates, procurement and vest value, population health management, and system development. The JFP was developed collaboratively through a planning group and in conjunction with the Place Health and Wellbeing Boards using their Joint Strategic Needs Assessments. The work was coordinated by the Integrated Care Board for C&M for NHS C&M.

Conclusion

6. Provider Boards are all asked to endorse the plan and priorities, noting that the HCP remains in a developmental period and this plan will be refreshed again in 2023/24.

[1] Tackling health inequalities - NHS Cheshire and Merseyside
[2] NHS Long Term Plan

Recommendation

To note.

Author: Jan Ross, Chief Executive
Date: August 2023

Appendix 1 – C&M Joint Forward Plan 2023-28

www.cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Cheshire and Merseyside

Joint Forward Plan

2023-28

SUMMARY

Foreword

Joining up health and care is nothing new - we have been working towards this for many years. There is much that has been excellent. But there is so much more that the health and care system must do together to play its full part in enabling citizens, patients and service users to thrive and achieve their full potential.

The creation of our Health and Care Partnership (HCP) provides a platform on which all partners can challenge their mindsets, share learning and work differently to optimise our collective contribution to people's lives.

This Joint Forward Plan is driven by the ambitions of the Cheshire and Merseyside Interim HCP Strategy, which is built around four core strategic objectives:

- Tackling health inequalities in outcomes, experiences and access (our 8 Marmot principles)
- Improving population health and healthcare
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

The challenges faced by our citizens and communities are immense, but so is their passion to overcome them. The Integrated Care Board and our partners are committed to working with all communities to support them to improve their health and wellbeing, reduce inequalities, agree what constitutes good experience and deliver on this and improving health and wellbeing outcomes in targeted areas. Intrinsic to our ambition is to optimise the opportunities for supporting social and economic development.

A core principle is to treat every pound of funding as a precious asset, driving out waste and doing the things that matter to people so that we maximise the value that our communities gain from our plans and delivery.

We also strongly believe that it is our local communities and front-line teams are best at knowing what matters most and to determine the best way to make improvements. We will support this by encouraging decisions are made as locally as possible and ensuring that our plans are co-produced to ensure they truly meet the needs of our population. It will be the case that learning, spreading best practice and innovation will be core to all we do.

Sometimes, operating at scale or standardisation will be the best solution. Our commitment is that the communities we serve will be provided with the opportunity to question these options and seek the relevant assurances.

We know we need to be different and work differently; our plans describe our ambitions in a range of areas and based on what our population has said matters to them, including:

- Supporting all our children to have a good start to life both in terms of their health and wellbeing and educational attainment to enable them to go on to live long and happy lives
- Raising the number of years people live in good health whilst narrowing the gap we see between those in the most and least deprived communities
- Ensure that our care communities transform how services work for residents to offer world leading primary and community care
- Working with our provider collaboratives to build a strong and sustainable NHS provider sector that delivers services which offer consistently high levels of access and quality
- Making sure we maximise the positive role we play as employers and as anchor institutions in contributing to our local communities.

We have some of the best organisations in the country who have committed to work together with common purpose. The variety of organisations, local authorities, VSCE, NHS and private sector, have huge talent and passion to make a difference. We have a once in a generation opportunity to make significant and lasting difference to people's lives. Let's not waste this opportunity and we urge you to join us our mission.

Graham Urwin, Chief Executive

Raj Jain, Chair

1. About this document

We know that people's lives are better when organisations that provide health and care work together, particularly at the times when people need care most.

This document – our Joint Forward Plan (JFP) – describes how Cheshire and Merseyside Integrated Care Board (ICB), our partner NHS Trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

This Joint Forward Plan contains the actions we will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards
- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24 (Appendix 1)

Our Joint Forward Plan aims to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of our resources.

We are committed to working on all three of these aims simultaneously to best meet our population's needs and to reduce inequalities in access and outcomes.

These aims also align to our statutory duties as an ICB. The details of these statutory duties can be found here.

Our Joint Forward Plan aligns with the recently published Hewitt Review (April 2023), which considers the future development of Integrated Care Systems in England. The review supports taking a 'whole system approach' to addressing wider determinants of health, and a shift of focus away from treating problems towards maintaining good health. These two themes align with our statutory duty and also our local commitment to integrate services to benefit our population.

Our approach to developing this Joint Forward Plan

The Cheshire and Merseyside Integrated Care Board was formally established in July 2022. We have already made significant progress, but we are still in a developmental phase and we have considerable work to do to further develop our plans and priorities. This Joint Forward Plan should be read in this context.

Whilst the responsibility to develop this plan sits with NHS Cheshire and Merseyside, and our NHS Providers, we have adopted a collaborative approach to developing this plan. We drew on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to help us identify ways to improve integration and innovation. This will help us to deliver better outcomes for our population.

This 2023-2028 Cheshire and Merseyside Joint Forward Plan describes at a summary level the approach we are taking to tackle the current challenges we face in recovering access to services following the COVID-19 pandemic.

It also outlines a programme of radical transformation across our health and care system to address longstanding issues of inequalities in outcomes and financial sustainability.

This JFP builds on our draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

These objectives support us to work towards achieving our vision and mission. The draft interim Health Care Partnership Strategy is broadly focused and contains many priorities. The HCP recognise the need to decide what to prioritise to enable progress to be made. Our residents provided feedback on the draft interim strategy during March and April 2023 which supported this view.

Figure 1: Cheshire and Merseyside Health Care Partnership Vision and Mission

The HCP Strategy is currently in draft form and will be finalised later in 2023, in recognition of this ongoing work we have identified a number of priorities which contribute to making early progress against the ambitions outlined in the draft interim Strategy.

When the priorities in the HCP Strategy are finalised, we will refresh these priorities in our updated Joint Forward Plan, which will be published in March 2024.

Figure 2: Cheshire and Merseyside Priorities

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans *	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme	**2**	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years)
		Supporting the safety of vulnerable Women and Children	**2**	Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing violence against women and girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of early detection of cancer • Work towards MECC (Making Every Contact Count) • Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	**1,2,3**	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services
			2,3	Increased sign up to the NHS prevention pledge
			2,3	Reduction in smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active.
			2	Improved access to safe Housing (metric to be agreed)
Enhancing productivity and value for money	• Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	**1**	Financial strategy and recovery plan in place by Sept 2023
Helping to support broader social and economic development	• Embed, and expand, our commitment to social value in all partner organisations • Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people • Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care	Develop as key Anchor Institutions and progress advancing at pace the associated initiatives.	**2**	Grow the number of anchor framework signatories to 25
		Embed and expand our commitment to Social Value	**2**	Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%)
		• Developed focused work in schools around encouraging careers in health and social care • Ensure a health and care workforce that is fit for the future.	**2**	To be finalised in advance of the final publication in June 2023 Publish a Strategic Workforce Plan by March 2024
		Achieve Net Zero for the NHS carbon Footprint by 2040	**2**	For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

***1. Delivery against NHS Operational Plan and Long Term Plan (See appendix 1)**

***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)**

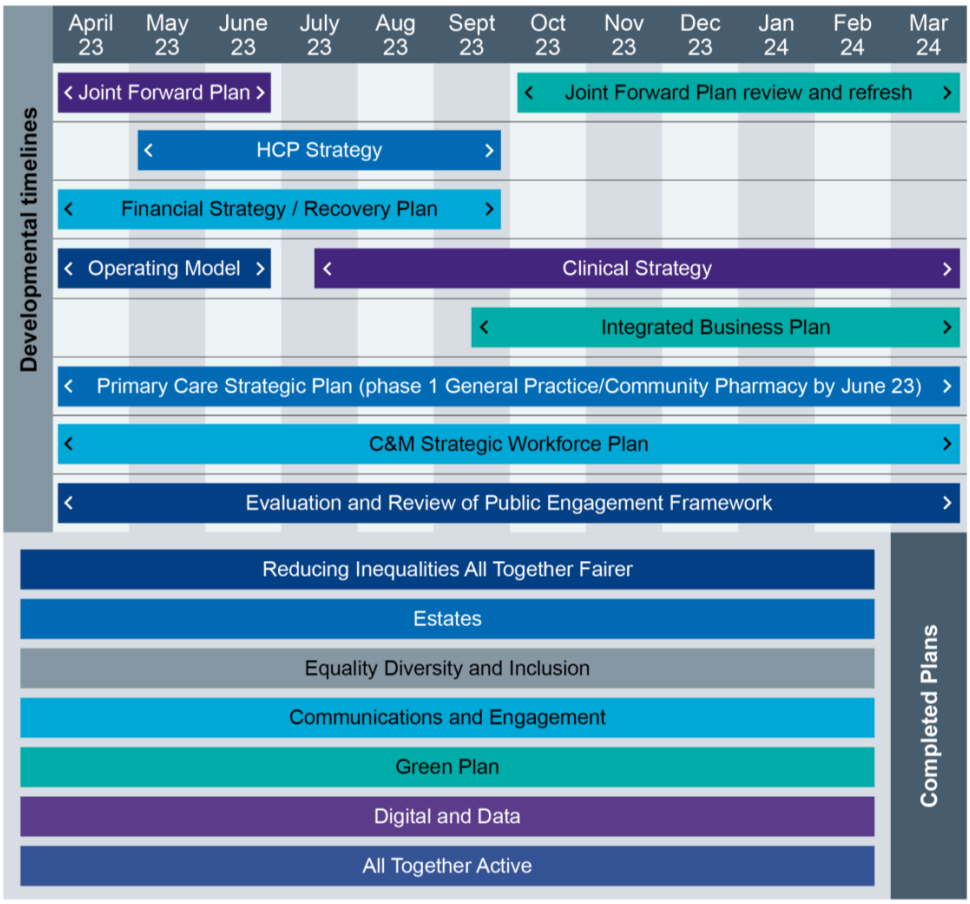
***3. Core20PLUS5 (See appendix 3)**

Whilst this summary document is relatively short, it is underpinned by significant activity across all of the priorities included in the table above. There are various links within this document which provide access to more detail about specific work programmes.

In developing this Joint Forward Plan, we recognise that we are in a developmental phase as an Integrated Care System and that there are some key pieces of planning and strategy work which we will need to align.

Alongside this we have developed an Annual Delivery Plan including a summary version.

We intend to develop a fully integrated business plan during 2023/24 that will incorporate the key strategic plans we have either already developed or intend to develop during this year. These will be reflected in the next iteration of this Joint Forward Plan in March 2024.The table below shows our completed plans and outlines our developmental timeline for 2023/24.



2. How we work as partners for the benefit of our population

Cheshire and Merseyside is one of the largest Integrated Care Systems in England, with a large number of stakeholders working together to improve the health and care of our population.

The figure below illustrates how we are configured at a Cheshire and Merseyside level. Some of the ways we come together in the Cheshire and Merseyside system are:

- The Cheshire and Merseyside Health and Care Partnership (HCP). This is a statutory joint committee between NHS Cheshire and Merseyside Integrated Care Board and our nine local authorities which also includes a wide range of partners from across the health and care system. This Board works together to support partnership working and is responsible for producing our Health and Care Partnership Strategy
- The NHS Cheshire and Merseyside Integrated Care Board. This is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services whilst supporting the integration of NHS services with our partners.
- Our nine Place Based Partnerships. These work locally to support the integration of health and care services in support of local Joint Health and Wellbeing Strategies
- In 2023-24 we will work with Healthwatch to establish a Cheshire and Merseyside wide forum to ensure engagement with each of the nine teams.

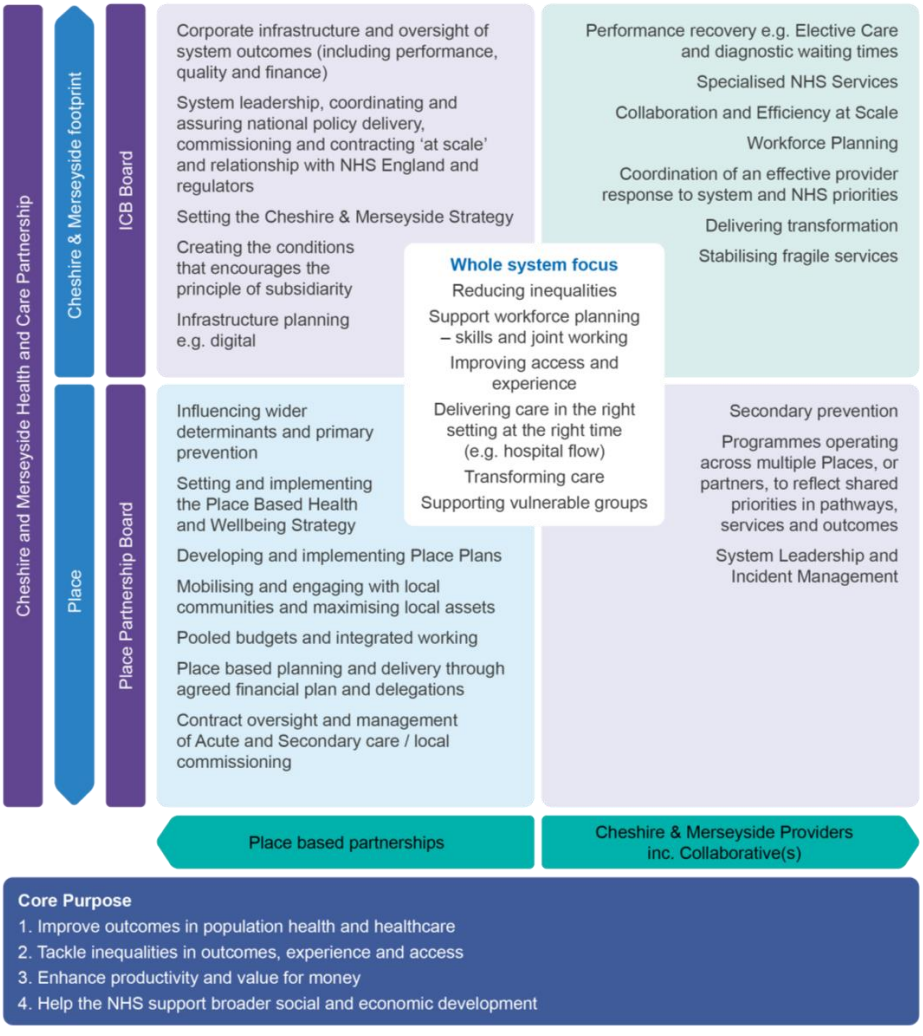
Figure 3: Cheshire and Merseyside Integrated Care System

Through our Place based partnerships and the communities within them we are committed to the principle of subsidiarity. This means that we want to make decisions as locally as possible. Our Places and communities are the 'engine room' which drive change by designing and delivering services around the needs of the local population.

Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver efficiencies and manage change. As an example, our two NHS Provider Collaboratives support our NHS providers to work together to deliver service improvement and enhance sustainability.

The picture below shows how we apply the principle of subsidiarity to decision making in our Places and the communities within them, whilst realising the benefits of working at scale in certain areas through our Health and Care Partnership, or ICS wide programmes or through our two Provider Collaboratives.

Figure 4: Decision making and subsidiarity in Cheshire and Merseyside



Communications and engagement

As system partners we are committed to engaging with people and communities. We know that harnessing the knowledge and experience of those who use and depend on the local health and care system can help improve outcomes and develop better, more effective services including removing or reducing existing barriers to access.

We are committed to working with those with lived experience to understand the impact of health inequalities and to support us in designing and implementing solutions to address these. For example, supporting unpaid carers is an essential contribution to narrow health inequalities in access, outcomes & experiences. Our vision is for all carers in Cheshire and Merseyside to have the support they need and recognition they deserve.

Our Green Plan

Climate change poses a threat to our health as well as our planet. Across Cheshire and Merseyside, we are committed to achieving net zero by 2040 (or earlier). The ICB and NHS Trusts and many Local authority partners have well established plans to achieve this.

Complementary to these local plans, NHS Cheshire and Merseyside has a strong system level Green Plan, and we work collaboratively as system partners to maximise the impact of our initiatives.

Our planet will continue to warm until circa 2060 we will continue climate adaptation / mitigation work to ensure we can continue to provide access to quality health and care for our population even as the climate changes. Including work to tackle air pollution, increased access to mental health services, coastal and other flooding, vector-borne diseases / prep for changing patterns of disease / sustained heat and high temperatures / impact on patients and on workforce etc.

We will:

Reduce the emissions we control directly (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

Supporting wider social and economic development

Supporting social and economic development is one of our strategic objectives. We are working together on a plan for improving health including addressing wider determinants. Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health.

We can ensure we contribute both in terms of the services that are delivered but also as employers and as part of our local communities.

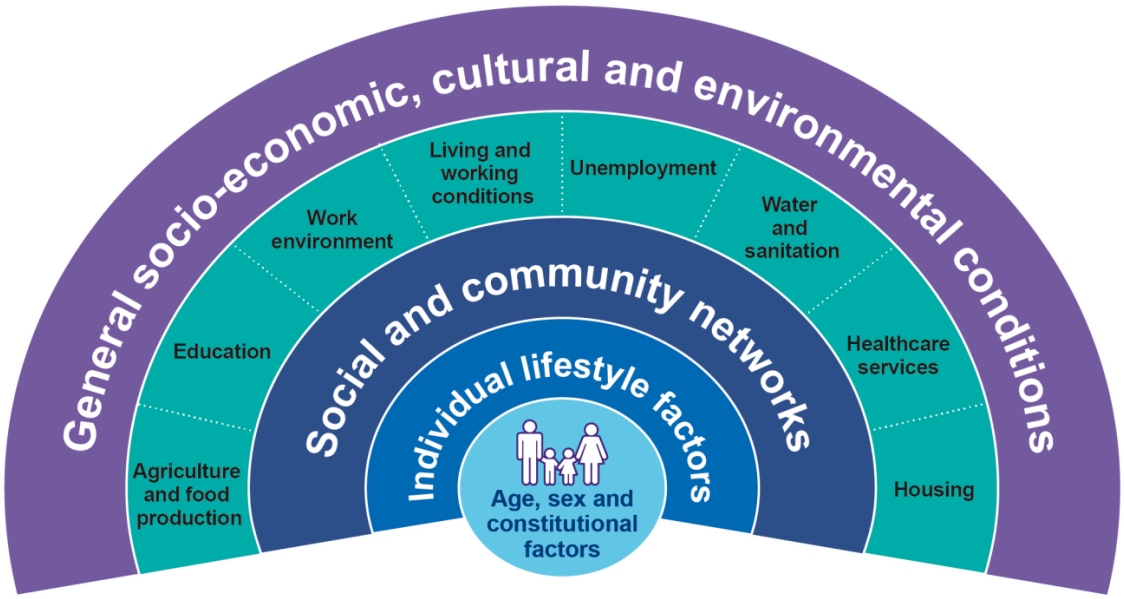
We will:

Increase the number of Anchor Framework signatories to 25 by the end of March 2024.

And:

- **Embed, and expand, our commitment to social value**
- **Develop as key Anchor Institutions within Cheshire and Merseyside**
- **Use an asset and strengths-based approach to planning**
- **Share data and insights, so resource can be targeted**
- **Ensure service, pathway and care model redesign is undertaken in collaboration**
- **Develop outcomes-focused funding models and contracts**
- **Support health and care professionals to think about care and support holistically**
- **Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%)**
- **We will maximise our efforts in relation to regeneration and planning including work to support the levelling up agenda.**

Figure 5: Wider social determinants of health and health inequalities, Dahlgren and Whitehead 1991



Safeguarding our population

Safeguarding is a shared responsibility across the health and care economy. Our teams work with colleagues from across the NHS, local authorities, the police, and other partner agencies to drive improvements through local and regional partnership working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business.

We are committed to:

- Strengthening collaboration and communication
- Improving training and awareness
- Early identification and intervention
- Strengthening partnership working
- Enhancing monitoring and evaluation
- Empowering service users
- Promoting a culture of safeguarding.

We will:

Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing violence against women and girls.

Want to know more?

Read the full version in Section 2 of our Joint Forward Plan Supporting Content

3. Our approach to improving Population Health

Our established Population Health Board oversees our Population Health programme of work. The aims of this are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and reducing health inequality. Our newly appointed Director of Population Health plays a key leadership role in this work.

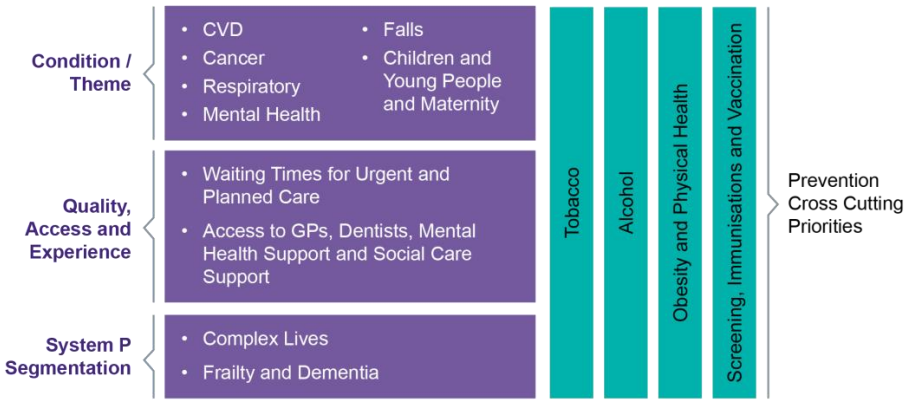
Figure 6 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the "England average", and where our people have told us their experience of accessing care does not meet their expectations.

We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Over time we expect that this will improve the health of our population, whilst helping to address the variation and inequality in access and outcomes we see across Cheshire and Merseyside.

The following programmes describe how we are approaching this.

Figure 6: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside



Strategic intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes.

As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality. This will enable us to better identify areas for targeted interventions and monitor progress.

All Together Fairer

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities, this commitment is at the heart of all of our programmes of work. This includes through our established All Together Fairer programme where we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level. The All Together Fairer programme supports the eight Marmot principles, which are to:

1. Give every child the best start in life.
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination, and their outcomes.
8. Pursue environmental sustainability and health equity together.

An example is how we will work together to support our population to access safe, secure, and affordable housing.

> We know that access to safe, secure, and affordable housing has a huge impact on the health of our population, and also that providing the right accommodation in the community supports people with a mental health condition or learning disability to access services in a more appropriate environment. A number of partners across our Health and Care Partnership provide excellent services which support our population to meet their housing needs.
>
> Within the NHS many of our services such as community nursing services often involve visiting people at home. We can 'Make Every Contact Count' by using these interactions as opportunities to sign-post people to other local services which can help improve the environment they live in, impacting positively on their overall health and wellbeing.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set *(Appendix 2)*.

We will:

- **Increase the % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage**
- **Reduce hospital admissions as a result of self-harm (15-19 years).**

Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities. It identifies focused clinical areas requiring accelerated improvement. Making progress against these areas is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

Our Population Health Programme strategic intelligence and system leadership will strengthen the oversight and monitoring of progress against the Core20PLUS5 clinical priorities *(Appendix 3)*.

We will:

Focus on delivery of the CORE20PLUS5 clinical priorities with an emphasis on:

- **Increasing the proportion of cancers diagnosed at an early stage (stage 1 or 2)**
- **Increasing the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024**
- **Improving access, and equity of access, to Children and Young Peoples Mental Health services (0-17).**

System-wide action on prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count. This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

We are also focusing on evidence-based and high impact interventions which include:

- Reducing smoking prevalence
- Reducing harm from alcohol
- All Together Active Physical Activity Strategy
- Promoting healthy weight
- Increasing health checks
- Mental wellbeing.

We will monitor our progress against key system objectives using an integrated framework that is currently being co-produced by system partners, and will incorporate key metrics in ICS, ICB and Marmot (All Together Fairer) dashboards.

We will:

- **Reduce smoking prevalence**
- **Reduce the % drinking above recommended levels**
- **Increase in the % who are physically active.**

NHS Prevention Pledge

Our providers are delivering against the 14 core commitments in the NHS Prevention Pledge. We are strengthening our focus on prevention, social value, and inequalities, embedding Making Every Contact Count (MECC) at scale, and supporting participating Trusts to achieve Anchor Institution charter status.

We are also exploring how we interpret the Pledge in a primary care setting, which involves considering how it may apply to colleagues such as GPs, dentists, optometrists, and pharmacists. This may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings.

We will:

Increase sign up to the NHS Prevention Pledge.

Screening, immunisation and vaccination

We plan to work with NHS England, UK Health Security Agency (UKHSA) and Place based commissioning teams to strengthen screening, vaccination and immunisation uptake, and to reduce inequalities.

We will:

Work with partners to strengthen screening, vaccination and Immunisation uptake and reduce inequalities.

Want to know more?

Read the full version in Section 3 of our Joint Forward Plan Supporting Content

4. How we will improve our services and outcomes

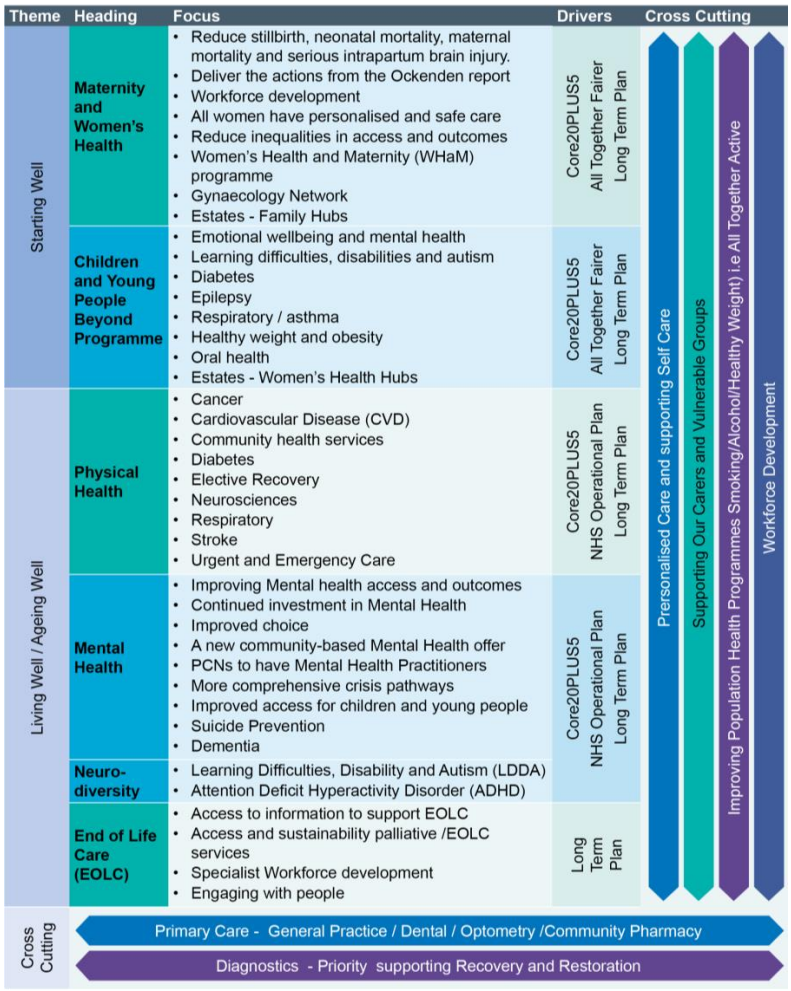
We have adopted a life course (starting well, living well, ageing well) approach to improving services and outcomes.

We are working hard to improve services and outcomes for our residents through a wide range of programmes. We want world leading services across our system, from GPs to highly specialised hospital care.

The table below summarises our core areas of focus.

Want to know more?

Further details of our work can be accessed in Section 4 of our Joint Forward Plan Supporting Content



5. Our workforce

Our plans recognise the importance of investing in our workforce.

We recognise the skills, abilities and dedication that our staff show each day and the importance of maintaining their Health and Wellbeing.

To achieve Cheshire and Merseyside Health and Care Partnership's strategic priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and Places.

In 2022/23 the Cheshire and Merseyside People Board, which has a broad membership across Cheshire and Merseyside stakeholders, agreed a set of ambitious Workforce Priorities for 2022-25 (see below).

Our system Workforce Strategy and the programme to support delivery of these priorities will be further developed during 2023/24.

Systemwide Strategic Workforce Planning to:	Creating New Opportunities across C&M to:	Promoting Health and Wellbeing to:	Maximising and valuing the skills of our staff to:	Creating a positive and inclusive culture to:
• Ensure a health and care workforce that is fit for the future • Smarter workforce planning linked to population health need • Creation of a 5-, 10- and 15-year integrated workforce plan • Developing a greater triangulation and monitoring between workforce / productivity / activity / finance.	• Grow our own future workforce • Increased focus on apprenticeships • Embed New Roles • Review barriers to recruitment • Work with the further and higher education sector • PCN Development • Greater links with social care and primary care • Ensuring an effective student experience.	• Ensure appropriate health and wellbeing support for all staff • Ensure good working environment • Focus on retention. • Preventing burnout • Ensuring appropriate supervision and preceptorship is available.	• Understand the impact of 5 generations working together/ changing expectation of the workforce • Developing career options at different stages of our lives and across health and social care • Responding to reviews / staff surveys and recommendations in a positive manner.	• Ensure proactive support of inclusion and diversity as a priority • Collaborative and inclusive system leadership • Understanding the barriers for staff / future employees • Development of learning and restorative practice.

Developing our culture and leadership

We plan to adopt, apply, and invest in the following areas to develop our culture, workforce, and ways of working as a system.

We will:

Ensure a Health and Care workforce that is fit for the future.

And:

- **Publish a Strategic Workforce Plan by March 2024**
- **Create new opportunities across health and care providers**
- **Promote health and wellbeing of all our workforce**
- **Maximise and value the skills of our workforce**
- **Create a positive and inclusive culture**
- **Ensure digital upskilling for the whole workforce**
- **Further develop our partnerships with Health Education Institutes (HEI's), further education providers and school.**

Cultural transformation

- Organisational and system redesign necessary for integration
- Competence and capability development to deliver integrated ways of working.
- Team cohesion to drive resource optimisation through sustainable collaboration.
- Growth mindset to stimulate systems leadership thinking and practice.
- A shared cultural identity values and behaviours premised on the principles of public service founded by the NHS Constitution, Equality Act and Nolan Principles

Talent management

- Talent management for effective capacity, demand and supply planning mapped to population health / market trends.
- Robust succession planning strategies for business-critical roles and hard to fill roles specifically.
- Reward and recognition strategies to ensure that success is rewarded and celebrated and improve staff engagement and retention.

Leadership development

- Resilient collective (systems) leadership evidenced in the continual enablement of integration for improved health and care integration.
- Compassionate and inclusive leadership cultures towards improving health inequalities.
- Culturally competent leadership to drive cultural competence in decision making for integration.
- Clinical leadership for integration towards health creation models of care

Want to know more?

Read the full version in Section 5 of our Joint Forward Plan Supporting Content

6. System development

Our Integrated Care System is geographically large and comprises a wide range of partners. This is reflected in how we apply our intention to distribute leadership to the most appropriate point in the system, which in many cases is as locally as possible.

In line with the concept of a "self-improving system" described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside the plans already outlined in this document.

In early 2023/24 we will be delivering work to develop and embed an agreed operating model for our system, working alongside system partners. Part of this will involve considering how we can work more efficiently as a system to enable the integration of services across health, care and our wider partners and communities, within our Places and our communities to prosper whilst working collectively at a Cheshire and Merseyside level when it makes most sense to do so.

Clinical and Care Professional leadership

We have developed a Clinical and Care Constitution which describes a set of principles that underpin all we do. It has been written by clinicians with input from clinical and care colleagues to support Cheshire and Merseyside ICS develop with our partners, an overarching population health approach, driven by the needs of our communities with a clear focus on addressing Health Inequalities.

It will:

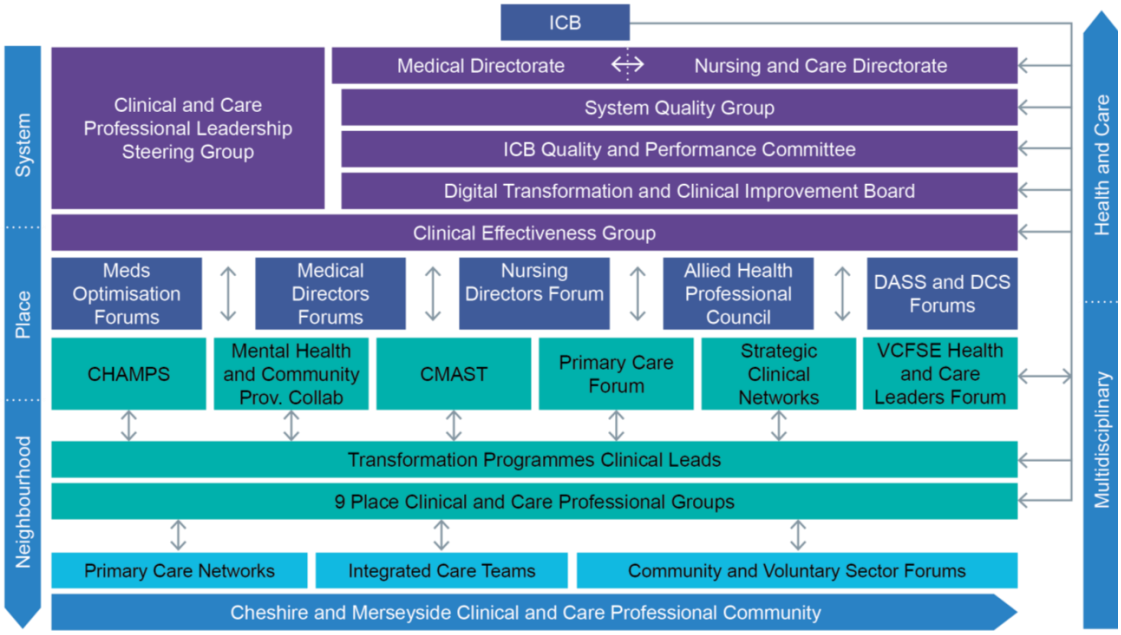
- shift the paradigm from reactive to proactive healthcare
- integrate clinical and care professionals in decision-making at every level of the ICS, creating a culture of shared learning, collaboration and innovation, working alongside patients and local communities
- provide a return on our investment in improving health will be evidenced through measures of both quality and effectiveness
- influence the wider determinants of health through collaboration, education and modernisation.

Our Constitution sits alongside our established Clinical and Care Leadership Framework (see figure 7) which outlines how clinical and care leaders across Cheshire and Merseyside will be involved in the key aspects of ICS decision making.

We will:

Implement the commitments and pledges within our Constitution.

Figure 7: Clinical and Care Leadership in Cheshire and Merseyside



Quality improvement

The government and public rightly expect Integrated Care Boards and their respective systems to ensure that the services we commission provide the highest standards of care. The development of our system quality strategy is being informed by the National Quality Board (NQB) guidance. The NQB publication 'Shared Commitment to Quality' provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through ICSs.

Quality principles

We will work together as a system to improve quality and use the key principles for Quality Management, as set out by the NQB, in developing our approach to deliver care that is:

- Safe
- Effective
- A positive experience
- Responsive and personalised
- Caring
- Well-led
- Sustainably resourced
- Equitable.

Our provider collaboratives

Effective collaboration and system working provides us with an opportunity to continually evolve, develop, improve and partner to further embed progress and capacity within the ICS and ultimately to provide extended and better care to our residents and patients.

In Cheshire and Merseyside, we have two provider collaboratives:

- Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST)
- Mental Health, Community and Learning Disability and Community Provider Collaborative (MHLDC).

Our collaboratives are leading a range of work programmes which support delivery of the Cheshire and Merseyside HCP strategic priorities.

Our Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST) programmes and key areas of focus are listed below:

- Elective recovery and transformation
- Clinical pathways
- Diagnostics
- Finance, efficiency and value
- Workforce.

Our Mental Health Learning Disabilities and Community Provider Collaborative (MHLDC) is a joint working arrangement between the nine providers of community, mental health and learning disabilities services. The work programme priorities for 2023/24 are:

- Community urgent care:
- Urgent community response teams
- Intermediate care
- Roll out of Urgent Treatment Centre specification
- Virtual wards
- Community services for children and young people
- Access to care, fragile services and community waiting times
- Population health and prevention
- Mental health transformation
- Workforce transformation.

We will:

Work with our collaboratives on a range of work programmes which support delivery of the HCP strategic priorities.

Adult Social Care Collaborative (ASC)

We recognise, in line with the national picture that the pressures being seen in adult social care have been increased since the COVID Pandemic adult social care and we need to work collectively to find ways to mitigate these pressures. ASC plans are currently in development and these will be published on the Cheshire and Merseyside Website.

As a Cheshire and Merseyside system, working across our nine Places we are focussed on how we can work collectively to identify innovative approaches to:

- Workforce recruitment, development and retention
- Digital transformation and technology enabled care
- Supporting people to live well at home (Home First)
- Market shaping and reform to build the social care market
- Care Home improvement and sustainability
- Supporting Carers
- Mental Health support
- Learning Disability and Autism support
- Housing and estates solutions.

Our VCFSE Transformation Programme

In Cheshire and Merseyside we are fortunate to have a strong and engaged Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector across our nine Places. This is supported by established local infrastructure organisations providing skills, knowledge, and capacity to enable two-way communications and engagement between local neighbourhoods and the health and care system.

The new health and care structures which have recently been established provide an opportunity to transform services and make a lasting difference to patients and communities. VCFSE partners will play a vital role in transformation programmes.

NHS Cheshire and Merseyside's draft Public Engagement Framework was co-produced with Healthwatch and the Voluntary, Community, Faith and Social Enterprise Sector and published in July 2022.

We will:

Focus on embedding the VCFSE as a key delivery partner.

And

- **Supporting investment in the VCFSE both financially and organisationally**
- **Building on VCFSE infrastructure and assets.**

Our places

Our nine Cheshire and Merseyside Places have been working collectively since before the formation of ICS in 2022, working through local partnership arrangements to deliver against the priorities in their local joint health and wellbeing strategies.

We have used a 'Place Development Assessment Framework' to support our Place Partnerships in their development, applying learning from other geographies. There are 4 key domains:

- Ambition and Vision
- Leadership and Culture
- Design and Delivery
- Governance

Place Partnerships have developed detailed plans to improve local services and outcomes.

We will:

As part of our Operating Model, we will enable our nine places to most effectively deliver functions and decision making at a local level.

Evolving our commissioning and corporate services

We are developing a single suite of commissioning policies across Cheshire and Merseyside by March 2024, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

The Health and Care (2022) Act has created provisions for NHS England to delegate functions relating to the planning/commissioning of certain services to Integrated Care Boards. In April 2023 the ICB took on responsibility for dental, ophthalmic and pharmacy services, and we are planning for future delegation of Specialised Services from April 2024.

We have a number of programmes of work designed to support our system to improve consistency and value for money as its functions evolve. These include:

- Corporate infrastructure: we are reviewing the licenses and applications in use across our nine places, to improve consistency and realise operational and financial efficiencies
- Commissioning support functions: we are reviewing all services currently provided to the ICB by Midlands and Lancashire Commissioning Support unit for consistency and value for money.

Research and innovation

As described in our draft interim Health Care Partnership Strategy we have an ambitious vision for research in Cheshire and Merseyside. Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research to work closely with our stakeholders to develop the best performing research network in the country.

We are working closely as a system involving the CHAMPS public health collaborative, our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

We will:

- **Establish a Cheshire and Merseyside Research Development Hub**
- **Create a network of research champions across our system**
- **Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects**
- **Contribute to the development of a North West Secure Data Environment for research.**

Digital and data

Cheshire and Merseyside ICS published its three year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board. We are committed to using digital and data to improve outcomes and services for our residents.

The strategy describes an ambition to improve the health and well-being of our region now and into the future by incorporating digital and data infrastructure, systems, and services throughout the pathways of care we provide.

This requires 'levelling up' our digital and data infrastructure to help address the significant inequalities so clearly faced by parts of our population and to ensure we successfully support all we serve.

We are committed to turning 'intelligence into action' by using increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to improve their health and care outcomes in an equitable way.

We will:

Work in partnerships to deliver the goals outlined in the Digital and Data Strategy, including making the Share2Care (shared care record) platform available in all NHS and Local Authority Adult Social Care providers, by March 2024.

Want to know more?

Read the full version in Section 6 of our Joint Forward Plan Supporting Content

7. Effective use of resources

In line with many other systems Cheshire and Merseyside faces significant financial challenges. As a system, we are spending more money on health and care services then we receive in income. We must take action to improve the long-term sustainability of the Cheshire and Merseyside health and care system by managing demand and transforming the way we use services, staff, and buildings.

As part of the Cheshire and Merseyside draft interim Health Care Partnership Strategy there is a commitment to developing a system-wide financial strategy during the first half of 2023-24 to:

- Determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Support health and care integration
- Identify key productivity and efficiency opportunities at both a Place and ICS footprint
- Outline system-wide estates and capital requirements and plans.

As recommended in the Hewitt Review, we are focussed on ensuring we are getting best value from our investments and increasing the proportion of our ICB budgets allocated to prevention of ill health.

We will:

Agree a financial strategy and recovery plan by September 2023 which details how we will move to a sustainable system-wide financial position in Cheshire and Merseyside.

Finance efficiency and value plans

As part of our wider development of a system financial strategy, we have established an Efficiency at Scale programme. One of our provider collaboratives, CMAST, is hosting the programme on behalf of the ICB. The programme works across the NHS and links with partners from the wider system as appropriate.

The key areas of focus for the Efficiency at Scale programme are:

- Consolidating financial systems, approaches and capacity across organisations where appropriate, including financial ledgers.
- Delivering a structured procurement workplan to reduce influenceable spend across all providers.
- Building on existing medicines optimisation projects to deliver a more sustainable approach to pharmacy capacity and resourcing across Cheshire and Merseyside.
- Specific discrete workforce projects, for example a collaborative staff bank for Health Care Assistants.

This complements wider work on our financial strategy and recovery plan where system partners work to reduce costs, through ICB, Place, provider and partner led plans.

Capital plans

We have developed a Capital Plan which describes how we will use available capital funding to invest in our buildings and infrastructure. The dedicated page is publicly available to view at: Capital Plan

Our capital plans will be routinely shared with members of the Cheshire and Merseyside Health and Care Partnership and the nine Health and Wellbeing Boards in Cheshire and Merseyside.

We will:

Continue working in partnership to deliver against our Capital plans.

Estates

Cheshire and Merseyside Health and Care Partnership's Estates Strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

- Fit for purpose
- Maximising utilisation
- Environmentally sustainable
- Value for money and social value
- Services and buildings in the right place
- Flexibility
- Technology
- Working in partnership.

We will:

Support our nine place partnerships and Primary Care Networks to ensure our focus areas translate into deliverable local plans.

All Age Continuing Health Care

The ICB is accountable for the fair and equitable commissioning of NHS All Age Continuing Health Care (AACC) to support the assessed needs of our residents. We are accountable for the quality, safety and financial assurance of the continuing care provided.

We have recently reviewed the services we provide to people who receive Statutory funded continuing care. This review will have a range of benefits. It will improve the appropriateness of the care provided, meaning care is of higher quality. By providing more appropriate solutions, we also expect to improve the value for money of the services we provide meaning our funding can go further.

We will:

Complete the review and work with partners to establish an equitable model for delivery of services across Cheshire and Merseyside.

Want to know more?

Read the full version in Section 7 of our Joint Forward Plan Supporting Content

8. Our place plans

Further detail on the plans is available in Section 8 of our Joint Forward Plan Supporting Content.

Health and Wellbeing Boards were asked to provide a statement outlining whether the Joint Forward Plan includes the relevant priorities within the Joint Local Health and Wellbeing Strategy. These will be published on the Cheshire and Merseyside Website.

9. Glossary

An online glossary of terms has been developed by NHS Cheshire and Merseyside and can be accessed through this link:

cheshireandmerseyside.nhs.uk/get-involved/glossary/

10. Summary of outcomes

In addition to the priorities outlined in Section 1 there are a range of additional outcomes the plans outlined in this document will deliver and can be accessed in Appendix A on page 185 of our Joint Forward Plan Supporting Content

11. Links to our partners plans

Links to the strategic plans of our NHS Provider and Local Authority Partners will be published on the Cheshire and Merseyside Website.

Appendix 1 NHS Operational Plan and Long Term Plan

NHS Operational Plan and Long Term Plan Objectives and Metrics				
Area	**2023/24 Planning Objective**	**Metric**	**Target Value**	**Cheshire and Merseyside position**
Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25	Percentage of attendances at Type 1, 2, 3 A&E departments, excluding planned follow-up attendances, departing in less than 4 hours	76%	76.9%
	Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25 (NWAS target set at 33 mins)	Ambulance Response Times - Category 2	National 00:30:00 NWAS 00:33:00	N/A
	Reduce adult general and acute (G&A) bed occupancy to 92% or below	Average number of overnight G&A bed occupancy - adult	92%	94.3%
		Average number of overnight G&A bed occupancy - Total (Adult & Paediatrics)		92.8%
Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard	Percentage of 2-hour Urgent Community Response referrals where care was provided within two hours	70%	2022/23 YTD = 74%. 14,985 UCR Contacts planned, 36% increase compared to 2022/23 FOT
	Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals	No specific metric defined		
Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need	% Appointments booked same day		Total GP Appoints 14.98m. Increase of 4.9% compared to 2021/22
		% Appointments booked within 1-14 days		
		% Appointments booked over 14 days		
	Continue the trajectory to deliver 50 million more appointments in general practice by the end of March 2024	Current gap to local ambition (down arrow indicates closing the gap)		
	Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024	Direct Patient Care (DPC) Roles in General Practice and PCNs (NB - manifesto commitment changed from ARRS to DPC roles, trajectory only available at region level)		57.9%
	Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels	2019/20 Baseline scheduled monthly % of usual annual contracted UDAs		83% below 19/20
		2022/23 scheduled monthly % of usual annual contracted UDAs		

Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)	Total waiting over 65 weeks	0	0
	Deliver the system- specific activity target (agreed through the operational planning process)	2022/23 Value Weighted Activity including adjustment for advice and guidance (NB - this measure will change for 2023/24)	105%	108.5%
Cancer	Continue to reduce the number of patients waiting over 62 days	The number of cancer 62-day pathways (patients with and without a decision to treat, but yet to be treated or removed from the PTL) waiting 63 days or more after an urgent suspected cancer referral excluding non-site-specific symptoms		1,095
	Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days	% Patients with diagnosis communicated within 28 days	75%	75.1%
	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028	Percentage of stageable cancers diagnosed at stage 1 and 2 (NB - data are Cancer Alliance not ICB footprint)	75%	80.0%
Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%	% Patients receiving diagnostic test within 6 weeks	95%	89.5%
	Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition	Acute Trust Diagnostic activity as % of baseline (current month v baseline month for 15 tests in DM01)	120%	116.4%
Maternity	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury	Stillbirths per 1,000 total births		
		Neonatal deaths per 1,000 total live births		
	Increase fill rates against funded establishment for maternity staff	Workforce data		
Use of Resources	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	Financial strategy and recovery plan in place by Sept 2023		
Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise	Total workforce	Publish a Strategic Workforce Plan by March 2024	
Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)	Number of CYP aged under 18 supported through NHS funded mental health services receiving at least one contact		23/24 = 135,601 Q4 = 37,590
	Increase the number of adults and older adults accessing IAPT treatment	Number of people who first receive IAPT recognised advice and signposting or start a course of IAPT psychological therapy within the reporting period.		23/24 = 72724. 100% of target

	Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services	Number of people who receive two or more contacts from NHS or NHS commissioned community mental health services (in transformed and non-transformed PCNs) for adults and older adults with severe mental illnesses	5%	Q4 23/24 = 20,600 Target achieved
	Work towards eliminating inappropriate adult acute out of area placements	Number of inappropriate OAP bed days for adults by quarter that are either 'internal' or 'external' to the sending provider		Q4 23/24 = 900
	Recover the dementia diagnosis rate to 66.7%	Dementia Diagnosis Rate	66.7%	66.7%
	Improve access to perinatal mental health services	Number of women accessing specialist community PMH and MMHS services in the reporting period		Q4 23/24 = 2,357
People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024	% of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register in the period	75%	75.0%
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults are cared for in an inpatient unit	Learning Disability Inpatient Rate per Million ONS Resident Population.	<30	36.5
	Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit		12 to 15	14.0
Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024		77%	
	Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%		60%	
	Continue to address health inequalities and deliver on the Core20PLUS5 approach	No specific metric defined		
Activity	Elective day case spells	Planned Activity Volumes 23/24		363,244
	Elective ordinary spells	Planned Activity Volumes 23/24		54,466
	RTT Clock Stops (admitted and non-admitted)	Planned Activity Volumes 23/24		879,054
	Number of requests for A&G	Planned Activity Volumes 23/24		417,246
	Outpatient attendances (all TFC; consultant and non-consultant led) - First attendance	Planned Activity Volumes 23/24		1,330,322
	Outpatient attendances (all TFC; consultant and non consultant led) - Follow-up attendance	Planned Activity Volumes 23/24		3,357,568

	Follow Up Outpatient Attendances without procedure	Planned Activity Volumes 23/24	Reduce by 25%	2,487,559
	Number of episodes moved or discharged to PIFU pathway	Planned Activity Volumes 23/24		171,366
	Number of attendances at all type A&E departments.	Planned Activity Volumes 23/24		1,181,165
	Non-elective spells	Planned Activity Volumes 23/24		398,629

Appendix 2 Marmot 8 principles and 22 Beacon indicators

The tables below highlight the principles describing how we intend reducing inequalities and the indicators we will use to measure progress.

Marmot 8 principles	
1	Give every child the best start in life.
2	Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3	Create fair employment and good work for all.
4	Ensure a healthy standard of living for all.
5	Create and develop healthy and sustainable places and communities.
6	Strengthen the role and impact of ill-health prevention.
7	Tackle racism, discrimination, and their outcomes.
8	Pursue environmental sustainability and health equity together.

22 Beacon Indicators

Life expectancy		Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
Give every child the best start in life					
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
Enable all children, young people and adults to maximise their capabilities and have control over their lives					
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
Create fair employment and good work for all					
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
Ensure a healthy standard of living for all					
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
Create and develop healthy and sustainable places and communities					
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
Strengthen the role and impact of ill health prevention					
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
Tackle racism, discrimination and their outcomes					
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
Pursue environmental sustainability and health equity together					
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

** Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.*

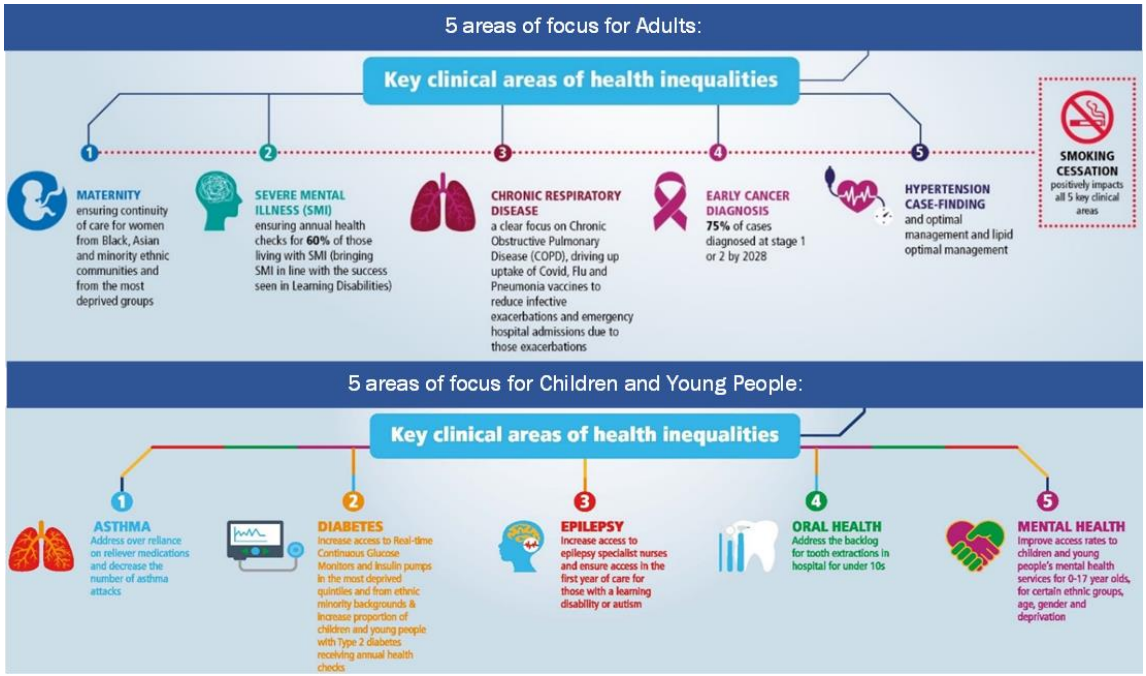
*** Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

**** These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

***** To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ Active Lives Survey states the length of continuous activity is at least 10 minutes.

Appendix 3 Core20PLUS5



Liverpool University Hospitals
NHS Foundation Trust

Board Committee Assurance Report

Report to	Board of Directors
Date	27 July 2023
Committee Name	Liverpool Trusts Joint Committee
Date of Committee Meeting	16 June 2023
Chair's Name & Title	David Flory, Chair Liverpool University Hospitals NHS Foundation Trust

Matters for Escalation

There are no matters for escalation.

Key Discussions

The Committee received an update on the activities from the following sub-committee as follows:

1. **The Walton Centre NHS Foundation Trust/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**
   - approval of the Terms of Reference
   - development of a Work Plan
   - focus on the existing collaborative work between the two trusts
   - Medical Directors leading on reviewing clinical pathways
   - review of estates to identify benefits and reduce duplication
   - review of procurement with specialist trusts to improve efficiencies.

2. **Liverpool Heart & Chest/Liverpool University Hospitals NHS Foundation Trust Joint Committee Update**
   - approval of the Terms of Reference
   - development of a Work Plan
   - an overview on the work of the established groups reporting into the Joint Committee, those being the Cardiology Partnership, an operational working group and a Joint Site Committee
   - an increase in mutual aid between the trusts on orthopaedic activity
   - the review of estates between the sites.

3. **Clatterbridge Cancer Centre NHS FT/Liverpool University Hospitals NHS FT Joint Committee Update**
   - approval of the Terms of Reference
   - development of a Work Plan
   - planned format of bi-monthly meetings, with scheduled deep-dives into specific workstreams planned.

4. **Liverpool Women's Health NHS FT/Liverpool University Hospitals NHS FT Partnership Group (Integrated Care Board sub-committee)**
   - Recruitment processes of specific roles to support the programme

- A verbal update on the development of a joint Risk Register between the Trusts which would be presented at a future meeting.

An update on the PLACE work updates was also presented detailing Alder Hey, Merseyside and Liverpool University Hospitals NHS FT.

Liverpool Electronic Patient Record Review Work
The Committee received an overview of progress on the Liverpool-wide review of Electronic Patient Records (EPR), which explored the following options:

- a consolidated EPR platform across all Liverpool Trusts
- integration of the existing EPR platforms across all Liverpool Trusts
- a 'do nothing' option to change existing EPR arrangements, whilst developing plans to collaborate more effectively.

An update would be presented at a future meeting.

Pathology Network Roadshows Update
Committee members received an overview of the Pathology Network Roadshows which detailed the Target Operating Model which had been developed in response to the change drivers identified. The Pathology Review was being undertaken at a Cheshire & Merseyside level, however, aligned with Recommendation 7 of the Liverpool Clinical Services Review which outlined the need to combine expertise in clinical support services to provide consistent services across Liverpool.

Decisions Made

The Terms of Reference were recommended for ratification by each Trust Board of Directors.

Recommendation

The Board of Directors is asked to note the Liverpool Trusts Joint Committee Assurance Report pertaining to the meeting of 16 June 2023.

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

CHAIRS REPORT

Joint Site Sub-Committee meeting held on Tuesday 22 August 2023 at 14.00, Boardroom, TWC

Introduction

The meeting of the LUHFT and TWC Joint Site Committee took place on Tuesday 22nd August 2023. The meeting involved representatives from Liverpool University Hospitals NHS Foundation Trust (LUHFT) and the Walton Centre NHS Foundation Trust (TWC).

A summary of the key agenda items and discussions is provided below.

Agenda Item	Key Discussions/ Decisions/ Actions
Minutes of Previous Meeting – 20th June 2023	The Committee **approved** the minutes from the Joint Site Committee (JSC) held on 20th June 2023.
Action Log	The Committee reviewed the rolling action tracker, from the meeting on 20th June 2023. The Committee **agreed** to close all outstanding actions for August following the updates.
Any Urgent Matters Arising	None
Joint Site Sub Committee Workplan Update • **Joint Partnership Group Exception Report**	The Committee received an update on the progress of the Joint Site Sub Committee workplan and the Joint Partnership Group (JPG). Key deliverables and the key performance indicators (KPI) across the focus areas had been developed and risks identified. Updates were provided on the agreed deliverables across the three agreed areas: • Emergency Clinical Pathways • Imaging • Estates and Digital The risks identified were as follows: • Clinical engagement and defining clinical pathways • Banding harmonisation for rotational staff across both sites • Equipment Utilisation • Interoperability of digital systems across both sites • Finance It was recommended that the Chief People Officers across Liverpool Providers are asked to review the issues of harmonisation of staff banding across Liverpool and this be escalated to the Liverpool Trusts Joint Committee (LTJC). The Committee **noted** the Joint Site Sub Committee Workplan Update and the Joint Partnership Group Exception Report
Joint Site Sub Committee Revised Terms of Reference	The Committee reviewed and accepted the Joint Site Sub Committee Revised Terms of Reference.

Agenda Item	Key Discussions/ Decisions/ Actions
Liverpool Trusts Joint Committee Update	The Committee received the update from the Liverpool Trusts Joint Committee (LTJC) meeting held on 27 July 2023 where the various Joint Site Sub Committee Terms of Reference and workplan had been approved.
Draft Agenda for the next meeting	The Committee **agreed** the following items will be included on the October agenda: • Joint Site Sub-Committee Workplan Update • Liverpool Trusts Joint Committee Update
Next meeting date and venue: Thursday, 10 October 2023, 14:00 at the TWC Boardroom.	

Recommendations for the Board of Directors

The Board of Directors is asked to:

- note the contents of the report

The Walton Centre
NHS Foundation Trust

Report to Trust Board
7th September 2023

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

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

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

Key Messages *(2/3 headlines only)*

- Joint Site Sub Committee (JSSC) Terms of Reference (ToR) were updated to bring these into line with those of the Liverpool Trusts Joint Committee (LTJC).
- The Terms of Reference (ToR) have been agreed by the JSSC for the Aintree Site

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

- Implement the agreed workplan and develop on already existing areas of collaboration across both sites.

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

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

002 Collaborative Pathways	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Liverpool Trusts Joint Committee	21 July 2023	Jan Ross, Chief Executive	Terms of Reference approved and recommended for approval to the Joint Site Sub Committee and to each Trust Boards
Joint Site Sub Committee	22 August 2023	K Dowson, Corporate Secretary	Terms of Reference agreed

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

Executive Summary

1. In order to ensure the delivery of six of the recommendations of the Liverpool Clinical Services Review (LCSR), a Liverpool Trusts Joint Committee (LTJC) had been set up. The LTJC Terms of Reference (ToR) and organogram were approved at the LTJC meeting on 16 June 2023 and by the Walton Centre Trust Board on 6 July 2023.

Background and Analysis

1. In response to the approved LJSC Terms of Reference (ToR) and organogram all Joint Site Committees were reviewed to become sub committees of the LJSC and the ToR for the three LTJC sub-committees were updated to bring these into line with those of the LTJC and to reflect the change in governance.

2. The revised version of the Joint Site Sub Committees ToR for the Aintree Site was developed through contribution by all members of the committee. The ToR for the Aintree site together with the two other site Committees were formally approved by the LTJC on 21 July 2023. The draft ToR is attached at Appendix 1 for approval by the Board.

3. The ToR will be reviewed after the first six months of its operation (by no later than January 2024) and then on an annual basis unless required by the Joint Site Sub-Committee. Any proposed amendments to the ToR will be required to be approved by the LTJC.

Reporting

4. The JSSC will have delegated powers from the Board to make decisions as described in the ToR to support collaborative programmes of work between the two Trusts and shall report to the LTJC.

5. The JSSC shall submit a summary of the minutes from the Chair to each LTJC meeting. The Sub-Committee shall ensure that the work of any working groups is reflected in its own minutes. The Sub-Committee shall provide an annual report to the LTJC and Trust Boards.

Conclusion

6. The ToR will be reviewed after the first six months of its operation (by no later than January 2024) and then on an annual basis unless required by the Joint Site Sub-Committee. Any proposed amendments to the ToR will be required to be approved by the LTJC. The Sub-Committee is accountable to the LTJC.

Recommendation

To approve.

Author: Katharine Dowson, Corporate Secretary
Date: 29 August 2023

Appendix 1 – Joint Site Sub Committee Revised Draft Terms of Reference

Appendix 2 – Liverpool Clinical Services Review Governance Organogram

The Walton Centre NHS FT and Liverpool University Hospitals NHS FT Sub-Committee for the Aintree Hospital site

Terms of Reference

Version	DRAFT 2.0
Implementation Date	July 2023
Review Date	January 2024
Approved By	Liverpool Trusts Joint Committee
Approval Date	[ ]

REVISIONS		
Date	**Reason for Change**	**Author**
	Version 1.0	
28 June 2023	Version 2.0 Amendments following establishment of LTJC and amendments to accountability/reporting arrangements for sub-committees.	DS

1	Name	The Walton Centre NHS FT (TWC) and Liverpool University Hospitals NHS FT (LUHFT) Sub-Committee
2	General	Capitalised terms have the meaning set out below: "**2006 Act**" means the National Health Service Act 2006 (as amended); "**Chair**" means the chair of the TWC/LUHFT Sub-Committee; "**C&M MHLDC**" means the Cheshire and Merseyside Mental Health, Learning Disability & Community Collaborative; "**CMAST**" means the Cheshire and Merseyside Acute and Specialist Trusts Collaborative; "**Delegation**" means the terms of any delegation to the Sub-Committee including any associated delegation agreement as agreed by the relevant board(s) and appended to these Terms of Reference at Appendix 2 and "Delegated" shall be construed accordingly; "**ICB**" means the NHS Cheshire and Merseyside Integrated Care Board, including any individual, organisation or committee to which its powers or responsibilities are delegated;

		"**LCSR**" means the Liverpool Clinical Services Review "**LCSR Recommendations**" means the six recommendations from the Liverpool Clinical Services Review which come within the scope of the LTJC, as set out in paragraph 4; "**LTJC**" means the Liverpool Trusts Joint Committee; "**Member**" refers to a member of the Sub-Committee listed in paragraph 9; "**Purpose**" the purpose of the Sub-Committee as set out in paragraph 3; "**Trusts**" are The Walton Centre NHS Foundation Trust (**TWC**) and Liverpool University Hospital NHS Foundation Trust (**LUHFT)** "**Work Plan**" means the rolling plan of work to be carried out by the Sub-Committee over a 12-month period (or such longer period as may be agreed by the Trusts). For the avoidance of doubt the Work Plan does not form part of these Terms of Reference. All references to legislation are to that legislation as updated from time to time.
3	Purpose	The Liverpool Clinical Services Review was commissioned in 2022 to realise opportunities for greater collaboration between acute and specialist trusts, to optimise acute care clinical pathways in Liverpool and beyond. A diagram setting out the various governance groups and organisations involved in overseeing and implementing the recommendations from the LCSR is set out at Appendix 1. Through delivering its Work Plan (via the LTJC Sub-Committees), the LTJC will be responsible for leading and overseeing the development and implementation of the Liverpool Acute (Provider) Strategy and the six LCSR Recommendations within the scope of LTJC. The six LCSR Recommendations within the scope of the LTJC and this Sub-Committee are as follows: • R3 - Improving outcomes and access to emergency care using existing co-adjacencies • R5 - Providing timely access to high-quality elective care through existing estates/assets • R7 - Combining expertise in clinical support services to provide consistent services (Liverpool) • R9 - Attracting and retaining talent in Health and Social Care within Liverpool City Region

		• R11 - Integrating digital systems to improve care delivery • R12 - Making best use of resources to secure financial sustainability for all organisations in Liverpool. Should the Sub-Committee identify further opportunities to improve clinical services on the Aintree Site through collaboration, these additional workstreams will be agreed to and overseen by the Sub-Committee as part of the Work Plan. The following principles will inform the work of the Sub-Committee in delivering the Work Plan: • Ensure that proposals are underpinned by demand and capacity analysis • Ensure that clinicians are at the forefront of the development of the envisaged approach on each site, with appropriate clinical leadership from each organisation to oversee the work and facilitate involvement from the clinical community • Ensure engagement with partners in the urgent care pathway, including General Practice, community and mental health providers, North West Ambulance Service NHS Trust, to incorporate pre- and post-hospital elements of the pathway • Ensure engagement with wider system partners who may be impacted or have the potential to mitigate the impact of any proposed pathway changes including the ICB, neighbouring Place systems, CMAST, NHS Commissioning: Specialist Services, and the C&M MHLDC • Ensure that programmes of work are resourced to deliver, securing a dedicated team from relevant Trusts to support the Sub-Committee to develop and implement the operating model for each site, undertaking design work and modelling for operational and proposed service transformation. • Ensure that the Work Plan complies with statutory duties and best practice standards in delivering service change • Ensure that any need for patients, public and stakeholders' involvement are identified as a core part of the Work Plan and form part of a planned engagement approach with patients, public and stakeholders • Ensure no detriment to patients within a wider geography to Liverpool.

4	Scope	The Sub-Committee shall identify the projects and areas it will work on to achieve its Purpose in its Work Plan. The Sub-Committee may add and remove projects and areas from the Work Plan from time to time provided that they are linked to the Purpose set out in Section 2.
5	Status and legal basis	The Sub-Committee is established by the LTJC pursuant to sections 65Z5 and 65Z6 of the 2006 Act. Functions within its scope which are formally delegated by the Trusts to the LTJC and any approved sub-group in accordance with paragraph 6 below. The Trusts have the power to arrange for any of their functions to be exercised by the other or jointly with each other under section 65Z5 of the 2006 Act. Where the Trusts have arranged for functions to be exercised jointly, they have the power to form a joint committee for this purpose under section 65Z6 of the 2006 Act, and to establish and maintain a pooled fund. The Trusts must have regard to the guidance published by NHS England in March 2023 (and any subsequent/replacement guidance) about the exercise of these powers.
6	Decision-Making	The Trusts may formally delegate decision-making to the Sub-Committee in relation to particular projects or workstreams within the Work Plan. Such delegations will be in accordance with the guidance given by NHS England. Delegations will be appended to these Terms of Reference and must be delivered in accordance with these Terms of Reference and the Delegation. If there is any conflict between these Terms of Reference and a Delegation, the Delegation will prevail. The Sub-Committee shall make decisions by consensus of all Members. If consensus cannot be reached between all Members, the matter will be referred to the Trust boards for further consideration and/or escalated to the LTJC for an alternative non-binding perspective to be offered.
7	Accountability	The Sub-Committee is accountable to the LTJC.
8	Reporting arrangements	The Members from each Trust shall be responsible for ensuring that appropriate reporting is made to their Trust board and their Trust's Council of Governors and that feedback from their Trust is fed through to the Sub-Committee. The Sub-Committee shall submit a summary of the minutes from the Chair to each LTJC meeting. The Sub-Committee shall ensure that the work of any working groups is reflected in its own minutes. The Sub-Committee shall provide an annual report to the LTJC and Trust Boards.
9	Membership	The Members of the Sub-Committee are:

		• A Chair. This will be the Chair of TWC as appointed by agreement between Trusts. • A minimum of one Non-Executive Director from each Trust • A minimum of one Executive Director from each Trust • A medical or clinical leader from each Trust who operates from the site Decisions are taken by the Members as set out in paragraph 6 above.
10	Attendees	The Chair of the Sub-Committee may invite such attendees to meetings to provide information or be involved in discussion as the Chair considers appropriate. The following shall be invited to attend every meeting of the Sub-Committee: • Company Secretary, TWC • Company Secretary, LUHFT The Trusts agree to make any of their officers who are involved in delivery of the Work Plan available to attend the Sub-Committee as requested.
11	Deputies	With the permission of the Chair, Members may nominate a deputy to attend a meeting that they are unable to attend. The deputy may speak and vote on their behalf and count in the quorum. The decision of the Chair regarding authorisation of nominated deputies is final. Should permission not be granted, the Chair will provide details of the rationale to the respective organisation. Such nominations should usually be received five working days before the date of the meetings and should always include a short explanation as to why the nomination of a deputy is necessary. The nominated deputy must ensure that they understand the extent to which they are able to take decisions on behalf of their Trust.
12	Chair	The first Chair of Sub-Committee (the "**Chair**") shall be the Non-Executive Director of TWC. Unless otherwise agreed by a majority of the remaining Members, the Chair will rotate on an annual basis between the two organisational Non-Executive members. Meetings of the Sub-Committee will be run by the Chair. The decision of the Chair on any point regarding the conduct of the Sub-Committee shall be final. The first Deputy Chair of Sub-Committee shall be the Non-Executive Director of LUHFT who will remain in this position unless otherwise agreed by a majority of

		the remaining Members. If the Chair is not in attendance, then reference to Chair in these Terms of Reference shall be to the Deputy Chair.
13	Quoracy	As a minimum, two Members from each Trust, or their authorised deputy, must be in attendance for the Sub-Committee to be quorate. If any Member of the Sub-Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum. Members may participate in meetings by telephone, video or by other electronic means where they are available and with the prior agreement of the Chair. Participation by any of these means shall be deemed to constitute presence in person at the meeting provided all Members are able to hear and speak to one another.
14	Frequency of Meetings	The Sub-Committee will meet at least bi-monthly in private. Additional meetings may take place as required by giving not less than 14 calendar days' notice in writing to all Members. The Chair may call an additional meeting at any time by giving not less than 14 calendar days' notice in writing to Members. Three of the Members may request the Chair to convene a meeting by notice in writing, specifying the matters which they wish to be considered at the meeting. If the Chair refuses, or fails, to call a meeting within seven calendar days of such a request being presented, the Members signing the requisition may call a meeting by giving not less than 14 calendar days' notice in writing to all Members specifying the matters to be considered at the meeting. In emergency situations the Chair may call a meeting with two days' notice by setting out the reason for the urgency and the decision to be taken.
15	Declaration of Interests	If any of the Members has an interest, financial or otherwise, in any matter and is due to be present at the meeting at which the matter is under discussion, he/she will declare that interest as early as possible and act in accordance with the NHS England guidance on managing conflicts of interest in the NHS as

		applicable from time to time. The Chair of the meeting will determine how a conflict of interest should be managed. The Chair of the meeting may require the individual to withdraw from the meeting or part of it. The individual must comply with these arrangements, which must be recorded in the minutes of the meeting.
16	Support to the Sub-Committee	The Lead Officer for the Sub-Committee is the Company Secretary of TWC and is responsible for managing agendas and all governance arrangements for the Work Plan. The Sub-Committee will be provided with administrative support. This will include: • Seeking agenda items from Members two weeks in advance of each meeting; development and agreement of the agenda with the Chair in consultation with the Lead Officer • Sending out agendas and supporting papers to Members at least five working days before the meeting • Liaising with attendees invited to Sub-Committee meetings under paragraph 10 • Drafting minutes including an updated version of the Work Plan for approval by the Chair within five working days of any Sub-Committee meeting • Distributing approved minutes (including updated Work Plan) to all attendees following within 10 working days of Chair's approval • Maintaining an on-going list of actions, specifying which Members are responsible, due dates and keeping track of these actions • Publicising Sub-Committee meetings, minutes and associated documents as appropriate • Providing such other support as the Chair requests, for example advice on the handling of conflicts of interest.
17	Authority	The Sub-Committee is authorised to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires within its remit, from any officer of the Trusts. The Trusts shall ensure that their officers co-operate fully and promptly with any such request made by the Sub-Committee. The Sub-Committee is authorised to commission any reports or surveys it

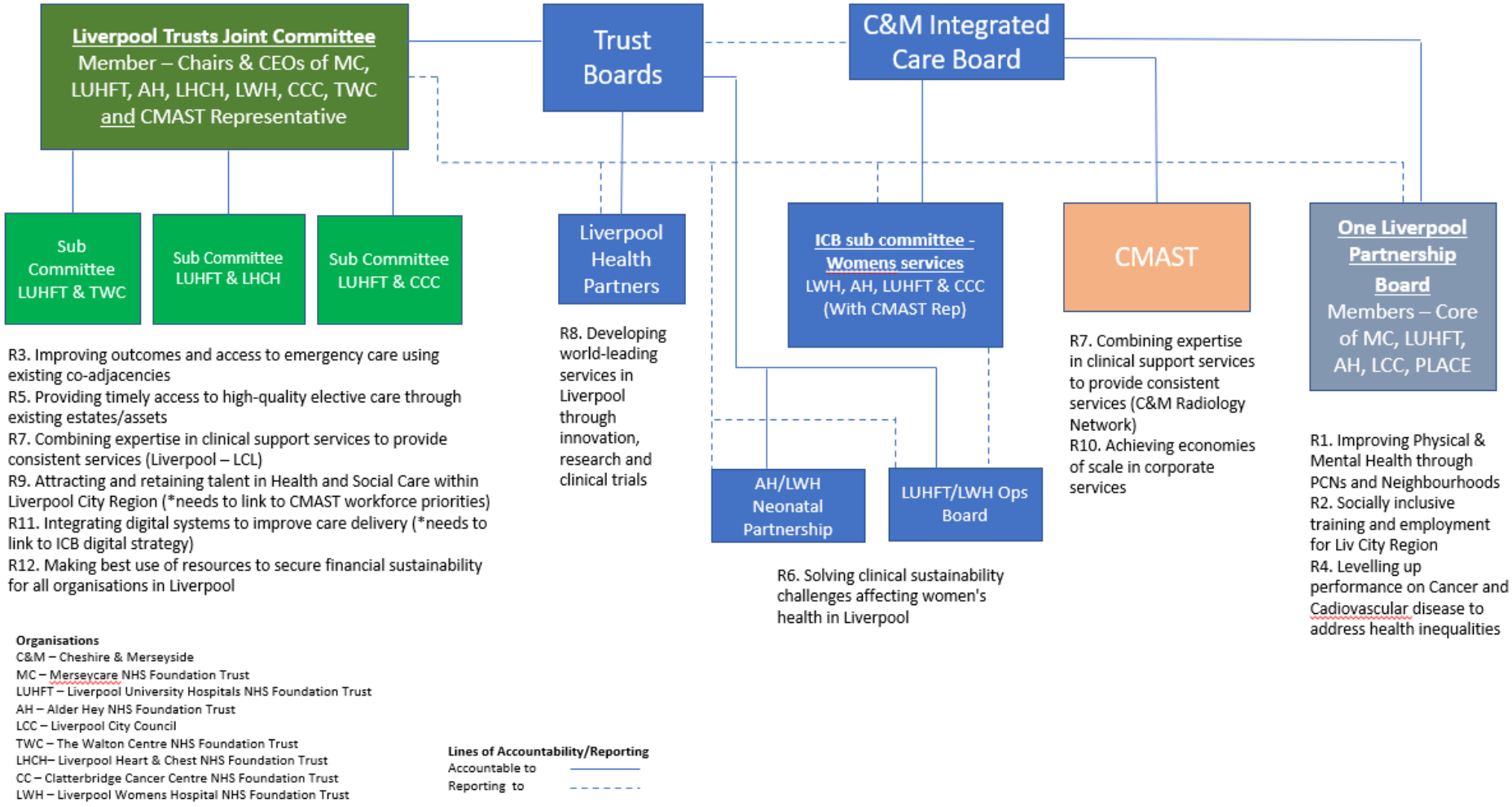
		deems necessary to help it fulfil its obligations provided it ensures that full funding is available to meet the associated costs. The Sub-Committee will require the authorisation of the LTJC to obtain legal/other independent professional advice. The Sub-Committee is authorised to create working groups as are necessary to achieve its Purpose. The Sub-Committee is accountable for the work of any such group.
18	Conduct of the Sub-Committee	Members must demonstrably consider the equality and diversity implications of decisions they make and consider whether any new resource allocation achieves positive change around inclusion, equality and diversity. Members of the Sub-Committee will abide by the 'Principles of Public Life' (The Nolan Principles) and the NHS Code of Conduct. Members will act in accordance with the principles for collaboration agreed by all trusts: • The best interests of patients and the financial sustainability of the system will lead decision making. Organisational interests are important, but subservient to this principle • Working together to create a strong employer brand to improve recruitment and retention rates, reduce recruitment costs, and increase pride amongst staff • Decision-making will be evidenced based and collective. An infrastructure will be established to ensure consistency of evidence and data to enable trusts to seek assurance on a case for change, proposals and business cases. • Sub-Committees must meet the standards of openness and engagement that are expected of NHS bodies delivering care for patients. Decision making will be clinically led, with patients, public, staff and other stakeholders engaged and involved. The Sub-Committee shall undertake an annual self-assessment of its own performance against the Work Plan and these Terms of Reference. This self-assessment shall form the basis of the annual report from the Sub-Committee to the LTJC and each of the Trust boards.
19	Amendments	These Terms of Reference may only be amended by resolution of the LTJC. Any amendments shall only take effect upon the LTJC agreeing the change to the Terms of Reference.

20	Review date	These Terms of Reference will be reviewed after the first six months of its operation (by no later than January 2024) and then on an annual basis unless required by the Sub-Committee. Any proposed amendments to the Terms of Reference will be required to be approved by the LTJC.

Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

APPENDIX 2 – LIVERPOOL CLINICAL SERVICES REVIEW GOVERNANCE ORGANOGRAM



Liverpool University Hospitals NHS Foundation Trust

The Walton Centre NHS Foundation Trust

TEMPLATE DELEGATION

[To be determined]

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

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

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

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

Key Messages *(2/3 headlines only)*

- See summary for performance overview

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

- Ongoing

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

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

001 Quality Patient Care	004 Operational Performance	003 System Finance

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Integrated Performance Report

Executive Summary

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

Operations & Performance Indicators

High Performing
Cancer Standards
Diagnostics
28 Day Emergency Readmissions
% of Patients on a PIFU
New Referrals
Flow (leading indicators)

Opportunity for improvement
Activity Restoration
Referral to Treatment
Outpatient Waiting List

Underperforming
% of beds occupied by 14 day stranded patients
Theatres

Workforce Indicators

High Performing
Vacancies
Mandatory Training

Opportunity for improvement
Other Staff Turnover
Appraisal Compliance

Underperforming
Sickness/Absence

Quality Indicators

High Performing
VTE
Mortality
Surgical Site Infections
Hospital Acquired MRSA, C Difficile, E coli and Klebsiella.

Opportunity for improvement
Hospital Acquired Pseudomonas
Hospital Acquired MSSA
Never Events
CAUTI
Friends and Family Test (% Recommended)

Underperforming
Hospital Acquired Pressure Ulcers
Serios Incidents

Finance Indicators

Key Performance Indicators	May	June	July
% variance from plan - Year to date	0.9%	0.5%	0.3%
% variance from plan - Forecast	0.0%	0.0%	0.0%
% variance from efficiency plan - Year to date	0.0%	0.0%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	-53.3%	9.1%	46.2%
Capital % variance from plan - Forecast	0.0%	0.0%	0.0%
Capital Service Cover *	5.0	3.1	3.6
Liquidity **	40.8	40.8	43.7
Cash days operating expenditure ***	103.0	92.0	100.0
BPPC - Number	86.5%	87.9%	88.9%
BPPC - Value	83.7%	87.7%	89.6%

Conclusion

Performance is generally good in spite of several opportunities for improvement. There was one Serious Incident raised in July which was related to a wrong site operation in theatres. This means we have seen more than the targeted trajectory of Serious Incidents in 2023/24 to date.

Recommendation

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

Author: Rebecca Sillitoe – Senior Information Analyst
Date: 29/08/2023

The Walton Centre NHS
NHS Foundation Trust

Board Report
September 2023

Data for July 2023 unless indicated

Notes

Explanation of SPC Charts and Assurance Icons

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

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

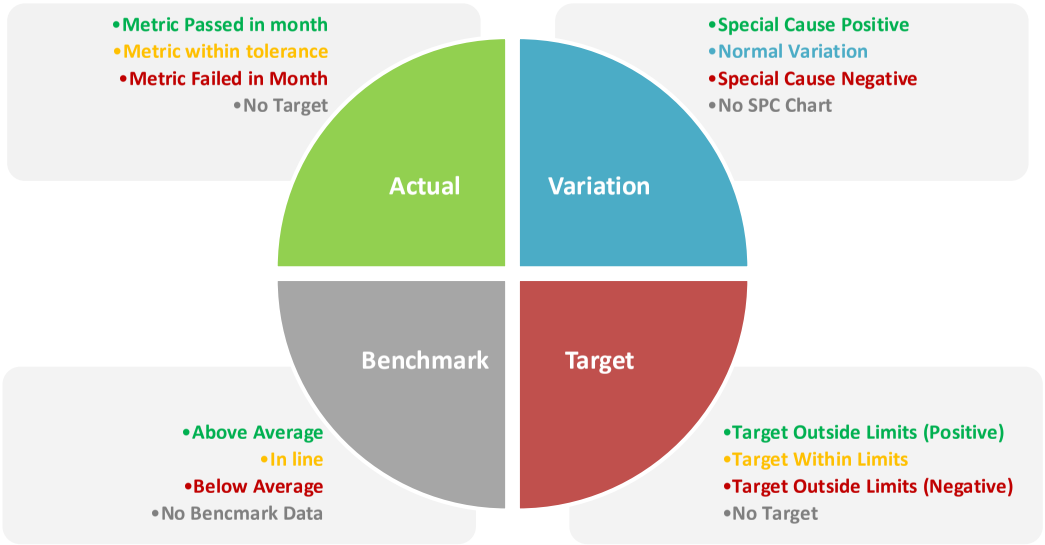
All SPC charts will follow the below key unless indicated

Actual UCL Average LCL National Average Target

= Part of Single Oversight Framework = Mandatory Key Performance Indicator

Assurance Icons (Colour Key)

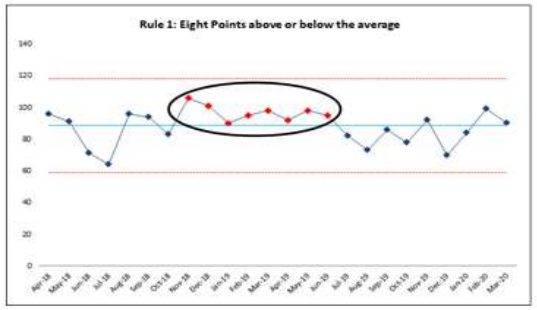
All metrics now have an Assurance Icon consisting of 4 components. These give assurance on; in month performance against target, whether any SPC variation rules have been triggered, whether the target is achievable, and how the organisation compares to benchmarked data.

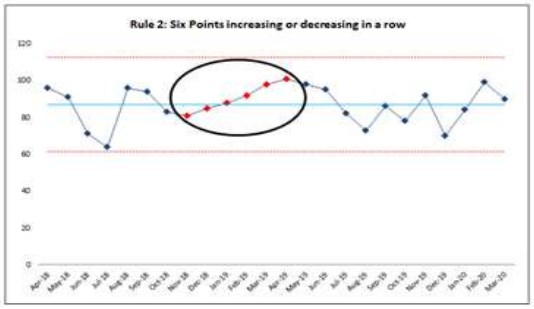


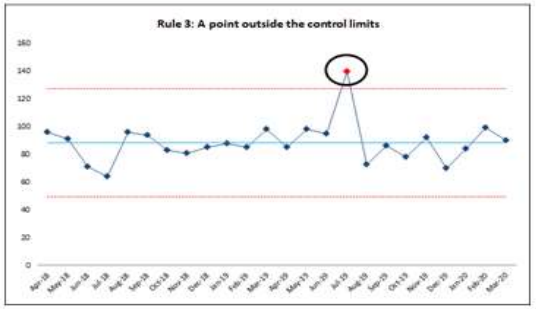
Notes

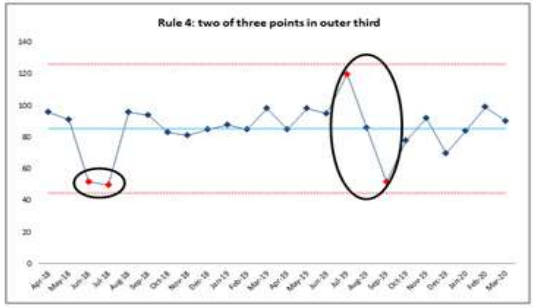
Statistical Process Control Chart Rules

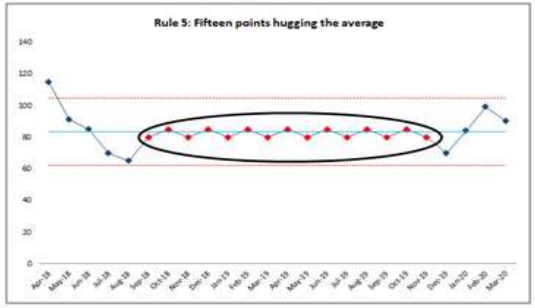
When using SPC Charts we are looking for unexpected variation. Variation occurs naturally in most systems, numbers fluctuate between typical points (control limits) the below rules are to assist in separating normal variation (expected performance) from special cause variation (unexpected performance).











Operations & Performance Indicators

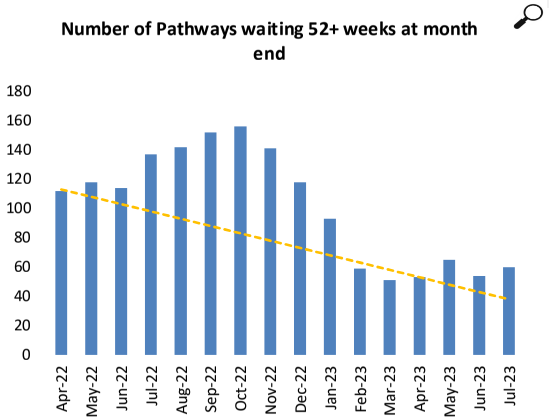
Operational - Responsive

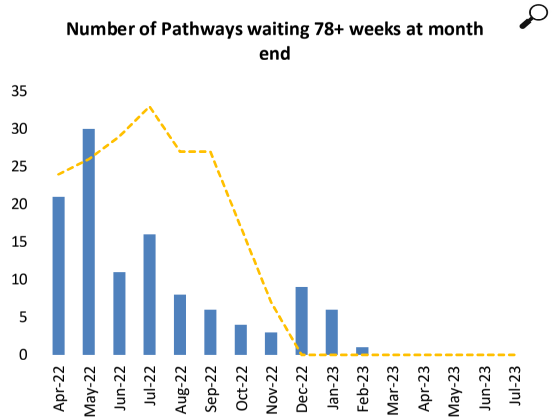
Referral to Treatment

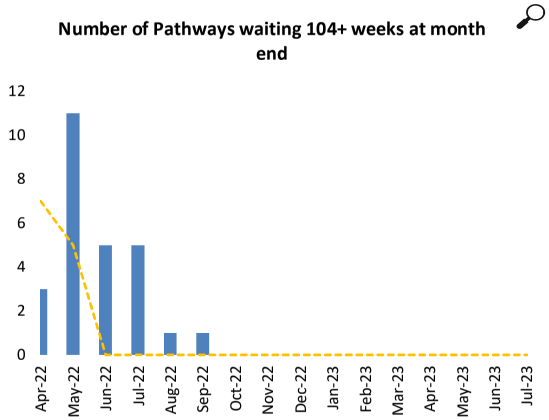
The number of patients waiting more than 52 weeks for treatment has increased slightly this month compared to last but is in line with figures for the last six months. There are currently no patients who have been waiting longer than 78 weeks for treatment. The trajectory to reach zero patients waiting longer than 65 weeks has been extended to March 2024.

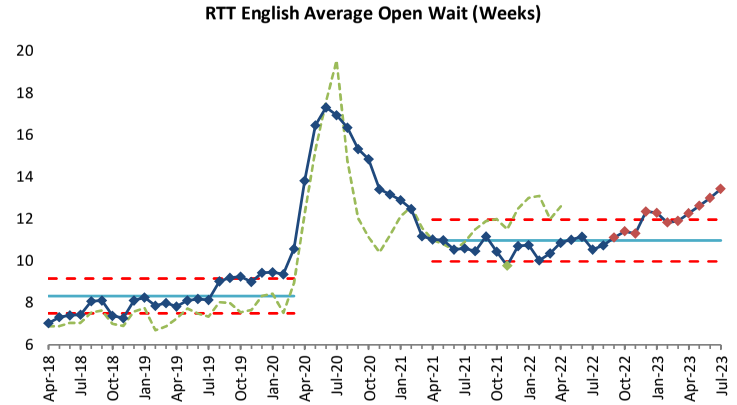
Waiting times in Wales remain in special cause negative variation with a run what is now fifteen months below the mean, and the English average wait has increased again this month, giving a run of eleven months above the mean, six of which are also above the upper control limit.

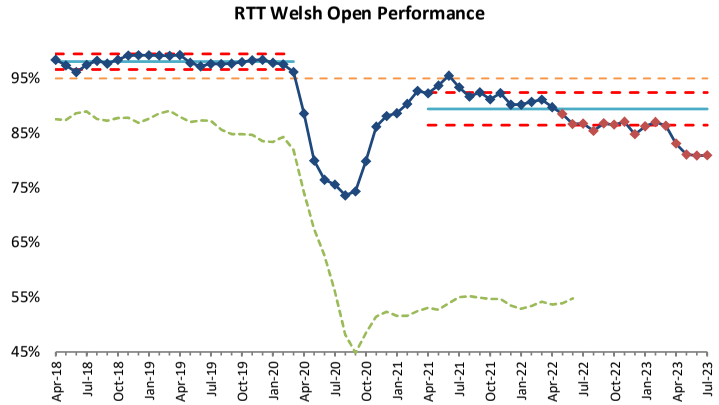
As part of plans to restore services to pre-COVID levels, each Trust was required to submit a trajectory along with timescales for reducing long waits. The Walton Centre have achieved this trajectory but may see fluctuations with mutual aid requests.









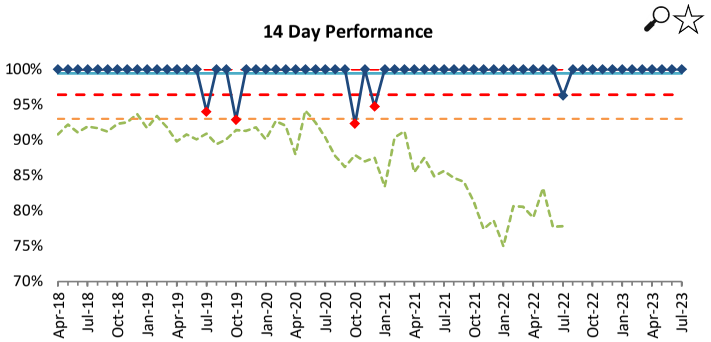


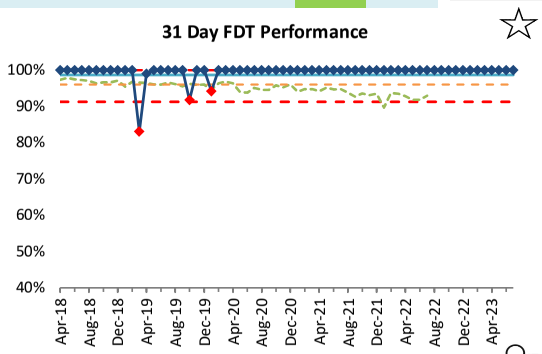
Operational - Responsive

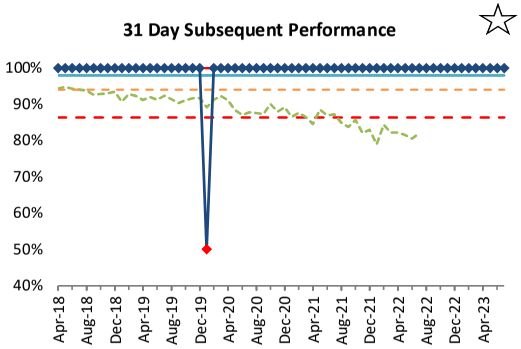
Cancer Standards

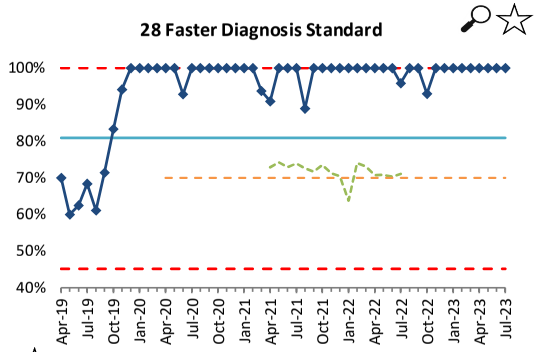
Access Standards	Target	Actual	
Cancer TWW	93%	100%	
Cancer 31 Day FDT	96%	100%	
Cancer 31 Day Sub	94%	100%	
Cancer 62 Day Standard	85%	NA	
28 Day Faster Diagnosis Standard	70%	100%	

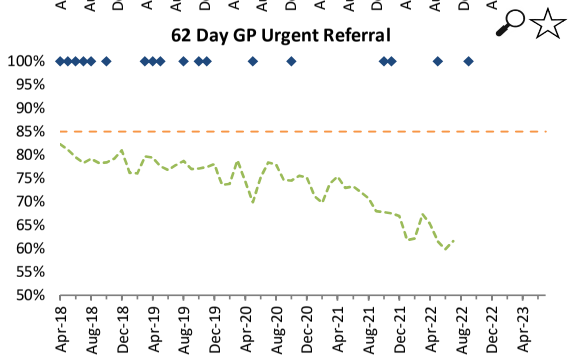
The Trust has continued to see and treat all cancer patients as these patients are designated as urgent, this is in line with NHSE requirements.

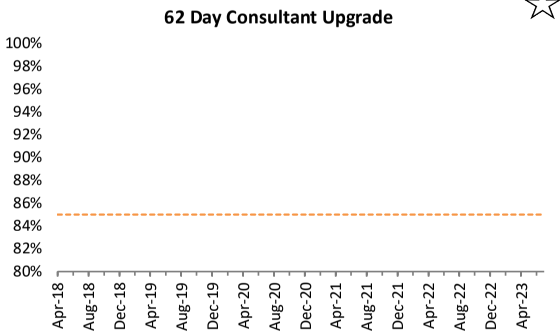












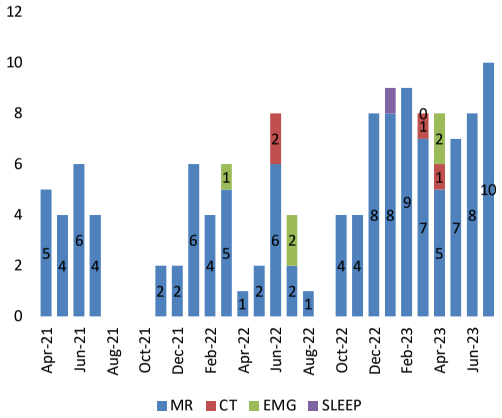
Operational - Responsive

Diagnostics

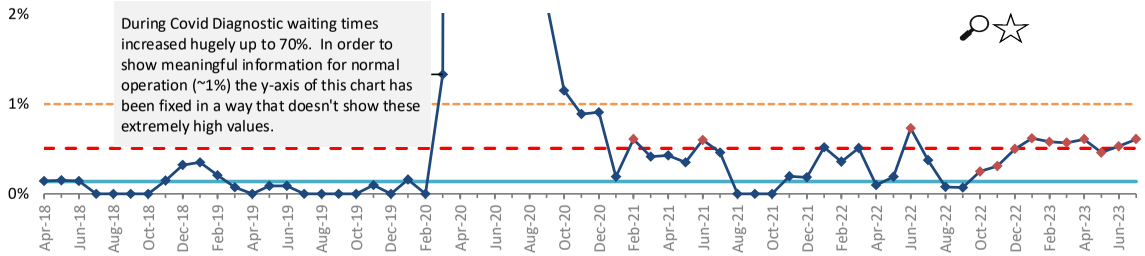
Access Standards	Target	Actual
Diagnostic 6 Week Performance	1%	0.61%

Achievement against the Diagnostic 6 week standard has been met in month. There were ten breaches of the six week standard in month, all MRI related. There has been industrial action among Radiologists in July. Diagnostic performance continues to run above the mean as it has for the past ten months. Performance continues to meet target.

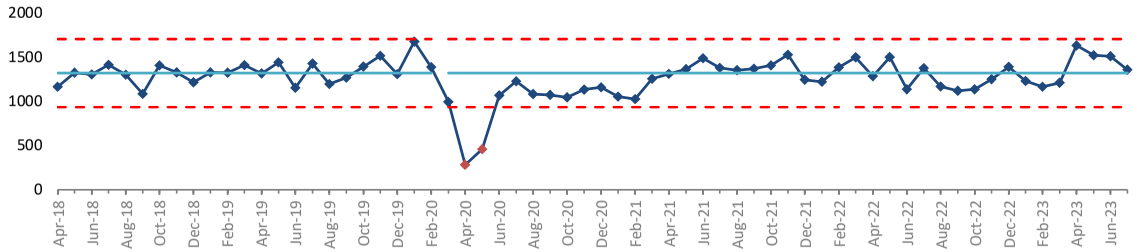
Diagnostic Breaches by Type



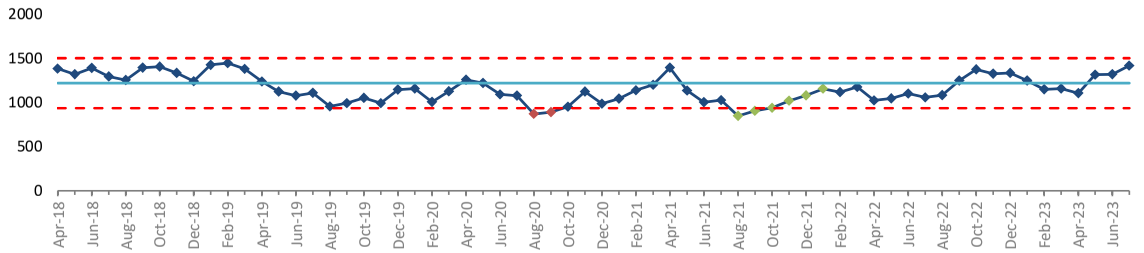
6 Week Diagnostic Performance



Total Diagnostic Activity in Month



Total Diagnostic Waits at Month End



Operational - Effective

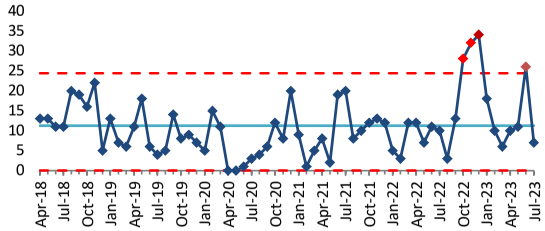
Theatres

	Target	Actual	Assurance
No. Non Clinical Cancelled Operations	-	7	
% Cancelled operations non clinical on day	0.80%	0.60%	
28 Day Breaches in month	0	5	

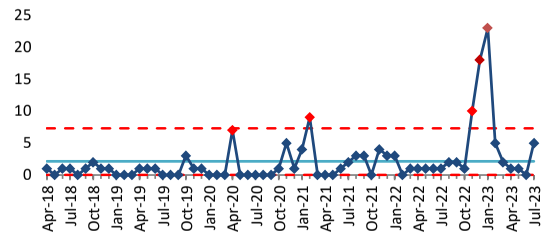
There were 53 unused sessions in July and utilisation remains below the lower control limit. The trust continues to work with Productive Partners as part of the theatre utilisation transformation work to ensure theatre capacity is utilised appropriately. The overwhelming majority (50 of 53) of unused sessions were related to strike action by either junior doctors, consultants or radiologists.

There were seven non-clinical cancellations in July and five breaches of the 28 day reschedule. Operations have been cancelled for various reasons with no particular reason dominating over others.

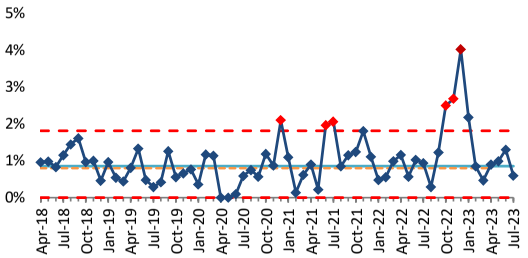
Number of Cancelled operations non clinical (on day)



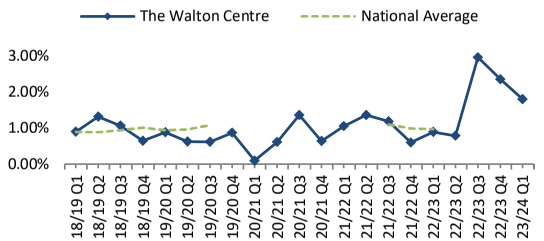
Number of cancelled operations not re-admitted within 28 days



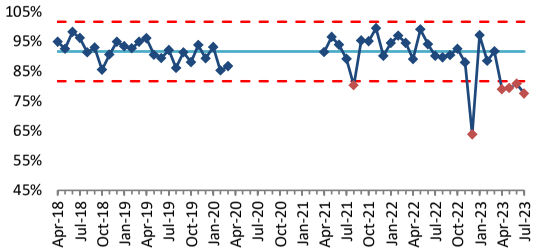
% of Cancelled operations non clinical (on day)



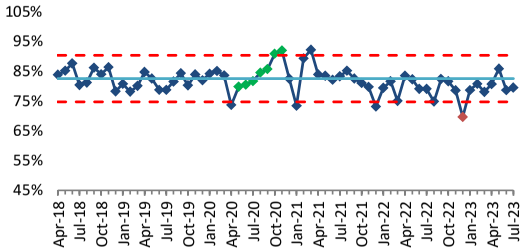
Non Clinical Cancelled Ops as a % of Elective Admissions



Theatre utilisation of Elective Sessions



Theatre utilisation of in Session Time



Operational - Effective

Elective Activity vs Plan

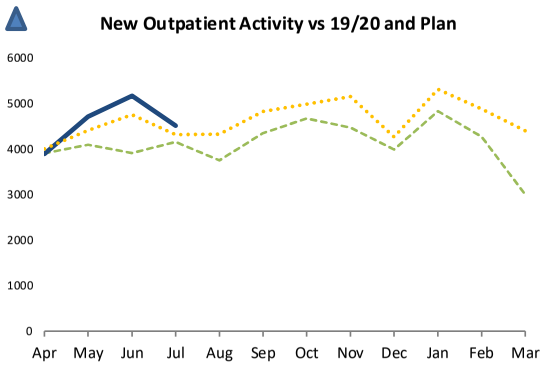
Legend for all charts on page

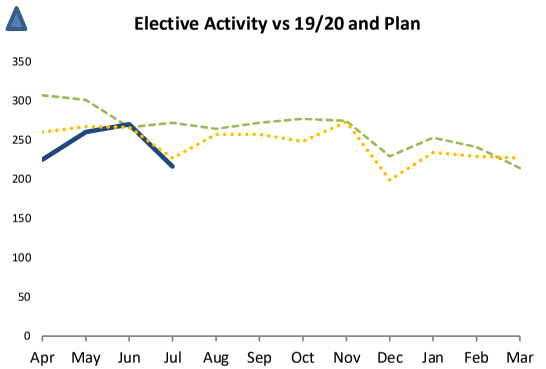
19/20 Act 23/24 Act 23/24 Plan

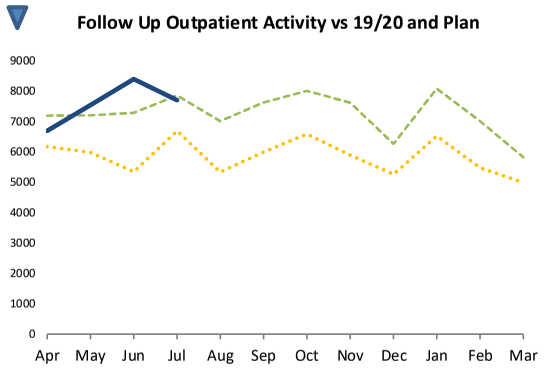
This page monitors the elective performance against plan for this year. The plan for follow up activity requires a reduction in activity rather than an increase as in the case of other metrics. The direction of good performance is indicated by the blue arrow in the top left of each chart.

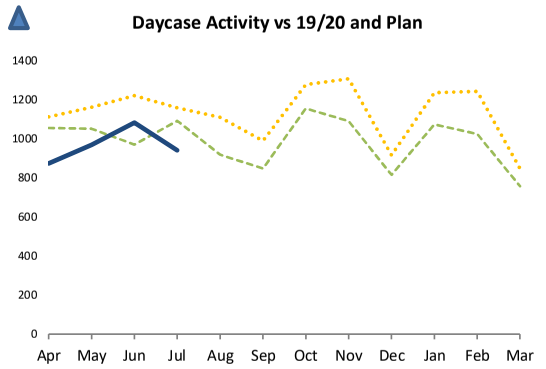
So far this year new outpatient activity slightly ahead of plan but follow ups remain higher than the targeted reduction. Every type of inpatient activity is behind the year to date plan for the year.

	Actual YTD 2023/24	Plan YTD 2023/24	Percentage of Plan YTD
Daycase	3,866	4,653	83.1%
Elective	971	1,020	95.2%
Elective & Daycase Total	**4,837**	**5,673**	**85.3%**
Non-Elective	587	607	96.7%
New Outpatient	18,288	17,488	104.6%
Follow Up Outpatient	30,311	24,181	125.4%









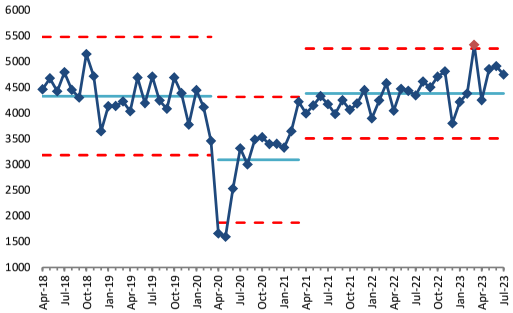
Operational - Effective

Activity

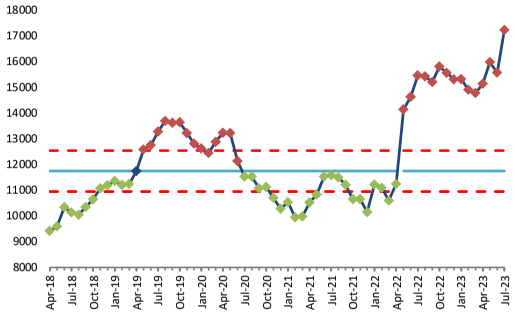
Referrals in month are slightly down from last month but remains within normal variation. New Outpatient Waiting List very high compared to the control range, still driven by pressures in Neurology division, specifically the transistion of patients to new consultants . Neurosurgery outpatient list continues to fall.

Overdue Follow Up Outpatient waiting list has been climbing slightly over the past two years but the small hump we saw at the beginning of 2023 has started to reduce over the last few months.

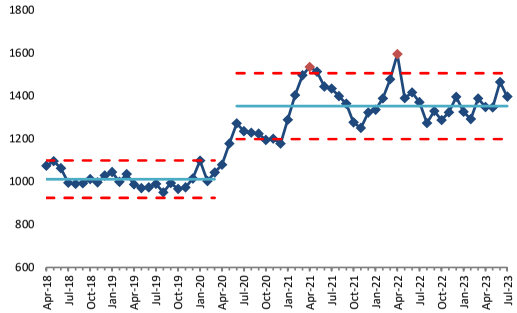
Total New Referrals Received



Trust New Outpatient Waiting List

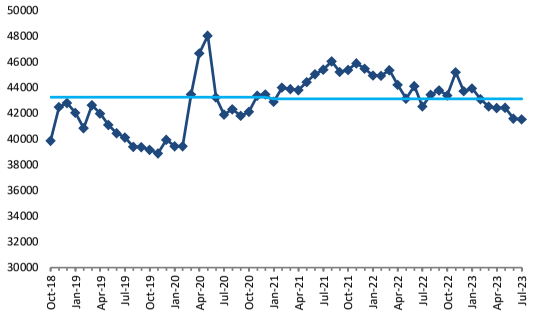


Inpatient Waiting List

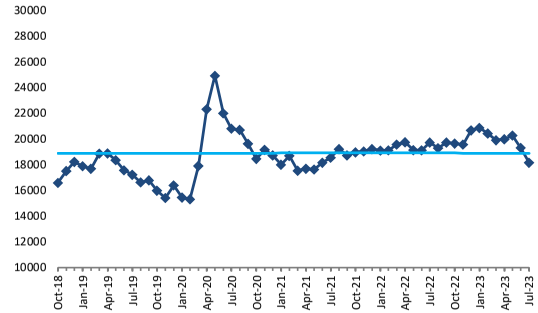


*Spinal transfer patients added to OPWL

Follow Up Outpatient Waiting List



Follow Up Outpatient Waiting List (Overdue)



Operational - Effective

Flow

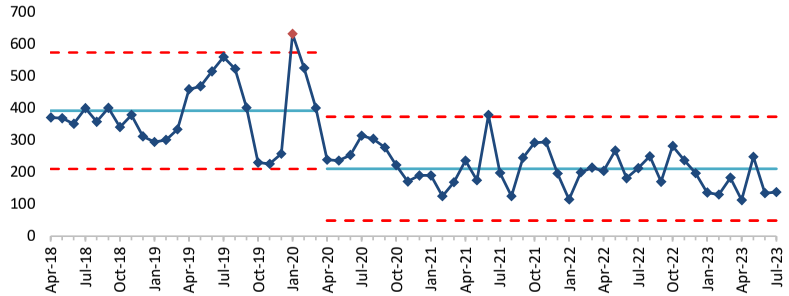
Effective - Flow	Target	Actual	Assurance
% 28 Day Emergency Readmissions (Local)	-	3.06%	
Total Delayed Discharge Days	-	138	
% Discharges by 5pm	-	58.28%	
% 14 Day Stranded Patients	-	27.06%	

The run of unusually high (above the mean) percentage 14 Day Stranded patients continues, meaning this metric has been high for the last ten months. All other flow metrics remain within normal variation.

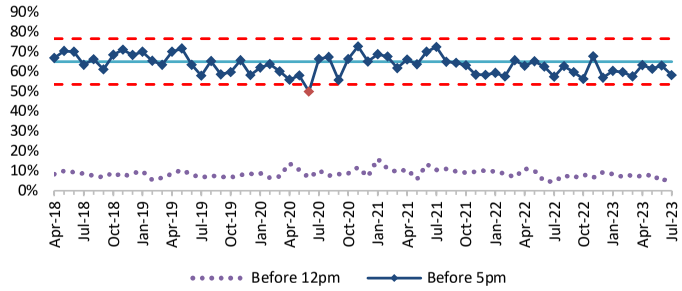
Rehab patients are excluded from the stranded patients metric as they are expected to have long lengths of stay. The majority of 14 day stay patients are non-elective admissions, which would be expected given mean non-elective length of stay in July was 15 days.

Emergency readmissions have dropped level with the lower control limit in July having been close to the upper control limit last month.

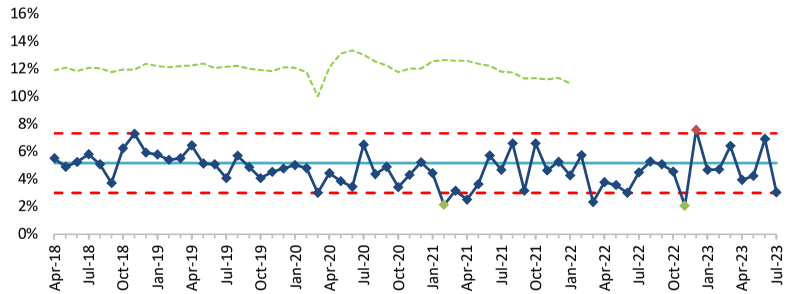
Total delayed transfer of care days



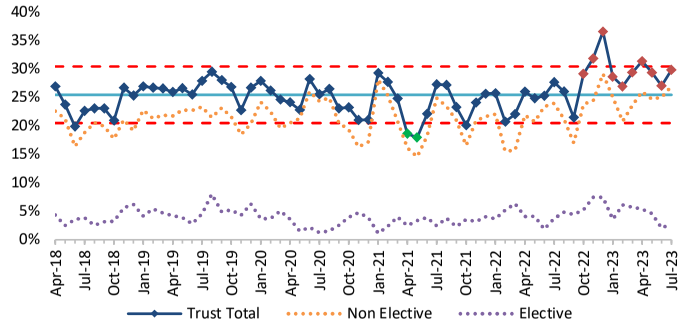
% Discharges to usual residence before 5pm



% 28 day emergency readmissions (local)



% of beds occupied by 14 day stranded patients



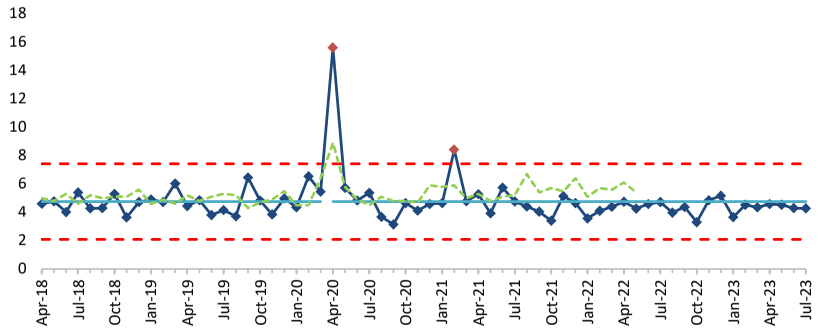
Operational - Effective

Flow (Leading Indicators)

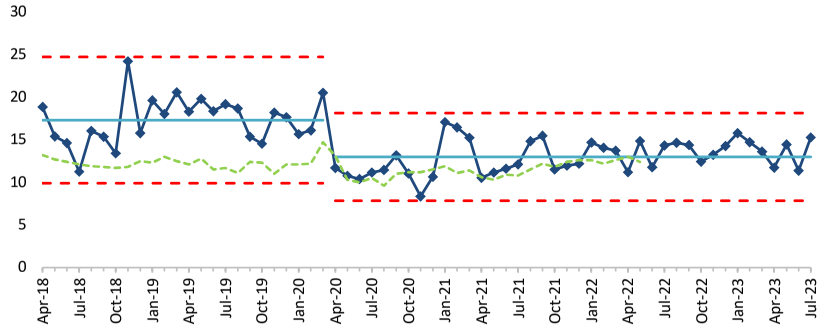
Effective - Flow	Target	Actual	Assurance
Elective LOS	-	4.28	
Non Elective LOS	-	15.27	
Day of Surgery Admission %	-	65.78%	
Daycase Rate	-	80.56%	

Non elective length of stay has increased this month compared to last. All metrics are within normal variation which is positive as this is an area of focus for patient flow transformation work. Day of surgery admission is within normal limits, we do recognise that not all patients can be admitted on the day of procedure due to complexities. Day case admission rates are being maintained.

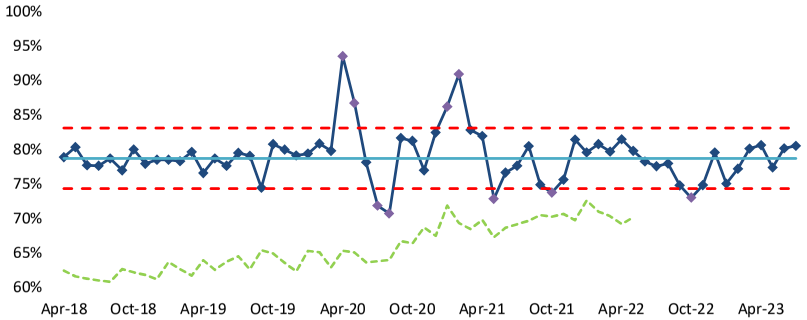
Elective Length of Stay (Days)



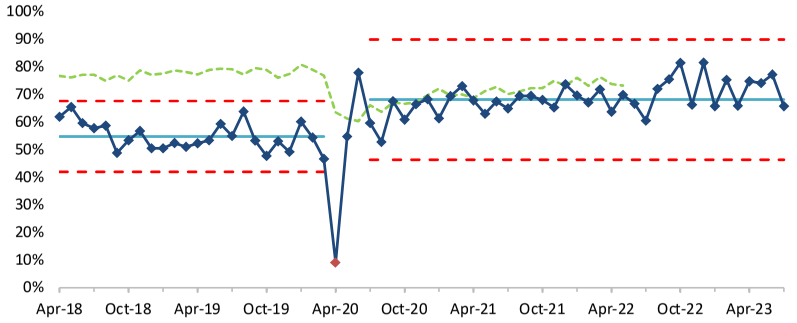
Non Elective Length of Stay (Days)



% of Elective Admissions as Daycases



Day of Surgery Admission %



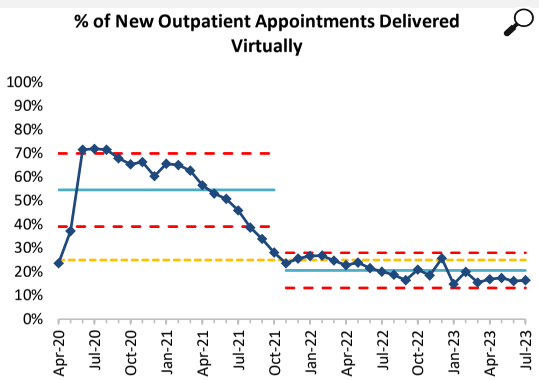
Operational - Effective

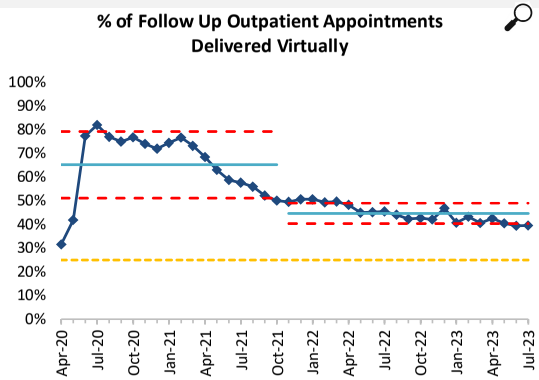
Outpatient Transformation

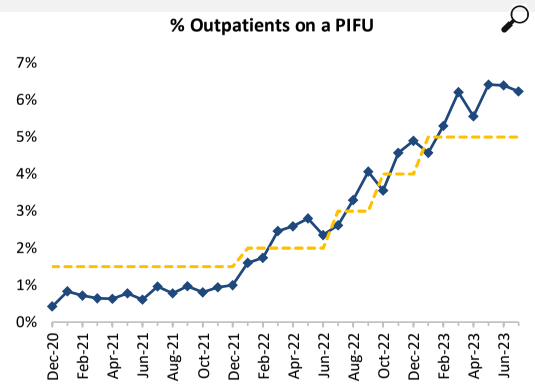
Virtual Appointments: The Trust is required to deliver a minimum of 25% of its total outpatient appointments virtually. Although new appointments have dipped below this threshold in the last five months the trust as a whole remains above the target. Following a switch to deliver mainly virtual appointments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

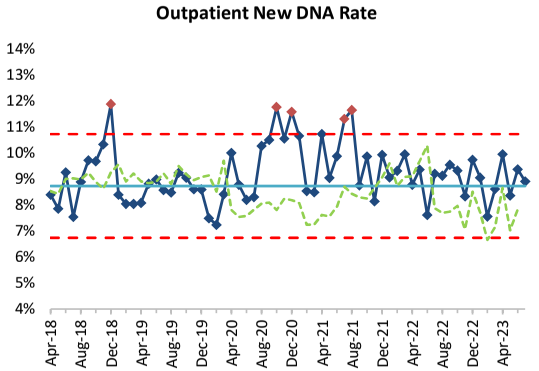
DNA Rate: The New DNA remains within normal variation, as it has been for the last 23 months. The follow Up DNA rate has increased again this month and is starting to approach the previous peak we saw in the winter of 2022. This remains a focus of work in outpatient transformation.

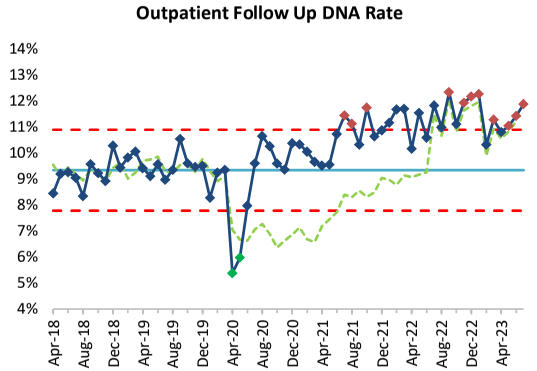
Patient Initiated Follow Up (PIFU): As part of national Outpatient Transformation schemes the guidance is to work towards 5% of our total outpatients on a Patient Initiated Follow Up by March 2023. The percentage of outpatient appointments with PIFU outcome in July (6.23%) is slightly less than June (6.40%) but broadly in line with the last two months.

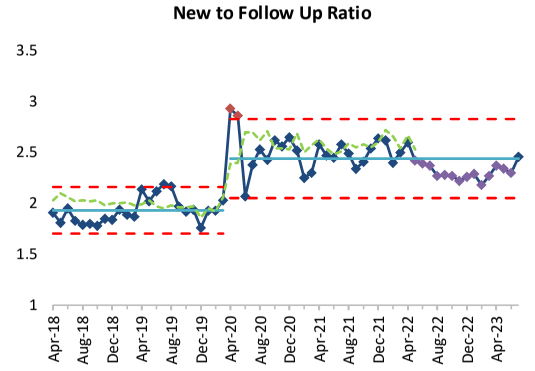












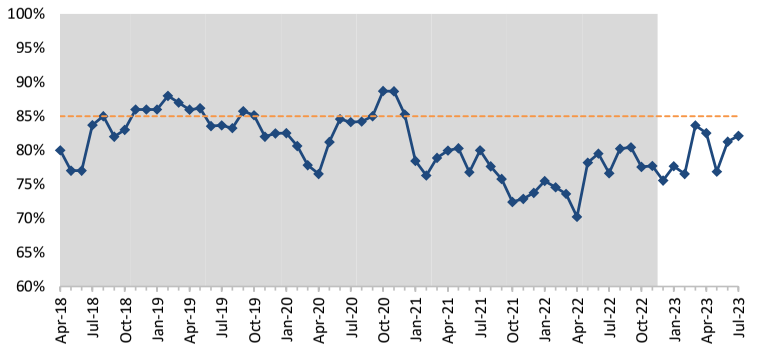
Well Led - Work force

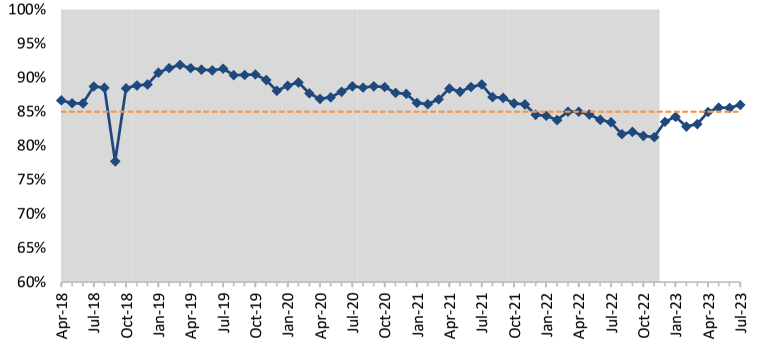
Workforce KPIs

Well Led - Workforce	Target	Actual	Assurance
Appraisal Compliance	85%	82.13%	
Mandatory Training Compliance	85%	86.02%	

Appraisal compliance has decreased this month but remains close to target. Mandatory training has increased again this month and remains above target.

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

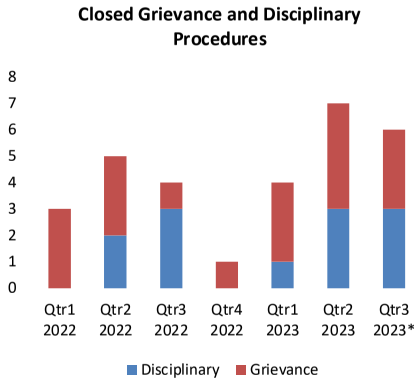




Grievance and Disciplinary Procedures

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

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



Open Disciplinaries

3

Open Grievances

3

Workforce KPIs

Well Led - Workforce	Target	Actual	Assurance
Sickness / Absence	4.75%	5.23%	
Trust Turnover	-	16.51%	
Nursing Turnover	-	11.98%	
Other Staff Turnover	-	18.48%	

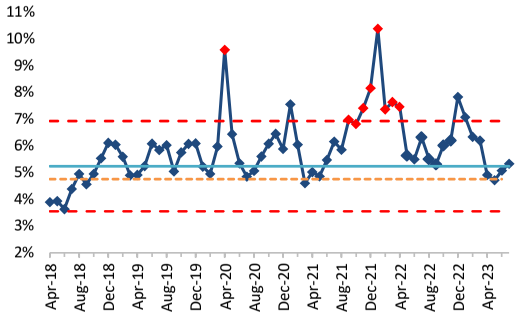
Sickness/Absence

Sickness absence has increased again in July but remains comfortably in the centre of normal variation.

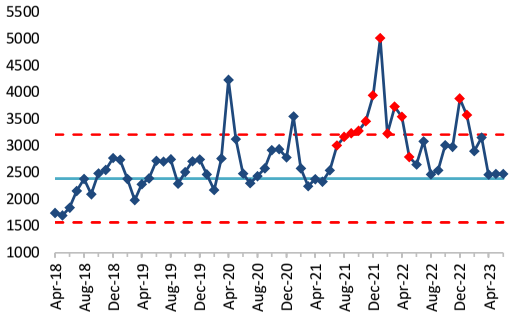
Turnover

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

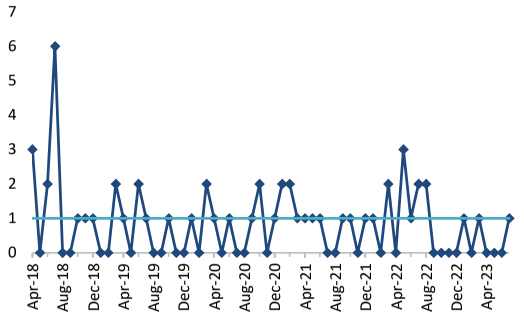
Sickness/Absence (Monthly)



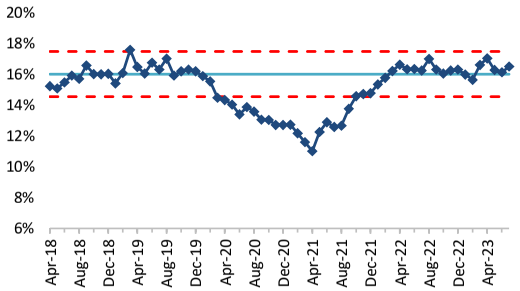
Lost Days due to Sickness/Absence (Monthly)



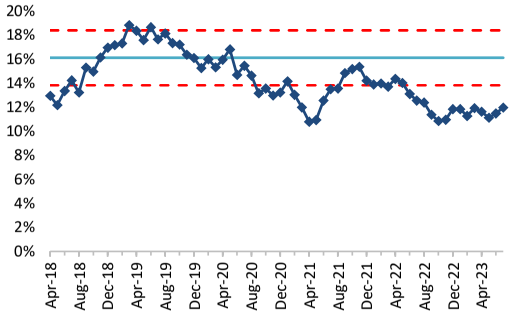
Medical Leavers



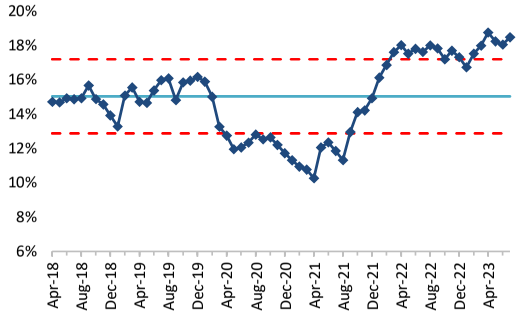
Trust Turnover (Rolling 12 months) - All Staff Groups



Nursing Turnover (Rolling 12 months)



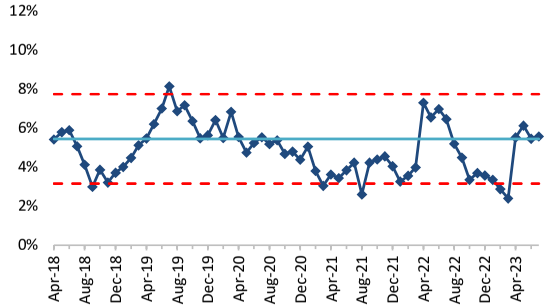
Other Staff Turnover (Rolling 12 months)



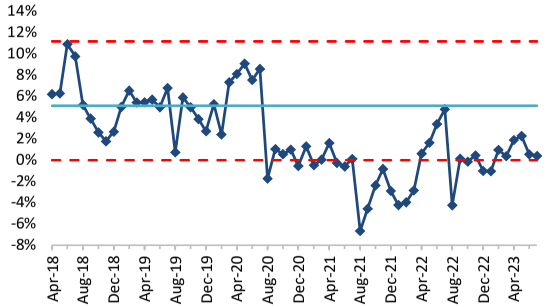
Well Led - Work force

Workforce KPIs

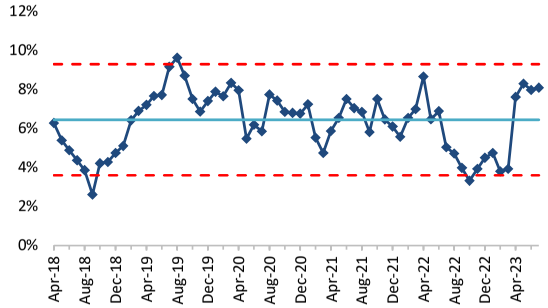
Overall Vacancy Level %



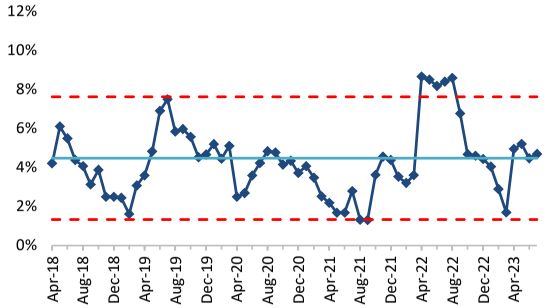
Medical Vacancy Level %



Nursing Vacancy Level %



Other Staff Vacancy Level %

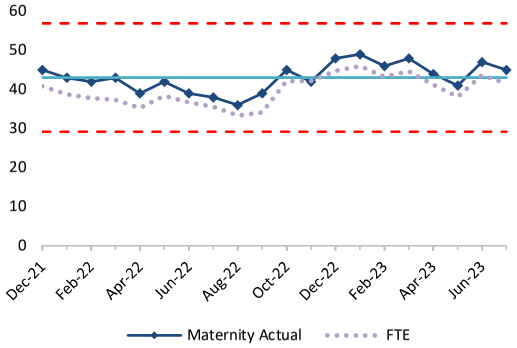


Vacancy Rates

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

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

Trust Level Maternity Data



Current month maternity figures

Directorate	Headcount	FTE
Corporate Services Directorate	2	1.8
Neurology & Long Term Care	20	17.81
Surgery & Critical Care	23	21.92
Grand Total	**45**	**41.53**

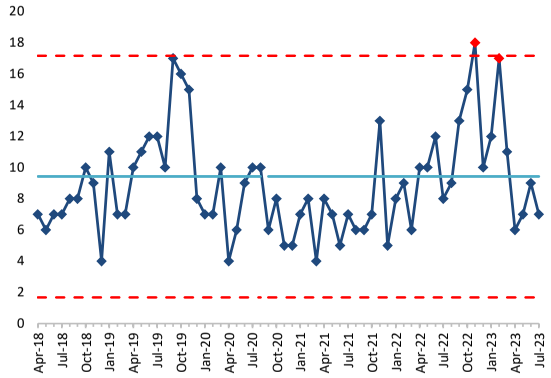
Quality Indicators

Quality of Care

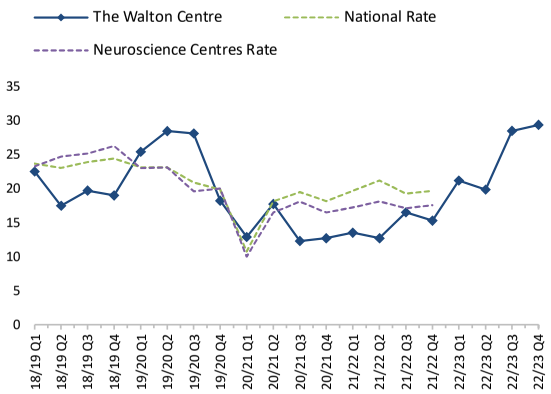
Complaints

In July 2023 the trust received seven new complaints, three in surgery, two in neurology, one corporate and one cross-divisional. Three of these complaints related to Diagnosis/Treatment; two to Communication, one to Inpatient Concerns and one to Coporate. In addition two complaints initially received earlier in the year were reopened in July.

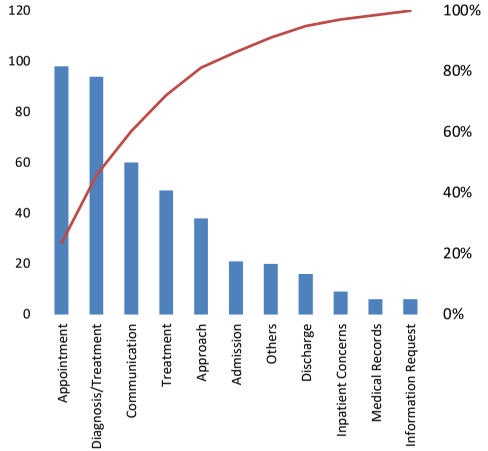
Total New Complaints Received in month



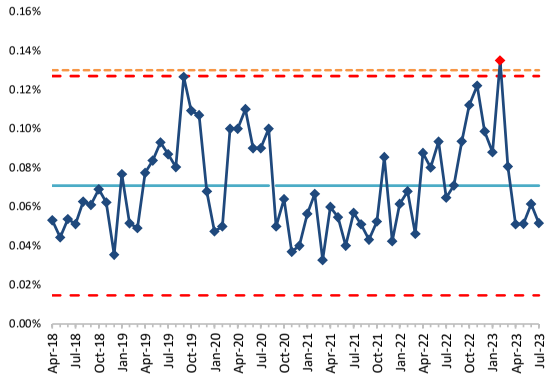
Quarterly Complaints per 1000 WTE



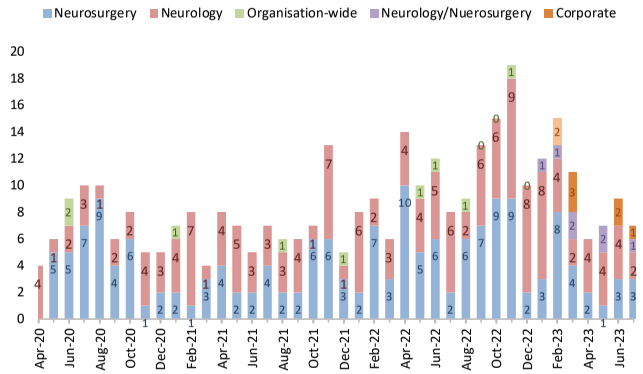
Complaints by Subject Apr 19 to present



% New Complaints Received against Activity



Total New Complaints Received



Complaints by Outcome

	Not Upheld	Partial Upheld	Upheld
19/20	38	18	17
20/21	44	24	5
21/22	38	22	10
22/23	64	36	36
23/24*	8	3	4

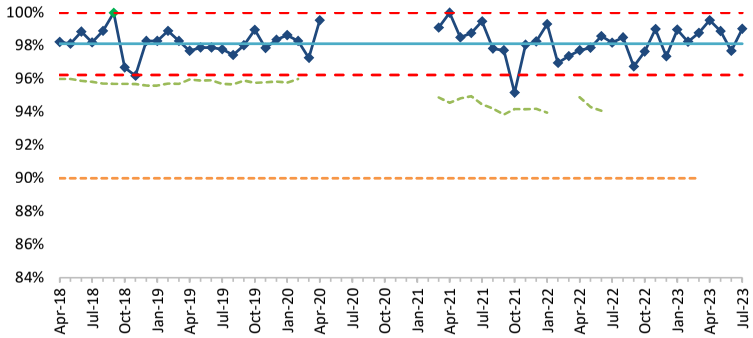
*from January 2023 there is now the option to attribute complaints to both divisions where this is necessary.

Quality of Care

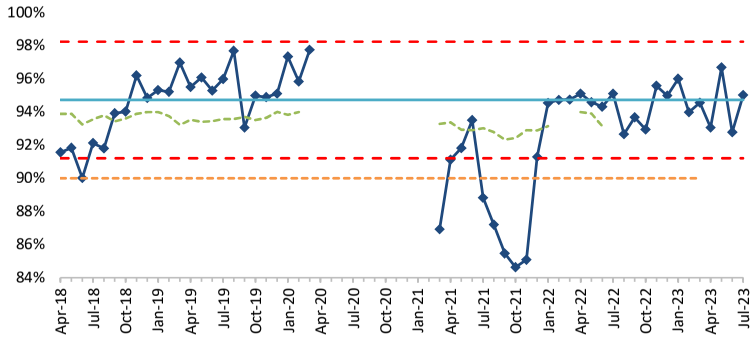
Family and Friends Test

The target for inpatient FFT response rate has been increased in this financial year to 50% which is the mean value for what we've previously seen. Once we have brought the lower control limit closer to 50% we can look again at increasing the target if that seems appropriate. The inpatient response rate for July has dropped again this month to 31%.

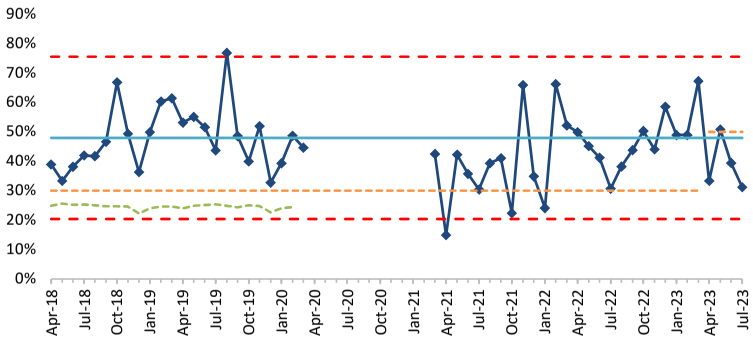
Inpatient FFT % Likely to Recommend



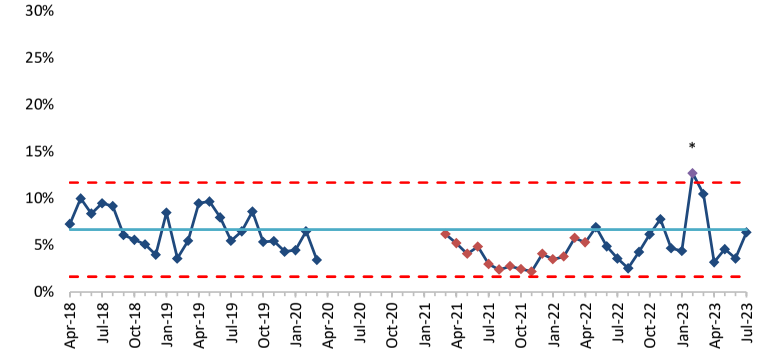
Outpatient FFT % Likely to Recommend



Inpatient FFT Response Rate



Outpatient FFT Response Rate

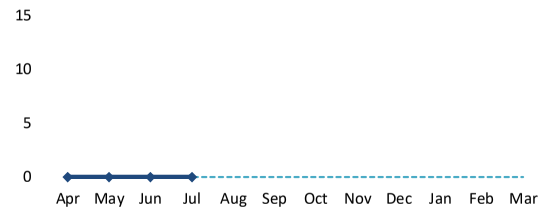


*The increase in OP response rate, though genuine, may be slightly inflated by a data collection issue at the end of January which meant that some January responses have been counted in February.

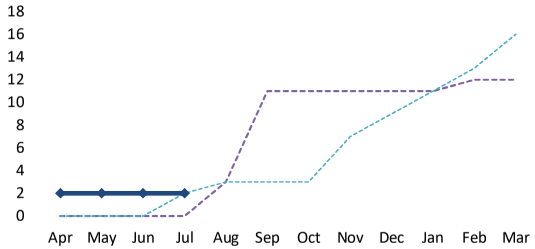
Quality of Care

Infection Control

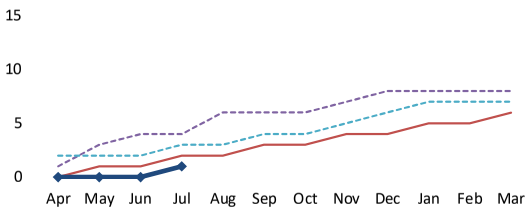
MRSA Bacteraemia



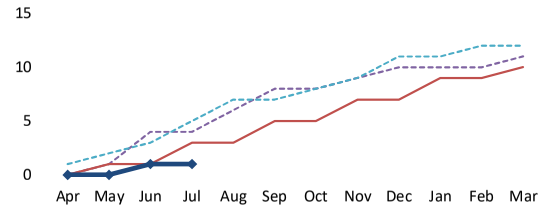
CPE



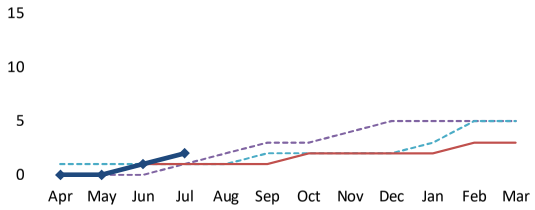
Clostridium difficile



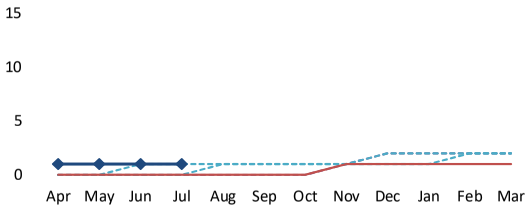
E.Coli



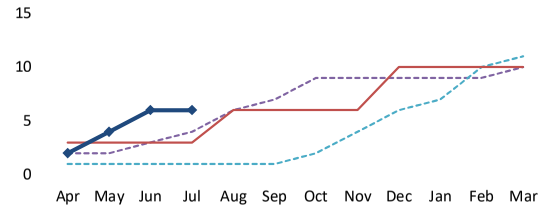
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 2023/24

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		1			1			**2**
Caton							1	**1**
Chavasse							3	**3**
CRU					1			**1**
Dott			1					**1**
Horsley		1		1		1	2	**5**
Lipton								**0**
Sherrington								**0**
Total	**0**	**2**	**1**	**1**	**2**	**1**	**6**	**13**

In Month Breakdown by Ward

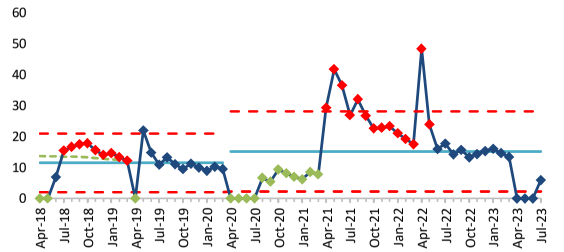
This month one patient acquired Clostridium Difficile on Dott ward and one patient aquired Klebsiella Bacteraemia on Cairns ward.

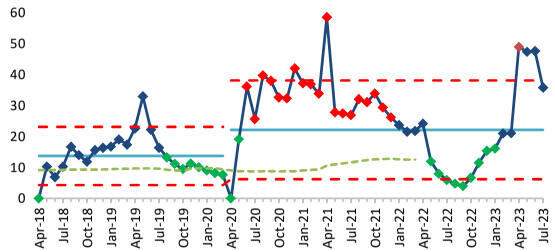
Legend for all charts

21/22 Actual YTD
22/23 Actual YTD
23/24 Trajectory YTD
23/24 Actual YTD

Quality of Care

Infection Control

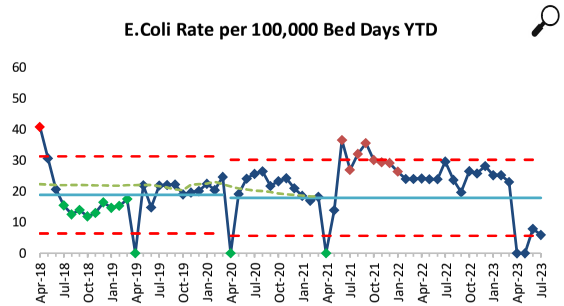


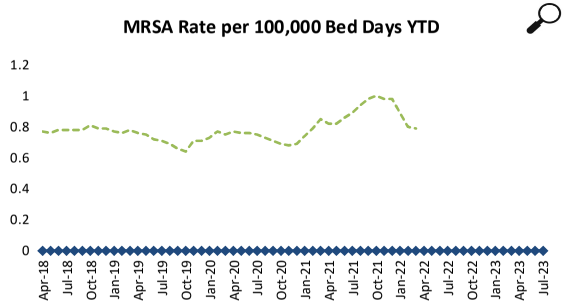


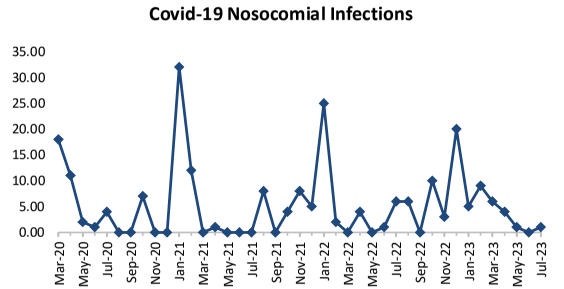
All infection rates are within normal variation this month.

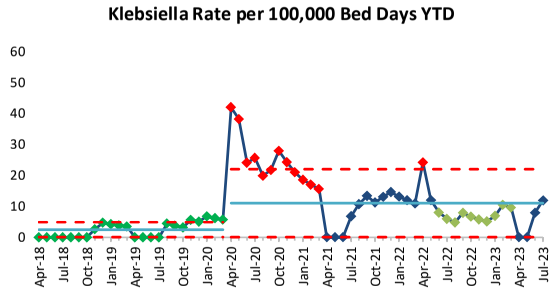
2023/24 to date

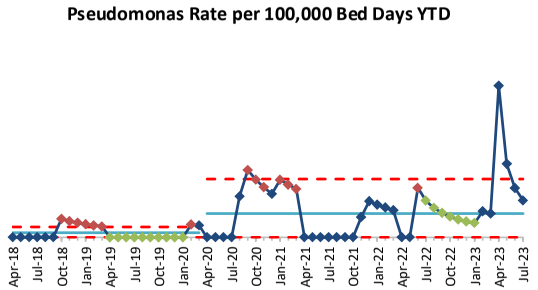
Infection	Number	Rate
C. Diff	1	5.97
MSSA	6	35.81
E. Coli	1	5.97
MRSA	0	0.00
Klebsiella Bacteraemia	2	11.94
Pseudomonas Bacteraemia	1	5.97
Covid -19	1	(in month)











Quality of Care

Harm Free Care

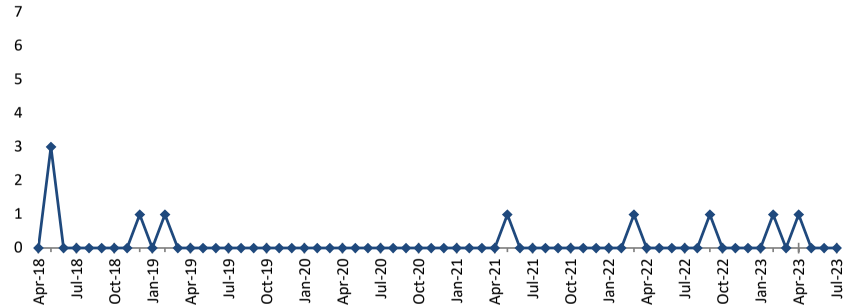
Pressure Ulcers: There were four hospital acquired pressure ulcers in July which means hospital acquired pressure ulcers have come back into negative special cause variation. Two of these were mucosal and two category 2.

CAUTI: There was one CAUTI incident this month.

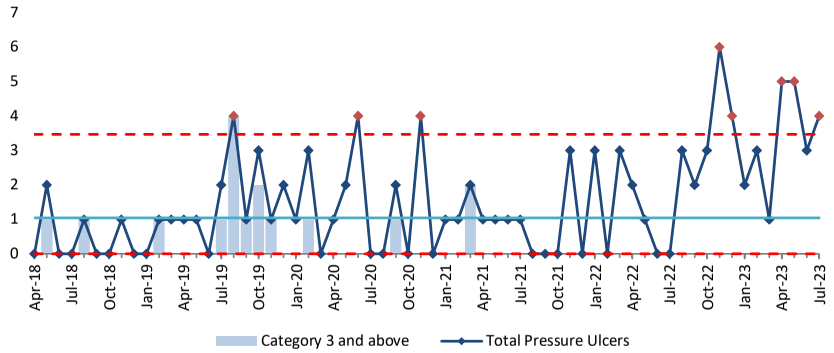
VTE: There were no VTE incident in month.

Falls: There were no serious falls in July.

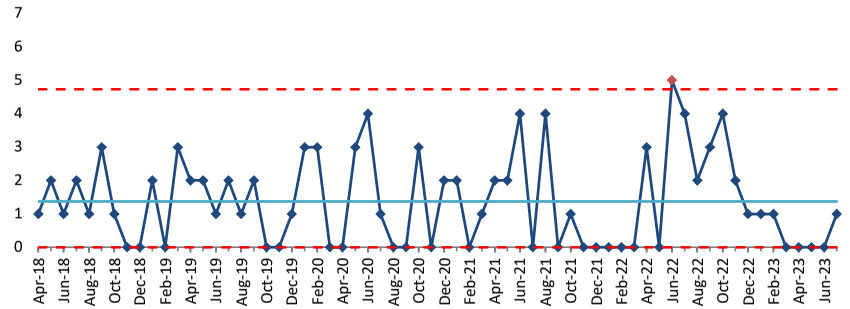
Total Moderate or Above Harm Inpatient Falls



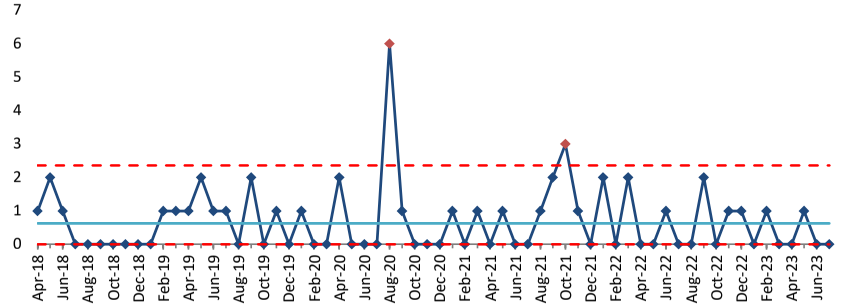
Total Hospital Acquired Pressure Ulcers



CAUTI Incidences



VTE Incidences

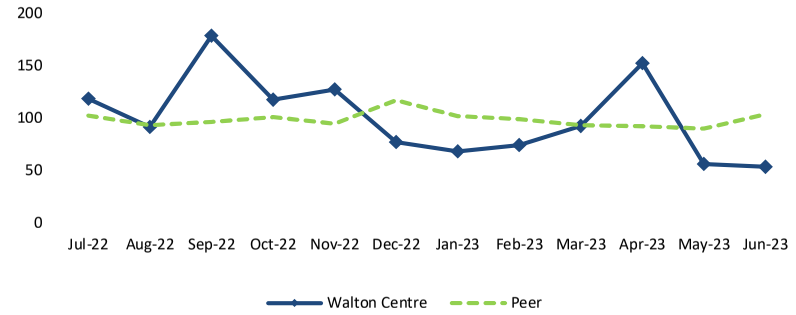


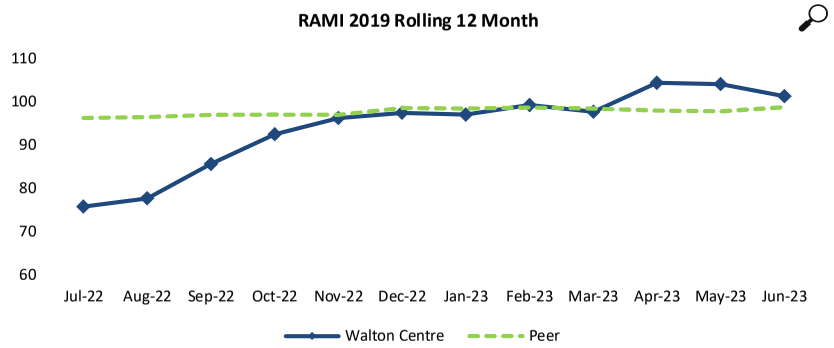
Quality of Care

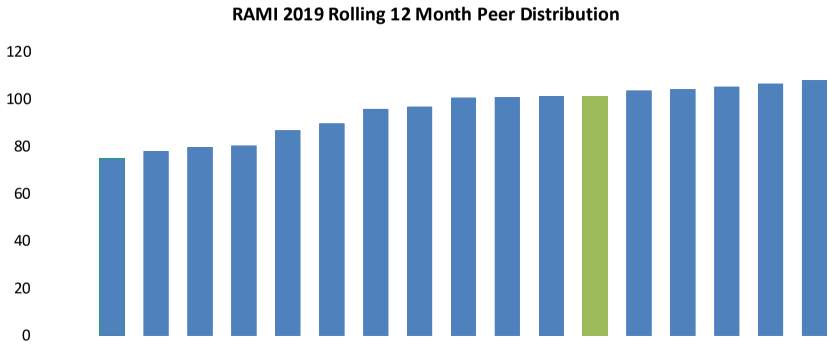
Mortality

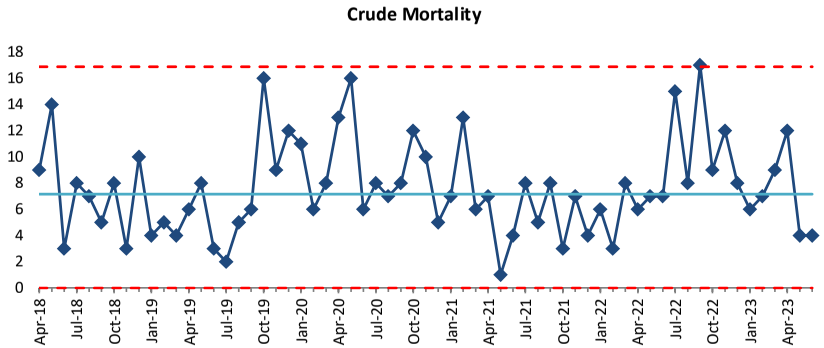
RAMI performance has declined over the last few months. As at May 2023 the rolling 12 month RAMI19 figure is 101.26. During the period there were a total of 100 observed deaths against 99 expected deaths. When viewed against peers the Walton Centre has dropped to 12th place. When looking at the 56 HSMR condition groups for the rolling 12 month period the RAMI risk is 96.8.

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





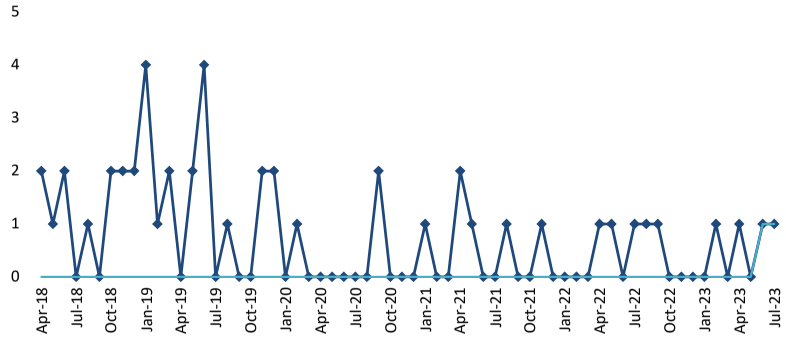




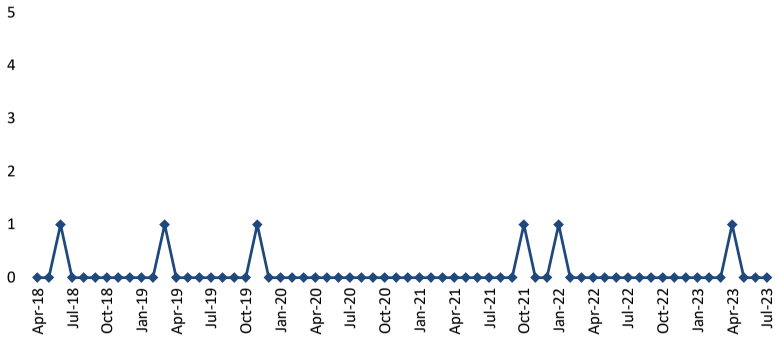
Quality of Care - Safe

Governance

Total Confirmed SIs Reported



Total Confirmed Never Events Reported



There was one serious incident reported during July which was a wrongly sited operation/procedure and which occurred in Theatre.

Quality of Care

Ward Scorecard

Number of shifts judged in each of the four categories and number flagged overall	Safe Staffing						Harms				Infection Control			
	Green	Grey	Amber	Red	Flagged	Walton Cares	Pressure Ulcers	Falls (Mod+)	UTI	VTE	MRSA	MSSA	E Coli	C Diff
Cairns	22	33	38	0		Gold	0	0	0	0	0	0	0	0
Caton Short Stay	3	4	1	1			0	0	0	0	0	0	0	0
Caton Ward	19	54	20	0		Silver	0	0	0	0	0	0	0	0
Chavasse	12	49	30	2		Gold	3	0	1	0	0	0	0	0
CRU	3	50	40	0		Gold	0	0	0	0	0	0	0	0
Dott	9	36	47	1		Gold	0	0	0	0	0	0	0	1
Horsley ITU	42	41	10	0			0	0	0	0	0	0	0	0
Lipton	37	50	5	1	1	Silver	0	0	0	0	0	0	0	0

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

Utilisation Key

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

* One further pressure ulcer occurred in month attributed directly to Theatres, not to any of the wards listed here.

WELL LED

Finance

Key Performance Indicators	May	June	July
% variance from plan - Year to date	0.9%	0.5%	0.3%
% variance from plan - Forecast	0.0%	0.0%	0.0%
% variance from efficiency plan - Year to date	0.0%	0.0%	0.0%
% variance from efficiency plan - Forecast	0.0%	0.0%	0.0%
Capital % variance from plan - Year to date	-53.3%	9.1%	46.2%
Capital % variance from plan - Forecast	0.0%	0.0%	0.0%
Capital Service Cover *	5.0	3.1	3.6
Liquidity **	40.8	40.8	43.7
Cash days operating expenditure ***	103.0	92.0	100.0
BPPC - Number	86.5%	87.9%	88.9%
BPPC - Value	83.7%	87.7%	89.6%

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

Trust I&E	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Operating income from patient care activities	14,025	14,647	622	56,100	58,624	2,524	168,305	175,460	7,155
Other operating income	645	787	142	2,580	3,036	456	7,741	9,133	1,392
Donated Income	0	0	0	0	0	0	0	0	0
Total Operating Income	**14,670**	**15,434**	**764**	**58,680**	**61,660**	**2,980**	**176,046**	**184,593**	**8,547**
Employee expenses	(7,479)	(7,905)	(426)	(29,915)	(30,813)	(898)	(89,787)	(93,020)	(3,233)
Operating expenses excluding employee expenses	(6,662)	(7,048)	(386)	(26,624)	(28,854)	(2,230)	(81,775)	(87,557)	(5,782)
Total Operating Expenditure	**(14,141)**	**(14,953)**	**(812)**	**(56,539)**	**(59,667)**	**(3,128)**	**(171,562)**	**(180,577)**	**(9,015)**
EBIT	**529**	**481**	**(48)**	**2,141**	**1,993**	**(148)**	**4,484**	**4,016**	**(468)**
Finance income	140	184	44	560	703	143	1,680	2,110	430
Finance expense	(47)	(44)	3	(191)	(180)	11	(578)	(540)	38
PDC dividends payable/refundable	(147)	(147)	0	(588)	(588)	0	(1,764)	(1,764)	0
Other gains/(losses) including disposal of assets	0	0	0	0	0	0	0	0	0
Financial performance surplus/(deficit)	**475**	**474**	**(1)**	**1,922**	**1,928**	**6**	**3,822**	**3,822**	**0**
I&E impact capital donations and profit on asset disposals	22	22	0	85	85	0	257	257	0
Adjusted financial performance surplus/(deficit)	**497**	**496**	**(1)**	**2,007**	**2,013**	**6**	**4,079**	**4,079**	**0**

The plan for 2023/24 is a £4,079k surplus position (submitted to the Cheshire and Merseyside Integrated Care System and NHS England in May as part of the 2023/24 planning process).

The current plan includes:

- 'Block' elective recovery fund (ERF) income and costs for the delivery of activity to deliver the national trajectory targets.
- 'Block' system funding for Top-up, and growth.
- Aligned incentive payment contracts (API) for both specialised and non-specialised activity in which all elective activity (outpatient first, procedures, day-case and inpatient elective activity) is paid on a cost per case basis.
- Recurrent efficiency requirement of 5.0% of operating expenses (excluding high-cost drugs and devices).

Month 4 – in month the trust posted a £496k surplus position against a plan of £497k, £1k behind plan.

Year to date-the Trust has reported a £2,013k surplus position against a planned position of £2,007k, £6k ahead of plan.

Income – Year to date overperformance of £2,980k, due to:

- Increased NHSE funding relating to the 2023/24 Agenda for Change pay award
- Increased Overseas, Injury Recovery, Northern Ireland, and private patient income;
- Income received in month for training from Health Education England;
- Salary recharge income to external bodies.

Expenditure (inc. Financing Costs) – Year to date over-spend of £2974k due to:

- Increased pay costs for year-to-date impact of pay award;
- Increased spend on High-Cost Drugs (Homecare Drugs); and
- Increased utility costs compared to budget and 2022/23.

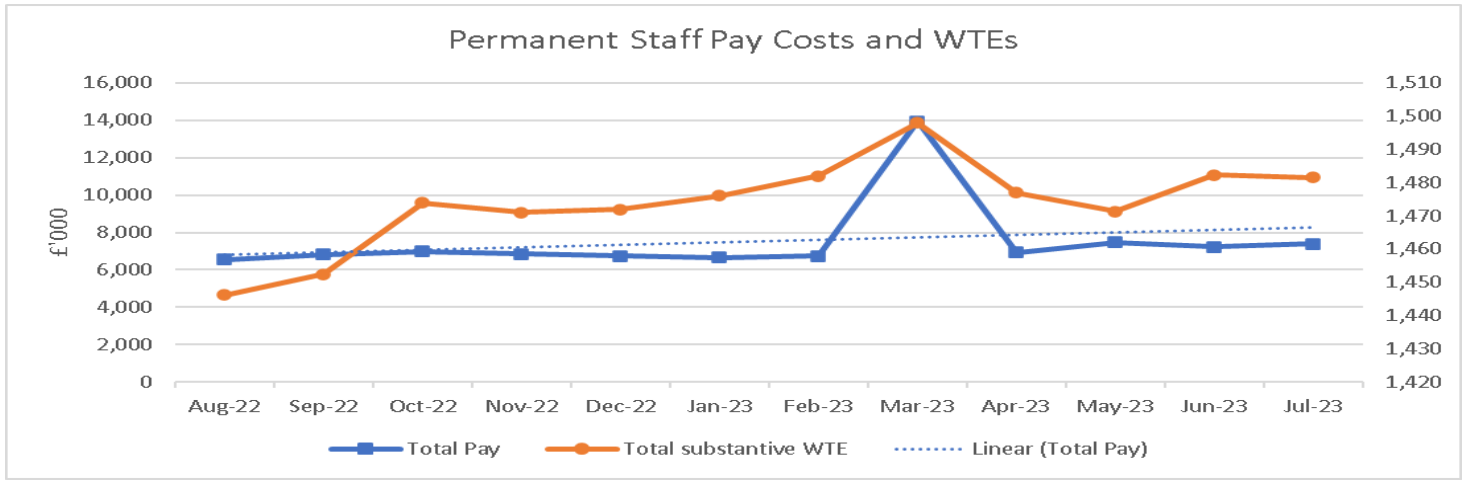
STATEMENT OF FINANCIAL POSITION - 2023/24	Plan July-23	Actual July 23	Variance
	£'000	£'000	£'000
Intangible Assets	871	840	(31)
Tangible Assets	102,321	101,743	(578)
Least Assets - Right of use assets	831	831	0
Receivables	324	325	1
TOTAL NON CURRENT ASSETS	**104,347**	**103,739**	**(608)**
Inventories	1,043	846	(197)
Receivables	7,401	7,003	(398)
Cash at bank and in hand	49,581	46,055	(3,526)
TOTAL CURRENT ASSETS	**58,025**	**53,904**	**(4,121)**
Payables	(35,648)	(30,976)	4,672
Borrowings	(1,748)	(1,669)	79
Provisions	(80)	(80)	0
TOTAL CURRENT LIABILITIES	**(37,476)**	**(32,725)**	**4,751**
TOTAL ASSETS LESS CURRENT LIABILITIES	**124,896**	**124,918**	**22**
Borrowings	(20,706)	(20,726)	(20)
Provisions	(513)	(509)	4
TOTAL ASSETS EMPLOYED	**103,677**	**103,683**	**6**
Public Dividend Capital	38,028	38,028	0
Revaluation Reserve	14,412	14,412	0
Income and Expenditure Reserve	51,237	51,243	6
TOTAL TAXPAYERS EQUITY AND RESERVES	**103,677**	**103,683**	**6**

Leased assets are now split in line with acccounting requirements under IFRS 16.

STATEMENT OF CASH FLOW - 2023/24	Plan July-23	Actual July-23	Variance
	£'000	£'000	£'000
Cash flows from operating activities			
Operating surplus/(deficit)	**2,141**	**1,992**	**(149)**
Non-cash income and expense:	2,612	2,817	205
Working Capital	(8)	(4,503)	(4,495)
Net cash generated from/(used in) operations	**4,745**	**306**	**(4,439)**
Cash flows from investing activities	(1,816)	(926)	890
Cash flows from financing activities	(1,067)	(1,044)	23
Increase/(decrease) in cash and cash equivalents	**1,862**	**(1,664)**	**(3,526)**
OPENING CASH	**47,718**	**47,719**	**1**
CLOSING CASH	**49,580**	**46,055**	**(3,525)**

At the end of July - £46,055k cash balance compared to £49,580k plan, an adverse variance of £3,525k:

- Movement in inventories: £197k
- Movement in payables/receivables: (£3,989k)
- Movement in deferred income: (£624k)
- Capital programme: £966k
- Other (£75k)
- **Total** **(£3,525k)**



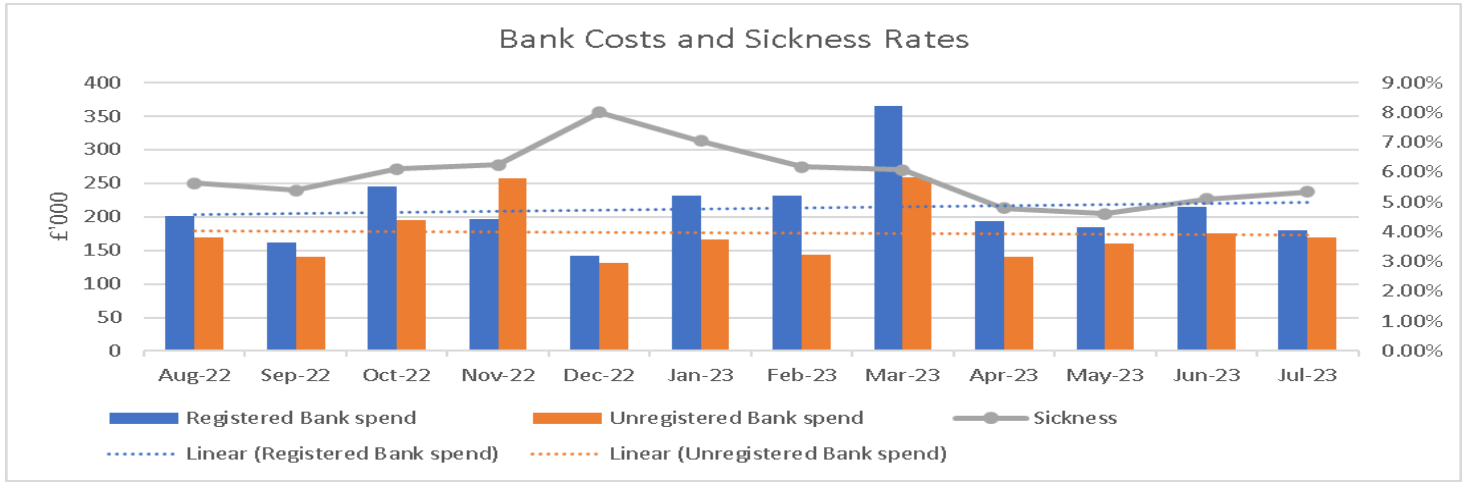
March 2023 increase is due to additional pay award and additional pension contribution, both offset in income.

Pay costs:

- May: £7,472k
- Jun: £7,227k
- Jul: £7,403k

WTE:

- May: 1,471 WTE
- Jun: 1,482 WTE
- Jul: 1,482 WTE



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

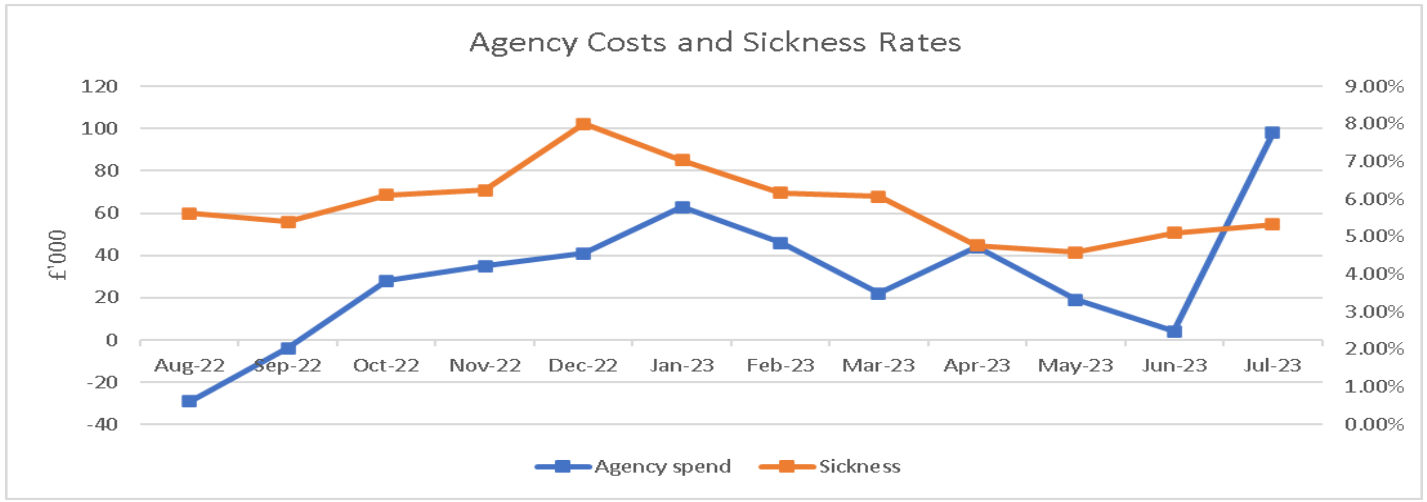
Increase in Registered Bank costs in October 2022, January 2023, and February 2023 across all wards. Increase in November 2022 due to pay award for all bank staff backdated to April 2022. Increase in March 23 is due to pay award for bank staff.

Nursing Bank costs:

- May: £345k
- Jun: £391k
- Jul: £350k

Sickness rate:

- May: 4.71%
- Jun: 5.07%
- Jul: 5.33%



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

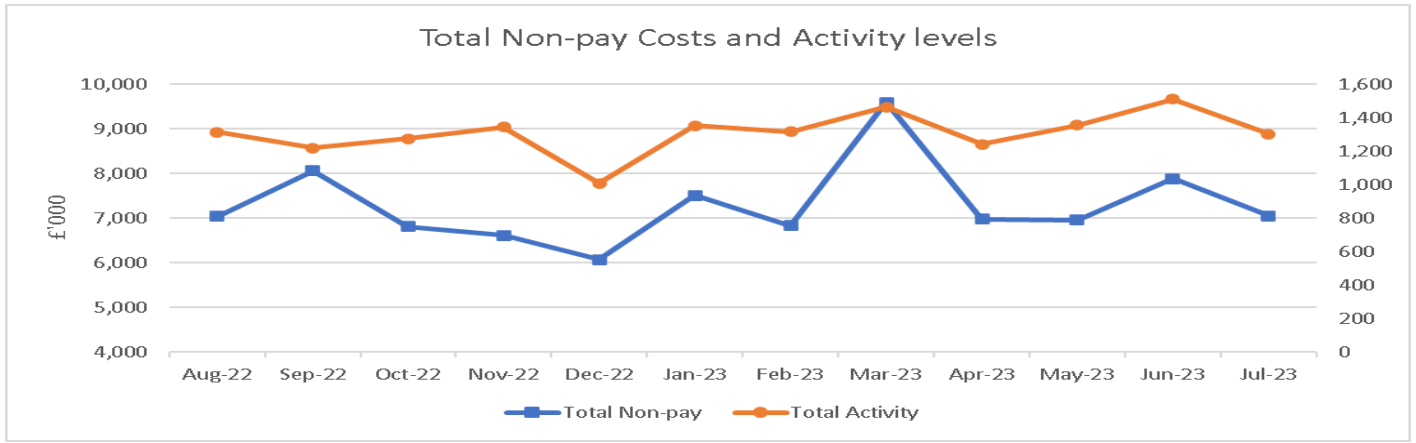
Prior year reversal in August and September, as all invoices have been received.
Increase in agency in M4 is due to recoding of IT agency staff previously allocated to specific capital projects.

Agency costs:

- May: £19k
- Jun: £4k
- Jul: £98k

Sickness rate:

- May: 4.71%
- Jun: 5.07%
- Jul: 5.33%



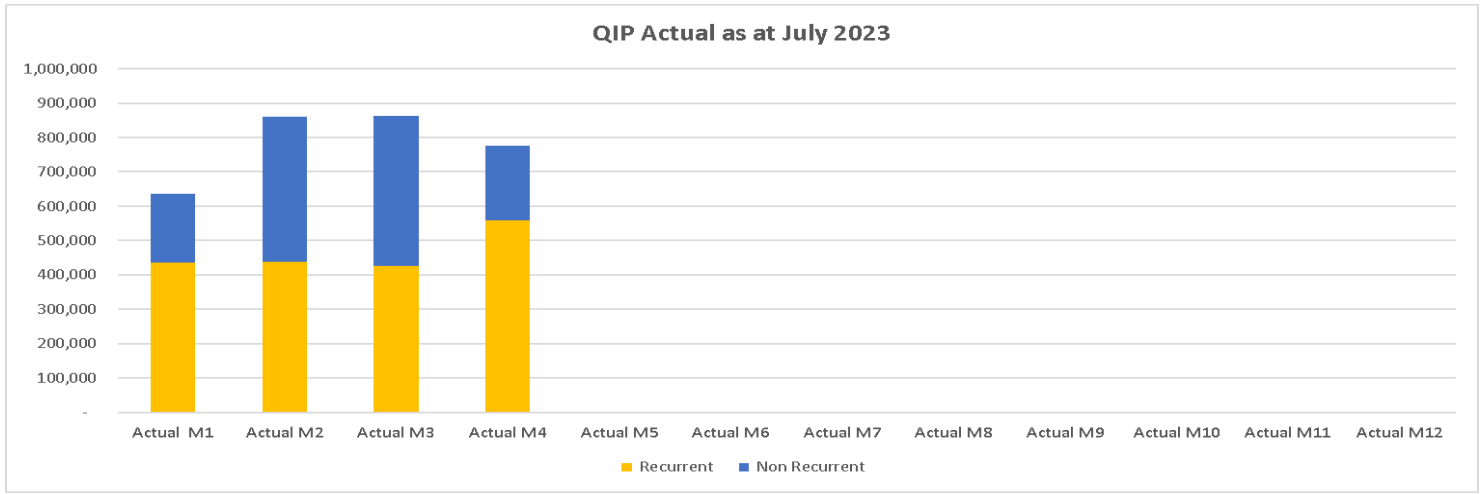
Increased costs in March 2023 are caused by increased consumable spend at the financial year end and works carried out by Estates.

Non-pay costs:

- May: £6,953k
- Jun: £7,879k
- Jul: £7,049k

Inpatient activity:

- May:1.335 spells
- Jun: 1.506 spells
- Jul: 1.302 spells



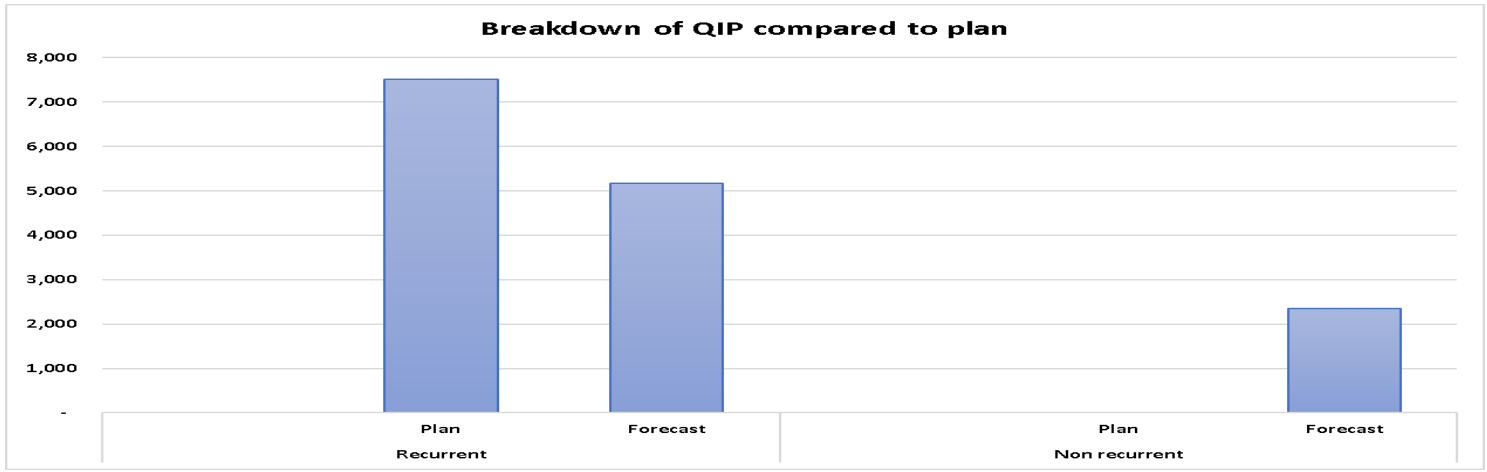
The Trust has a QIP target of £7,520k for the 2023/24 financial year. At M4 the QIP target YTD was achieved via £1,860k recurrently and £1,274k non recurrently.

Recurrent CIP:

- May: £438k
- Jun: £423k
- Jul: £559k

Non-recurrent CIP:

- May: £423k
- Jun: £435k
- Jul: £217k



All QIP has been set to be achieved recurrently this financial year with a total plan £7,520k.

Year to date 59% of the target was achieved recurrently, with 41% achieved non recurrently.

As service transformation projects take place it is hoped that further recurrent savings will be identified.

PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
Patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
NHS England	9,927	10,361	434	39,709	41,742	2,033	119,128	125,304	6,176
Clinical Commissioning Groups	2,099	2,070	(29)	8,397	8,447	50	25,191	25,344	153
Wales	1,748	1,949	201	6,991	7,291	300	20,972	21,517	545
Isle of Man	177	146	(31)	710	597	(113)	2,130	2,131	1
Other Patient Related Income	74	121	47	294	547	253	884	1,164	280
Total Patient Related Income	**14,025**	**14,647**	**622**	**56,101**	**58,624**	**2,523**	**168,305**	**175,460**	**7,155**

To note that patient related income includes ERF income.

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NON-PATIENT RELATED INCOME

	In month			Year to Date			Full Year		
Non-patient Related	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Forecast £'000**	**Variance £'000**
Research & Development Income	91	88	(3)	365	401	36	1,097	1,203	106
Education And Training	273	301	28	1,092	1,224	132	3,277	3,646	369
Employee Benefits Income	187	293	106	747	1,046	299	2,242	3,141	899
Other Non-patient Related Income	94	103	9	376	366	(10)	1,125	1,143	18
Total Patient Related Income	**645**	**785**	**140**	**2,580**	**3,037**	**457**	**7,741**	**9,133**	**1,392**

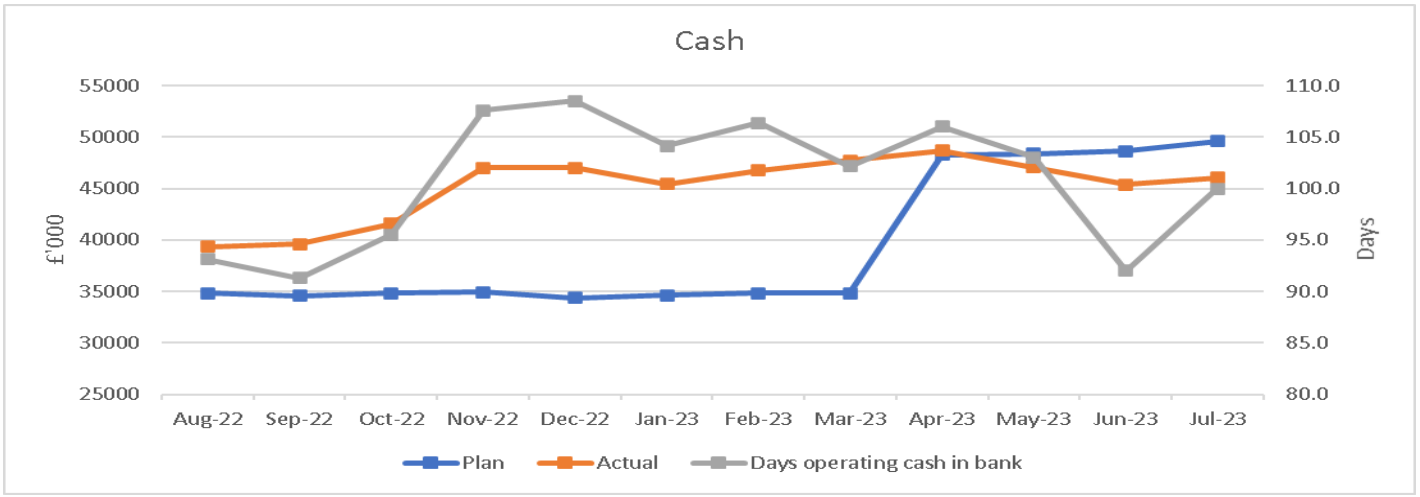
ERF

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Elective Recovery Funding	402	393	(9)	1,607	1,598	(9)	4,821	4,821	0

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	75	36	39	290	78	212	890	225	665
Estates-Ponta systems	225	0	225	450	370	80	450	429	21
Estates-Theatres air handling units	0	7	(7)	0	7	(7)	2,010	1,539	471
Estates-General	0	3	(3)	0	21	(21)	0	118	(118)
IM&T	18	(68)	86	72	0	72	220	0	220
Neurology-Ultramax Flouro machine	0	0	0	0	0	0	1,050	1,050	0
Neurophysiology Telemetry beds (x4)	0	0	0	0	0	0	0	320	(320)
Neurosurgery-Other clinical equipment	19	0	19	73	0	73	225	664	(439)
Corporate	0	0	0	0	0	0	0	500	(500)
TOTAL (excl. external funding)	**337**	**(22)**	**359**	**885**	**476**	**409**	**4,845**	**4,845**	**0**
Right of Use Assets - MRI	0	0	0	0	0	0	1,400	1,400	0
MR Offices and Canulation Area	0	0	0	0	0	0	13	13	0
Donated Assets	0	0	0	0	0	0	100	100	0
TOTAL (incl. external funding)	**0**	**0**	**0**	**0**	**0**	**0**	**1,513**	**1,513**	**0**
TOTAL	**337**	**(22)**	**359**	**885**	**476**	**409**	**6,358**	**6,358**	**0**

- Capital expenditure in month of (£22k), against a plan of £337k. Credit in month relates to recoding of IT spend to Revenue.
- Current year spend on divisional schemes includes:
  - Ponta Systems ITU – initially planned for June and July.
  - Heating & Pipework
  - Air Handling Units
- Meetings will take to prioritise the Capital scheme for 2023/24 and to establish timelines of when projects will start within the 2023/24 financial year.
- Full year plan is set at £4,845k (excluding the impact of IFRS 16 for leased assets).



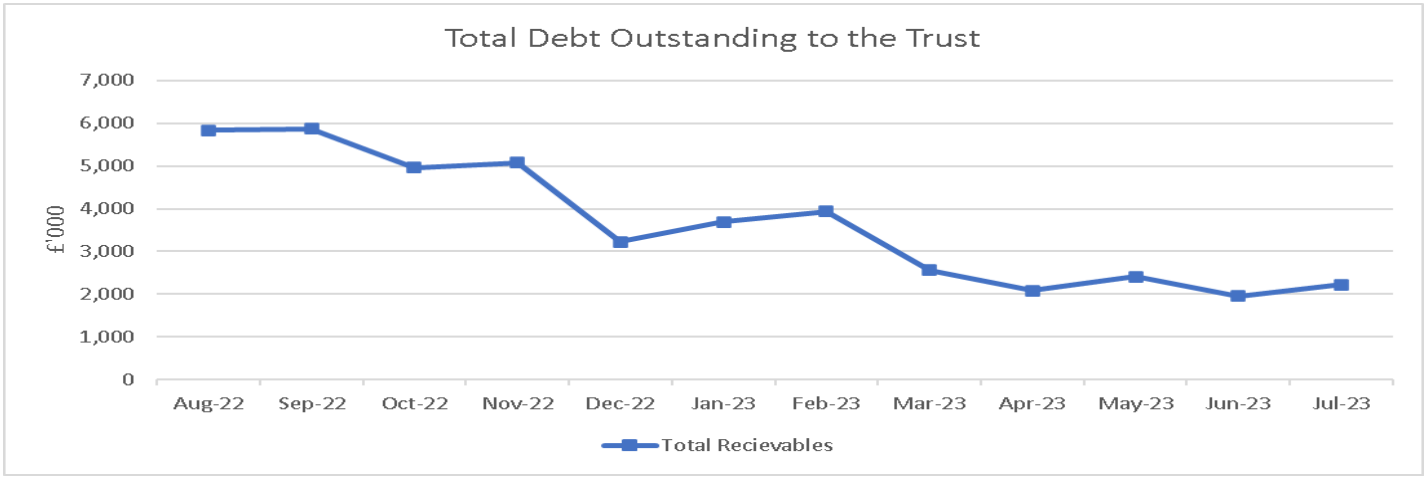
The cash plan was updated this year to reflect the higher cash balances held by the Trust in 2022/23 hence the increase in the planned amount in April 23.

Cash:

- May: £47,041k
- Jun: £45,359k
- Jul: £46,055k

Operating expenditure days cover:

- May: 103 days
- Jun: 92 days
- Jul: 100 days

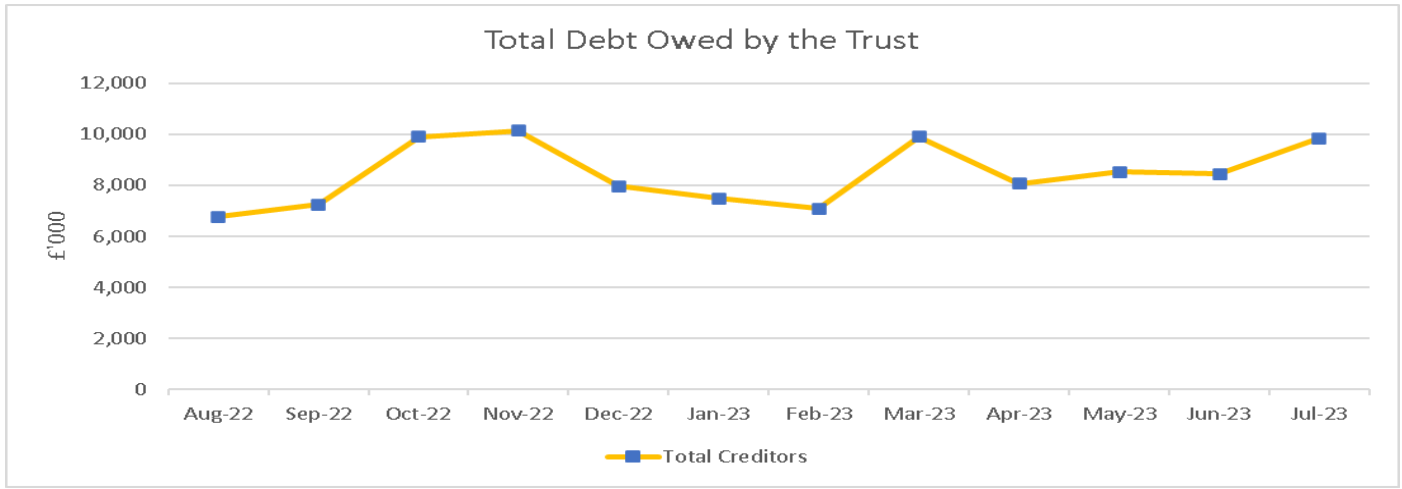


August and September 2022 increase, due to WHSSC year-end settlement invoice, Isle of Man M1-4 invoice, and Health Education England M4-6 invoice.

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

Debt outstanding to Trust:

- May: £2,415k
- Jun: £1,954k
- Jul: £2,230k

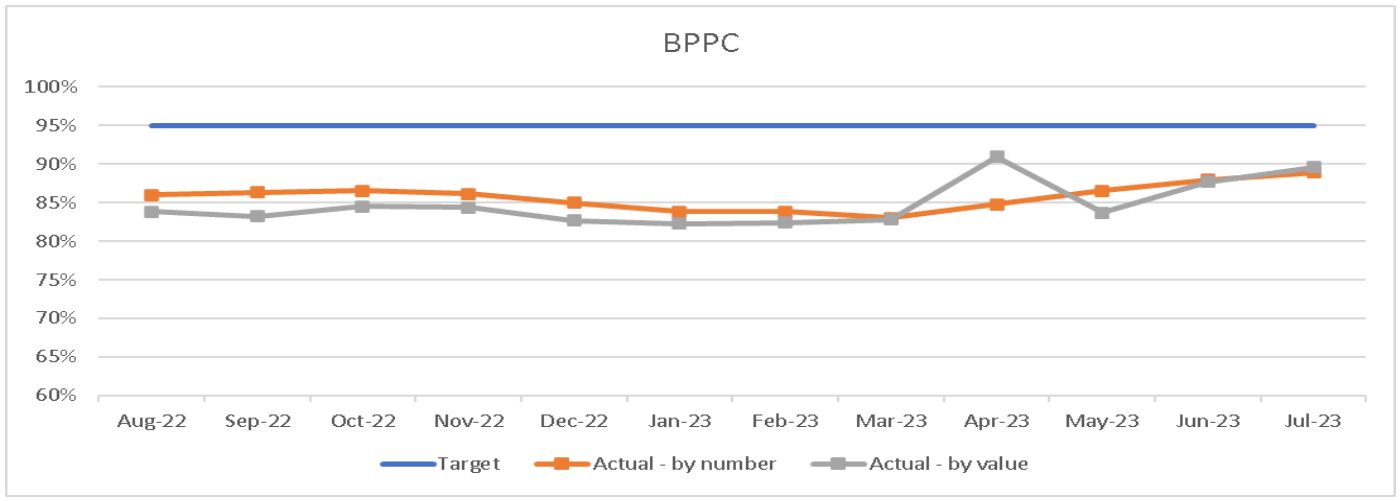


Debt owed by the Trust:

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

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

- May: £8,528k
- Jun: £8,452k
- Jul: £9,848k



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

- The Trust BPPC percentage (by number of invoices paid) at the end of July is 89.0%. This has increased from 87.9% at the end of June.
- The Trust BPPC percentage (by value of invoices paid) at the end of July is 90.0%. This has increased from 87.7% at the end of June.
- The Trust continues to follow the action plan to improve BPPC performance. This involves collaborative working across the finance team, procurement, and the divisions to ensure that invoices are approved in a timely manner prior to breaching the 30-day limit.
- BPPC is also being closely monitored by Audit Committee.

EXPENDITURE - NEUROLOGY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(516)	(447)	69	(2,065)	(1,817)	248	(6,193)	(5,392)	801
Allied health professionals	(550)	(535)	15	(2,171)	(2,091)	80	(6,498)	(6,374)	124
Other scientific, therapeutic and technical staff	(112)	(80)	32	(449)	(338)	111	(1,346)	(974)	372
Health care scientists	(67)	(67)	0	(266)	(265)	1	(798)	(803)	(5)
Support to nursing staff	(326)	(288)	38	(1,303)	(1,131)	172	(3,910)	(3,436)	474
Support to allied health professionals	(82)	(92)	(10)	(326)	(363)	(37)	(977)	(1,096)	(119)
Support to other clinical staff	(1)	(1)	0	(3)	(3)	0	(9)	(8)	1
Medical - Consultants	(850)	(827)	23	(3,358)	(3,261)	97	(10,048)	(9,690)	358
Medical - Junior	(248)	(254)	(6)	(999)	(989)	10	(2,979)	(2,974)	5
NHS infrastructure support	(233)	(214)	19	(930)	(855)	75	(2,790)	(2,569)	221
Bank/Agency	(47)	(183)	(136)	(168)	(682)	(514)	(168)	(2,144)	(1,976)
Total Pay Expenditure	**(3,032)**	**(2,988)**	**44**	**(12,038)**	**(11,795)**	**243**	**(35,716)**	**(35,460)**	**256**
Supplies and services – clinical (excluding drugs costs)	(733)	(772)	(39)	(2,861)	(3,324)	(463)	(8,583)	(9,972)	(1,389)
Supplies and services - general	(17)	(24)	(7)	(69)	(99)	(30)	(207)	(296)	(89)
Drugs costs	(2,004)	(2,286)	(282)	(8,015)	(9,083)	(1,068)	(24,044)	(27,248)	(3,204)
Establishment	(3)	(6)	(3)	(11)	(31)	(20)	(32)	(93)	(61)
Premises - other	(101)	(132)	(31)	(403)	(451)	(48)	(1,209)	(1,352)	(143)
Transport	(5)	(8)	(3)	(22)	(27)	(5)	(65)	(80)	(15)
Research and development - non-staff	0	(1)	(1)	0	(7)	(7)	0	(22)	(22)
Education and training - non-staff	(2)	(4)	(2)	(7)	(7)	0	(22)	(21)	1
Lease expenditure	(6)	(6)	0	(23)	(25)	(2)	(68)	(75)	(7)
Other	(8)	(15)	(7)	(32)	(10)	22	(96)	(29)	67
Total Non-pay Expenditure	**(2,879)**	**(3,254)**	**(375)**	**(11,443)**	**(13,064)**	**(1,621)**	**(34,326)**	**(39,189)**	**(4,863)**
Total Divisional Operating Expenditure	**(5,911)**	**(6,242)**	**(331)**	**(23,481)**	**(24,859)**	**(1,378)**	**(70,042)**	**(74,649)**	**(4,607)**

EXPENDITURE - NEUROSURGERY

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(1,346)	(1,162)	184	(5,388)	(4,729)	659	(16,105)	(14,025)	2,080
Allied health professionals	(197)	(204)	(7)	(787)	(829)	(42)	(2,343)	(2,460)	(117)
Other scientific, therapeutic and technical staff	(54)	(55)	(1)	(218)	(219)	(1)	(653)	(655)	(2)
Health care scientists	(82)	(80)	2	(327)	(322)	5	(981)	(963)	18
Support to nursing staff	(298)	(260)	38	(1,193)	(1,084)	109	(3,566)	(3,163)	403
Support to allied health professionals	(13)	(15)	(2)	(52)	(61)	(9)	(157)	(184)	(27)
Support to other clinical staff	(2)	(1)	1	(7)	(6)	1	(22)	(17)	5
Medical - Consultants	(796)	(812)	(16)	(3,160)	(3,164)	(4)	(9,271)	(9,649)	(378)
Medical - Junior	(379)	(437)	(58)	(1,518)	(1,636)	(118)	(4,536)	(4,710)	(174)
NHS infrastructure support	(246)	(221)	25	(984)	(874)	110	(2,951)	(2,642)	309
Bank/Agency	(32)	(204)	(172)	(101)	(827)	(726)	(101)	(2,463)	(2,362)
Total Pay Expenditure	**(3,445)**	**(3,451)**	**(6)**	**(13,735)**	**(13,751)**	**(16)**	**(40,686)**	**(40,931)**	**(245)**
Supplies and services – clinical (excluding drugs costs)	(1,293)	(1,473)	(180)	(5,171)	(5,691)	(520)	(15,513)	(17,072)	(1,559)
Supplies and services - general	(23)	(26)	(3)	(92)	(113)	(21)	(277)	(339)	(62)
Drugs costs	(85)	(81)	4	(341)	(354)	(13)	(1,024)	(1,061)	(37)
Establishment	(11)	(9)	2	(42)	(47)	(5)	(126)	(140)	(14)
Premises - other	(46)	(49)	(3)	(183)	(242)	(59)	(550)	(726)	(176)
Transport	(6)	(5)	1	(23)	(31)	(8)	(69)	(94)	(25)
Education and training - non-staff	(3)	(3)	0	(14)	(14)	0	(42)	(41)	1
Lease expenditure	(6)	(9)	(3)	(25)	(36)	(11)	(76)	(107)	(31)
Other	(17)	(26)	(9)	(68)	(93)	(25)	(205)	(280)	(75)
Total Non-pay Expenditure	**(1,490)**	**(1,681)**	**(191)**	**(5,959)**	**(6,621)**	**(662)**	**(17,882)**	**(19,860)**	**(1,978)**
Total Divisional Operating Expenditure	**(4,935)**	**(5,132)**	**(197)**	**(19,694)**	**(20,372)**	**(678)**	**(58,568)**	**(60,791)**	**(2,223)**

EXPENDITURE - CORPORATE

	In month			Year to Date			Full Year		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Registered nursing, midwifery and health visiting staff	(117)	(94)	23	(469)	(361)	108	(1,407)	(1,116)	291
Support to nursing staff	(1)	0	1	(4)	0	4	(11)	0	11
Medical - Consultants	(5)	(7)	(2)	(21)	(24)	(3)	(63)	(80)	(17)
NHS infrastructure support	(983)	(911)	72	(3,933)	(3,620)	313	(11,799)	(10,909)	890
Apprenticeship Levy	(27)	(46)	(19)	(107)	(132)	(25)	(321)	(499)	(178)
Bank/Agency	0	(95)	(95)	0	(188)	(188)	0	(591)	(591)
Total Pay Expenditure	**(1,133)**	**(1,153)**	**(20)**	**(4,534)**	**(4,325)**	**209**	**(13,601)**	**(13,195)**	**406**
Non-executive directors	(11)	(11)	0	(45)	(41)	4	(136)	(124)	12
Supplies and services – clinical (excluding drugs costs)	(25)	(44)	(19)	(107)	(121)	(14)	(322)	(363)	(41)
Supplies and services - general	(280)	(293)	(13)	(1,118)	(1,156)	(38)	(3,355)	(3,467)	(112)
Consultancy	(2)	(1)	1	(9)	1	10	(28)	2	30
Establishment	(82)	(113)	(31)	(327)	(397)	(70)	(982)	(1,192)	(210)
Premises - business rates payable to local authorities	(69)	(69)	0	(275)	(275)	0	(824)	(824)	0
Premises - other	(424)	(543)	(119)	(1,695)	(2,292)	(597)	(5,084)	(6,876)	(1,792)
Transport	(9)	(35)	(26)	(35)	(125)	(90)	(105)	(376)	(271)
Audit fees and other auditor remuneration	(9)	(9)	0	(34)	(38)	(4)	(103)	(113)	(10)
Clinical negligence	(528)	(528)	0	(2,112)	(2,112)	0	(6,337)	(6,337)	0
Education and training - non-staff	(11)	(29)	(18)	(43)	(92)	(49)	(128)	(276)	(148)
Other	(121)	(115)	6	(477)	(530)	(53)	(1,431)	(1,590)	(159)
Total Non-pay Expenditure	**(1,571)**	**(1,790)**	**(219)**	**(6,277)**	**(7,178)**	**(901)**	**(18,835)**	**(21,536)**	**(2,701)**
Total Divisional Operating Expenditure	**(2,704)**	**(2,943)**	**(239)**	**(10,811)**	**(11,503)**	**(692)**	**(32,436)**	**(34,731)**	**(2,295)**

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

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 07/09/2023		**Report of:** Business Performance Committee (BPC)
Date of last meeting: 25/07/23		**Membership Numbers: 6 (Quorate)**
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report • Kinevo Microscope Replacement Business Case • NHS Professionals Managed Bank Service Contract Renewal Proposal • Digital Substrategy Update • Estates, Facilities and Sustainability Substrategy Update • Health Procurement Liverpool Strategy • Digital Transformation Monthly Update • Strategic Project Management Office (SPMO) Quarterly Update • BPC Meeting Frequency and Cycle of Business • Digital Transformation Programme Board Effectiveness Review • Digital Strategy Group Terms of Reference • Equality, Diversity and Inclusion Group Effectiveness Review and Terms of Reference • Resilience Planning Group Effectiveness Review and Terms of Reference • Staff Partnership Committee Effectiveness Review and Terms of Reference
2	**Alert**	• Concern was expressed at the increasing extent of digital team resource required to address (system wide) NHS Digital Care Computing Emergency Response Team (CareCERT) cyber threat alerts, particularly those identified as high-level. Note this does not imply a specific vulnerability for the Trust but relates to the NHS as a whole.
3	**Assurance**	*Integrated Performance Report* ***Operations and Performance*** • All cancer wait/treatment and diagnostic standards continue to be achieved. • The number of long waiters (52+ weeks) has decreased slightly and remains a primary focus to eliminate by March 2024. There are no 78+week waits. Restoring improvement in average waits (Referral To Treatment) will become the focus after that. • Activity was slightly under plan for elective and day cases and above plan for new outpatients. • Outpatient waiting lists remain high, especially in neurology. The proportion of Patient Initiated Follow Up (PIFU) continues to increase. Focus remains on the high level of Did Not Attends (DNA) and revalidation of follow-up waiting lists within the outpatient transformation programme. ***Workforce*** • Sickness at 5.2% is now back within normal variation.

		• Mandatory training remains above target and Appraisal compliance is close to achieving target by September. • Turnover of corporate and other non-clinical staff remains high, reflecting pressures in the wider economy. In contrast, nursing and medical turnover and vacancies remain low. ***Finance*** • The Income & Expenditure surplus was on plan (£1.5m YTD). The Quality Improvement Programme (QIP) target of £2.35m YTD was delivered, however there was a lower proportion of recurrent QIP (55% compared to 100% planned). • Better Payment Practice Code stands at 88% of invoices paid and 88% of value against target of 95%. *Other matters* • Updates were received showing good progress implementing the Digital and Estates, Facilities & Sustainability sub-strategies. • The Health Procurement Liverpool strategy was reviewed, commended and endorsed with some minor comments. • Good progress seen in implementing transformation projects and QIP/CIP. Further assurance (including Quality Impact Assessments) via a deep dive into a couple of specific projects was requested for the next periodic review. • Annual effectiveness reviews were received for 4 sub-groups. The Equality, Diversity & Inclusion Group will from now on report into the Health Inequalities and Inclusion Committee. It was recognised that the Digital Transformation Maturity Group had struggled with poor attendance and had provided suboptimal levels of assurance, leading to BPC obtaining assurance in other ways. The ToR of a redesigned Digital Strategy Group was approved to replace it and oversee implementation of the sub-strategy; good engagement (especially clinical) will be vital to success. • Key Issues reports from seven subgroups were received and noted; no alerts were presented.		
4.	**Advise**	• Business cases for a replacement theatre microscope and contract renewal for the managed bank service were approved. • A reduction of the future meeting frequency from ten to six per year (consistent with board meeting changes) was agreed with a corresponding amended cycle of business.		
5.	**Risks Identified**	• No new risks		
6.	**Report Compiled**	David Topliffe Non-Executive Director	Minutes available from:	Corporate Secretary

Trust Board Key Issues Report

The Walton Centre NHS Foundation Trust

Date of last meeting: 20/07/2023		**Report of: Quality Committee**
		Membership Numbers: 7 (Quorate)
1.	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report and Joint Divisional Report • Risk and Governance Q1 Report • Patient Safety Incident Response Framework (PSIRF) Plan and Policy • Clinical Audit Plan 2023/24 • Clinical Audit Progress Report • Infection Prevention and Control (IPC) Q1 Report • Ward Accreditation Update Report • Pharmacy KPI Report • Pathology Quality Assurance Dashboard • Healthwatch Listening Event Update • Review of Quality Committee Sub Groups • IPC Effectiveness Review and Terms of Reference
2.	**Alert**	**Integrated Performance Report** There had been a category three pressure ulcer reported on a patient who had been transferred from Liverpool University Hospitals Foundation Trust (LUHFT) however this had since progressed to a category four. Documentation issues had been highlighted and the trust was working from LUHFT around lessons learned. The family had reported that they were happy with the care the patient had received from the Trust.
3.	**Assurance**	**Integrated Performance Report** The majority of indicators recorded on the IPR were within normal variation and high performing. An updated ward scorecard format was presented to provide improved assurance and comments were fed back for further improvements to be made. **Risk and Governance Q1 Report** All serious incidents had been investigated with learning outcomes and actions included in the report. A slight increase in the number of falls had been recorded and work to prevent falls continued. There had been a slight increase in numbers of Meticillin-Sensitive Staphylococcus Aureus (MSSA) recorded and a Trust wide action plan was in place regarding this with a deep dive to be presented at the September meeting.

		Clinical Audit Plan and Progress Report The clinical audit plan for 2023/24 was presented which included the process for identification and prioritisation of clinical audits. The plan provided flexibility for inclusion of audits identified as priorities through the year. The Clinical Audit Progress Report demonstrated continued excellent work in clearing the backlog of audits. **Infection Prevention and Control (IPC) Q1 Report** The report highlighted that there was a lot of good work being undertaken within the team that was making a positive impact on IPC metrics. Work to plan for the annual flu plan was underway. It was highlighted that the Trust had achieved level three Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) accreditation which was the highest level of accreditation. **Quarterly Pharmacy KPI Report** The Q1 Pharmacy Key Performance Indicator (KPI) report highlighted compliance with all performance KPIs with the exception of the percentage of discharge prescriptions verified on the ward. **Healthwatch Listening Event Update** The report provided an update on the patient listening event held by Healthwatch Liverpool in January 2023 and highlighted that the Trust received a rating of 4.8 out of a maximum of 5.		
4.	**Advise**	**Patient Safety Incident Response Framework (PSIRF) Plan and Policy** The Committee approved both the PSIRF plan and policy. The policy would be reviewed after a period of twelve months. **Infection Prevention and Control Committee (IPCC) Terms of Reference** The Committee approved terms of reference subject to clarification on the potential inclusion of the antimicrobial stewardship report to reports into the IPCC.		
5.	Risks Identified	It was noted that there were a number of unknowns related to the implementation of Patient Safety Incident Response Framework.		
6.	Report Compiled by	Ray Walker – Non-Executive Director	Minutes available from:	Katharine Dowson – Corporate Secretary

Report to Board of Directors
7 September 2023

Report Title	Proposal for Updates to the Standing Financial Instructions (SFIs) and Scheme of Reservation and Declarations (SoRD)
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Mike Burns, Chief Finance Officer Katie Tootill, Chief Procurement Officer Andy Green, Interim Deputy Finance Officer
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- Given the number of business cases that were being presented / submitted for Chairs Approval at BPC it was suggested that the levels of delegation for approval were reviewed in the Trust

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

- Embed changes ahead of full review of SFI's / SoRD for October Audit Committee.

Related Trust Strategic Ambitions and Themes	**Impact** *(is there an impact arising from the report on any of the following?)*		
Choose an item Finance & Commercial Development	Not Applicable	Not Applicable	Not Applicable

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

003 System Finance	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Team	24/05/2023	Mike Burns (CFO)	Request from Executive team to review Budget Holder approval limits in SORD
Executive Team	05/07/2023	Mike Burns (CFO)	Changes recommend the for submission to Audit Committee
Audit Committee	18/07/2023	Mike Burns (CFO)	Budget holder limits review included, approved by Audit Committee members

Proposal for Updates to the Standing Financial Instructions (SFIs) and Scheme of Reservation and Declarations (SoRD)

Executive Summary

1. Following recent discussions at the Business Performance Committee (BPC) with regard to the amount of business cases that were being submitted and with several only just being above the existing SoRD limits for approval by the committee it was requested that the levels of delegation were reviewed.

2. There was also discussion regarding BPC being held on a monthly basis and potential impractical delays to some projects that were in the main replacement cases, whilst some had external funding deadlines attached which meant they were time limited so delays could impact on funding sources.

3. During this review several other issues came to light in terms of streamlining current processes, helping to improve better payment practice code compliance and assessing the impact of the current economic environment on current procurement processes.

Background and Analysis

4. The current SFI's and SoRD are subject to an annal review which is reviewed at Audit Committee in October with recommendations to Trust Board in November. During the pandemic, and given the additional financial flexibilities over this period the Trust engaged MIAA to do a comprehensive review of its documents including benchmarking against some other Cheshire & Merseyside Trusts to ensure we:

    - Had similar coverage in terms of areas covered by the documents;
    - Were not an outlier in terms of values / delegation levels.

5. The final report detailed the key areas of difference in terms of coverage and benchmarking and although the Trust were similar for the majority, where we were an outlier, recommended changes were proposed, with subsequent agreement via the Audit Committee.

6. Since this comprehensive review, there have been several areas that have changed:

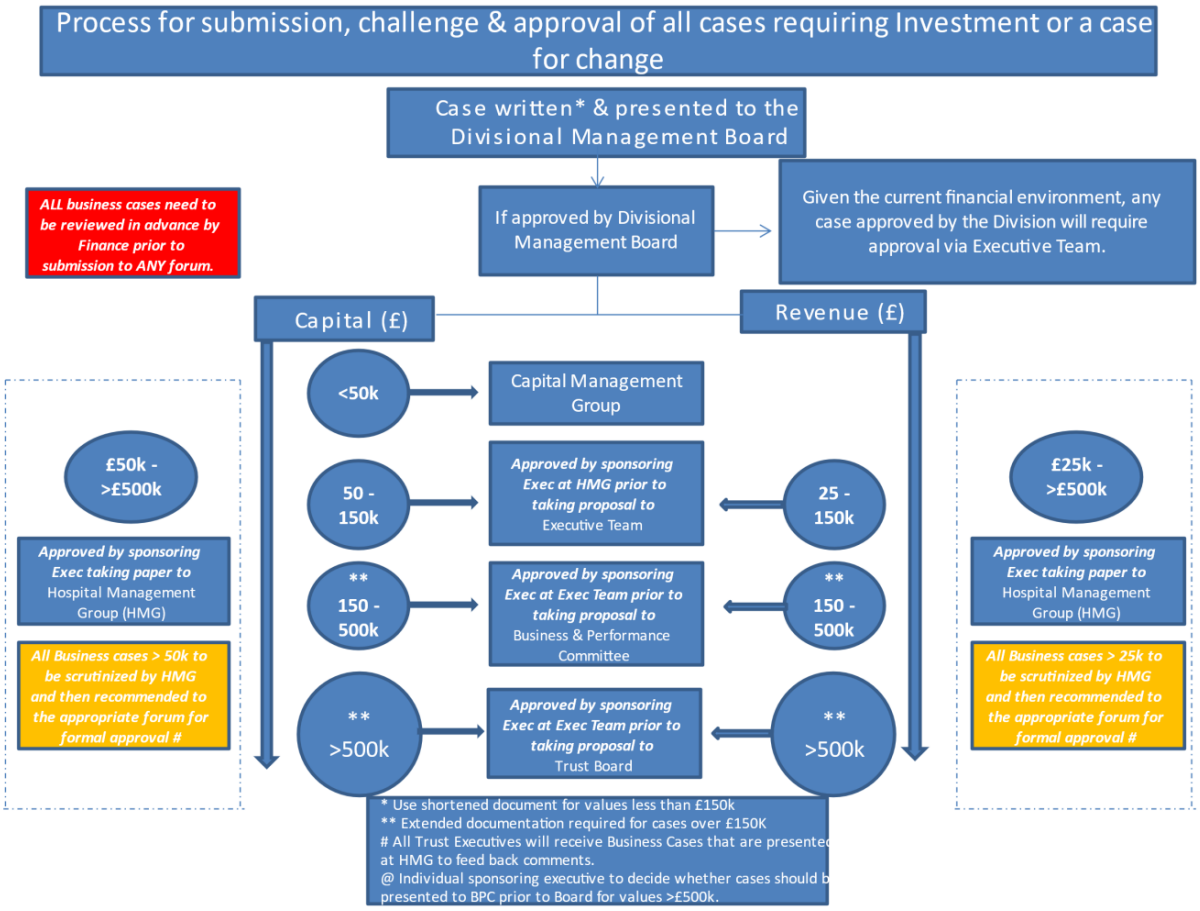
    - NHS capital allocations – there has been access to greater levels of 'external' capital funding and the Trust has successfully bid for this funding via Public Dividend Capital (PDC) across areas such as Digital, Estates, Medical equipment etc. This funding is usually allocated late in the financial year with directives that it must be spent in that year which shortens timescales for business case completion and approval;
    - Lead / Delivery times for items has become stretched due to supply side shortages which is lengthening the capital process in terms of planning timescales;
    - Inflation has run into double digits which is leading to some goods purchases being caught in new approval levels and associated delay levels associated with this (necessary) process.

7. Given the changes that have occurred it was noted that some capital business cases were being delayed (and some at relatively low values) given that BPC is a monthly process, when they could have been approved at another forum such as the executive team meeting, which happens weekly and is therefore able to be more agile in its approval cycle.

8. Therefore, given the inefficiencies that were perceived in the process, it was asked that the level of approval and process was reviewed to ensure that the process was as smooth as possible to ensure that the Trust wasn't disadvantaged from the areas that have changed.

Current Process for Expenditure Approval

9. The current process for business cases for both capital and revenue expenditure is shown below:



10. This shows that current levels for capital approval are as follows:

- CMG – up to £50k;
- Executive Team £50k - £150k;
- Business Performance Committee £150k - £500k;
- Trust Board £500k and above.

11. Given the changes noted and to aid process flow it is proposed that the following delegation levels are adopted:

- CMG – up to £100k;
- Executive Team £100k - £250k;
- Business Performance Committee £250k - £1m;
- Trust Board £1m and above.

SFI Thresholds for Quotations and Tenders

12. The current trusts quotation and tender and thresholds are:

- Up to £9,999k (inc VAT) – Obtain competitive price.
- Between £10k - £49,999k (Inc VAT) – Obtain three written competitive quotations.
- £50k – OJEU limit (inc VAT) – Undertake a competitive tendering exercise.
- Above OJEU Limit – Processes in line with over threshold public contract regulations

13. As part of the wider Procurement collaboration there are varying levels of SFI limits for quotation thresholds. Three of the HPL Trusts have recently reviewed the £10k threshold, with two of the three trusts in recent months agreeing to increase the level from £10k to £19,999k inc. VAT. The fourth HPL trust has had a £20k quotation threshold in place for several years. As part of the HPL governance it would be appropriate to look at standardising the thresholds across all partner sites moving forwards.

14. SFI thresholds at The Walton Centre have remained unchanged for several years and with the rising cost of inflation, it would be an appropriate time to review of these limits.

15. It is proposed that the SFI thresholds are updated to the below:

- Up to £19,999k (inc VAT) – Obtain competitive price.
- Between £20k - £49,999k (Inc VAT) – Obtain three written competitive quotations or use of a compliant framework.
- £50k – OJEU limit (inc VAT) – Undertake a competitive tendering exercise or use of a compliant framework.
- Above OJEU Limit – Processes in line with over threshold public contract regulations.

Waiver Exemptions (under threshold only)

16. Waivers are required when the trusts SFI's have not been followed and should only be used in exceptional circumstances.

17. The procurement team have noticed that there has been an increase in waivers over recent months and in some of these instances completing a waiver does not appear to add any value to process e.g., salary recharges for cross site working, grants and funding that must be spent with stipulated providers.

18. The reason for an increase in waivers is believed to have come from the drive-in improving PO compliance, ensuring more spend is visible to the Procurement team to actively help influence and support where possible. The Procurement team have seen an increase in waivers across the alliance as a whole and other HPL partners have recently agreed to amend SFI's to include the exemptions below.

19. It is proposed that for any quotation or local tender activities for the total value of the business/contract, up to the PCR 2015 threshold that fall under any of the below are exempt from a wavier:

- Salary re-charges to other NHS/Public sector organisations.
- Funding (if evidence is provided) that monies can only be spent with certain providers e.g., university grants.

- Funding Transfers to other organisations – Where evidence is provided that the monies are part of awarded funding to be shared with other organisations.

20. Procurement will keep an exemption register to support audit processes.

21. It is important to note that for over PCR 2015 threshold spending, public sector procurement rules will still need to be followed. Updates to regulations, the provider selection regime (which is proposed to exclude moving forwards any NHS clinical service spending with other NHS or Public sector bodies from the public contract regulations). This will likely help simplify processes and support wider integrated care service working across ICB's.

22. The updates to the regulations are still under review and we are expecting more detail around this in the coming months.

Approval of Supply Chain Invoices:

23. Currently the Associate Director of Procurement has responsibility of checking weekly order transactions against the invoices for NHS Supply and other third-party distributors.

24. It is proposed that this responsibility in shared with the Head of Procurement and P2P and Supply Chain Manager to ensure that there is adequate cover to check and approve these invoices in times of absence so that payments are not delayed.

Zero Cost Model

25. The zero-cost model was in place several years ago for high-cost tariff devices, all items had a zero cost, and the commissioners paid the trusts invoices form NHSSC.

26. This model has now changed to the Specialised Services Devices programme (SSDP). Orders are now place via NHSSC by individual trusts and as items now have a value, these orders follow the trusts internal approval processes. The trust is then re-imbursed with the costs for these devices.

27. It is proposed that reference to the zero-cost model in the SFI's is removed.

Credit notes approval limit:

28. Within the current SFI's, the credit note approval limit for the Deputy Chief Finance Officer is set at £25k, it is proposed that this is increased to £35k to align the Deputy Chief Finance Officers responsible approval limits across all areas within the SFI's.

Change to Budget Holder Approval Limits:

29. An increase to the Other Managers approval limits within SORD for All Other Expenditure (Pay and Non-Pay), section 5.3, increasing to £10k from the existing £5k limit.

Conclusion

30. The SFI's and SoRD are usually reviewed later in the year and approved at the Trust Board in November. However, given the discussions regarding approval limits and the general

requirement to streamline procurement and finance processes along with harmonising some processes in HPL there was a requirement to update this outside of the usual cycle of review.

Recommendation

- **To approve**

Authors: Mike Burns, Katie Tootill and Andy Green
Date: 22nd August 2023

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	2023/24 Expenditure Controls
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Andy Green, Interim Deputy Chief Finance Officer
Action Required	To approve

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

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

Key Messages

- To outline the Trust's expenditure controls in response to the national expenditure controls requirements.
- To provide assurance to the Board Directors of a strong system of internal control.
- To outline further steps for consideration.

Next Steps

- Submit draft expenditure controls to ICS by 31st August subject to board approval.
- Submit final board approval for expenditure controls to ICS following board meeting.
- To implement Trust recommendations on national expenditure control requirements.

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

Strategic Risks

003 System Finance	Not Applicable	Not Applicable

Equality Impact Assessment Completed

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors Meeting	23/08/2023	Mike Burns	Agreed

2023/24 Expenditure Controls

Executive Summary

1. In response to the Cheshire and Merseyside system plan submission, the national NHS England (NHSE) team wrote to the Cheshire and Merseyside Integrated Care Board (ICB) outlining the expectations for the year including standard national expenditure control requirements.

2. The National Standard financial controls heavily focus on the governance arrangements and processes.

3. On review the Trust operates a strong system of internal control, and there are a range of controls in place to provide assurance against the national and ICB expenditure control requirements. Improvements in rota management, consultant job planning, and vacancy control are highlighted, and work is being undertaken to implement recommendations made.

Background and Analysis

4. This letter asked that:
   - All organisations provide written assurance from the Board of Directors on expenditure controls within the organisation by the end of August (this could be in draft until formal approval at the next board); and
   - In addition, for each organisation with a planned deficit in 2023/24 or who reports an unplanned deficit in-year, an additional level of system assurance is put in place in the form of an Expenditure Controls Group.

5. The National Standard financial controls heavily focus on the governance arrangements and Trust processes in the following areas:

- Pay:
  - Review of Recruitment and Processes
  - General Vacancy Controls
  - Non-clinical Posts
  - Nursing
  - Medical
  - Agency controls

- Non-pay
  - Commitment of additional expenditure over £10,000 which will add to the expenditure run rate, excluding categories out of scope, to be approved at an executive chaired group.

- Exclusions from non-pay controls
  - Supplies & Services Clinical
  - Drugs Costs
  - Clinical Negligence fees
  - Audit fees
  - Depreciation and Amortisation

6. The areas for further improvement have been highlighted in Appendix 1. These focus on rota management and consultant job planning and vacancy control in which the Trust has an action plan in place for improvement.

Conclusion

7. The Trust operates a strong system of internal control, and there are a range of controls in place to provide assurance against the national and ICB expenditure control requirements.

Improvements in rota management, consultant job planning, and vacancy control are highlighted, and work is being undertaken to implement recommendations made.

Recommendation

8. Note the expenditure controls in operation at the Trust in response to the NHS E requirements and the recommendations for further enhancing the arrangements in place.

9. Approve communication to the ICB Chief Executive confirming the expenditure controls in place and the areas for improvement.

Author: Andy Green – Interim Deputy Chief Finance Officer
Date: 30th August 2023

Theme	Assurance	RAG	Recommendations
1. Pay Controls			
Review of Recruitment and Processes			
1.1 Produce and review a complete reconciliation of staff increases since 19/20 with full justification for post increases based on outcomes/safety/quality/new service models. A review of the value for money of the outcomes of these new posts should be included. Where value for money is not demonstrated a plan for the removal of the post needs to be in place. The overall plan to be signed off by the Board and the ICB.	Bridge of WTE increases was completed as part of 23/24 budget setting exercise, detailing increases between Additional Funding required wte and also income backed wte growth.		Produce document to Board detailing increases in service over this period of time
1.2 Review all current open vacancies to consider where the removal or freezing of posts is appropriate. This should initially focus on posts which have been vacant for over 6 months with a starting assumption that these should be removed or re-engineered.	As part of monthly budgets monthly and the annual budget setting process vacancies are reviewed on a regular basis, to see whether they still required.		
1.3 Review the establishment to remove partial posts not required and identify unfunded/unapproved posts which should be removed.	As part of monthly budgets monthly and the annual budget setting process vacancies are reviewed on a regular basis, to see whether they still required. Establishment sheets are reviewed on a monthly basis to identify over establishment and a plan put in place by the Financial Management team to reduce over time.		
1.4 Review current governance arrangements for recruitment and temporary staffing (panels and sign off at all levels of the organisation including groups, terms of reference, SFIs and sign off rights).	Current Posts are signed off through Request to Fill sheet, first by Service Manager, then Divisional Director, then Financial Management before finally being reviewed by a vacancy control panel. Nurse bank is outside of eRoster limits is reviewed by Matrons within eRoster reviewed by Ward Managers. Finance report includes financial information in relation to bank spend within each month.		
1.5 Ensure workforce plans are in place and that these are in a granular level of detail (e.g., by service, workforce type and substantive / temporary) and align to approved establishment levels and budget.	eRoster plans for a select number of services are already in place and finance have been aligning budgets to these levels.		Review Rotas ensure staffing times and numbers correct for the activity levels needed with budget to match.
1.6 Ensure that rigorous illness policy and procedure is in place and consistently applied.	HR have a sickness policy In place which is reviewed on regular basis with updates provided to service managers and Trust wide email was sent out to all teams to ensure policy is adhered to.		
1.7 Ensure that retention processes are reviewed – including exit interviews, flexible working options and retentions schemes.	Exit Interviews and Flexible working options are in place through HR policies. No current retention policy but we have action plans around staff experience and health and well-being which hopefully help with retention.		
1.8 Ensure that rota processes are reviewed to provide assurance to the Board that they are embedded and operate as anticipated across the organisation.	eRoster currently being rolled out across the trust.		
General Vacancy Controls			
1.9 Ensure that a regular vacancy control panel or equivalent is in place to check and challenge recruitment to ensure all vacancies remain within authorised budgetary limits.	Vacancy control panel takes place every Wednesday, with vacancies approved over email		Vacancy control panel to challenge posts that are being recruited into and whether the post is genuinely needed even when budget is available
1.10 Ensure Vacancy Control Panel terms of reference enable flexibility to avoid operationally delaying opportunities for savings and considering clinical need.	No formal Terms of Reference are in place, but sign off is required by the Deputy Senior Nurse, Deputy CPO, COO and Head of Financial Management.		Formal Terms of Reference required for Vacancy Control Panel.

Non-Clinical Posts			
1.11 No use of non-clinical agency staff, with exceptions authorised by an executive director and then requiring onward approval by ICB and NHSE regional director.	Non clinical agency only used when all other options have been exhausted and is currently approved as part of the vacancy control panel which includes the COO.		
Nursing			
1.12 Review one to one nursing policies, approvals, and tracking process to ensure standardised approach linked to patient need/acuity.	Special Observation of Patients policy in place, with staffing reviewed across the wards daily by the Nursing Team.		
Medical			
1.13 Review consultant job planning compliance and policies.	Job planning policy in place, with electronic job planning being rolled out across the trust		
1.14 Benchmark waiting list initiative and other additional payments against local organisations. An enhanced authorisation process for these payments should be in place, ensuring that such payments deliver value for money or are operationally critical before approving.	Waiting List Initiative rates have been reviewed in the past. WLI use is monitored by Financial management compared to the budget set.		
Agency Controls and Additional Payment Controls			
1.15 Established governance process to oversee agency staffing with clear terms of reference (either at overall level or by key staffing group e.g., nursing, medical, corporate) to be chaired by an executive director.	Agency recruitment is currently handled through the vacancy control panel. Due to the COO being on this panel an executive director is signing off this spend. The agency agreement also needs to go through procurement to ensure any supplier is on framework.		
1.16 Limit the authorisation of agency staff to Executives or named senior managers. Executive level sign-off of locum spend and off-framework spend.	Currently signed off at vacancy panel by COO. Gold on call currently approves agency staff out of hours.		Sign off of agency to be signed off by Medical Director for any Medical roles, with COO signing all other roles off. Exec roles should be signed off by CEO.
1.17 Agree an implementation date for the removal of all non-framework agency staffing with an associated organisation-wide temporary staffing policy.	Trust policy is not to recruit any staff from non -framework agency and currently no staff on agency are recruited via this way		
1.18 Clear Board accountability and reporting of plans and actual spend.	Current IPR includes graph detailing agency usage and cost each month		
2. Non-pay			
2.1 Commitment of additional expenditure over £10,000 which will add to the expenditure run-rate, excluding categories out of scope*, to be approved at an executive chaired group.	Currently we have a non recurrent expenditure sheet that is completed in year for spend over £10k and is presented to exec for sign off.		New non pay sheet currently being designed for sign off by performance group.
3. Cash			
3.1 Where a trust is seeking cash support for their revenue or capital position, they will need to continue to provide all of the documentation required as part of this process.	N/A		

*Non-pay categories of spend out of scope of non-pay controls:
Supplies and services - clinical (excl. drugs)
Drug costs
Clinical negligence fees
Audit fees
Depreciation and Amortisation

The Walton Centre
NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	NHS England Updated Fit and Proper Persons Test Framework
Executive Lead	Jan Ross, Chief Executive
Author (s)	Jennifer Ezeogu, Deputy Corporate Secretary Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages

- NHS England published a revised Fit and Proper Persons Test (FPPT) Framework for all board members on 2 August 2023
- A new standardised board member reference form to be held on file for leaving, retiring or resigning from 30 September 2023, further elements to be implemented by 31 March 2024
- An enhanced annual FPPT checks is to be completed as part of the annual appraisal and a summary submitted to NHS England Regional Director – submission deadline to be confirmed
- FPPT to be limited to substantive Board members only and no longer to include Deputy Directors

Next Steps

- Fit and Proper Persons Policy to be reviewed and updated once all elements confirmed
- Confirmation of full updated process to be advised once all details published
- Three-yearly renewals of DBS for Board Members to be introduced with immediate effect

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

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

NHS England Updated Fit and Proper Persons Test Framework

Executive Summary

1. New guidance has been issued to enhance the existing Fit and Proper Persons Test (FPPT) with some elements published and others planned before April 2024. This paper sets out the key messages and the implications for current, new and departing Board Members.

Background and Summary

2. NHS England (NHSE) published a new FPPT Framework [1] on 2 August 2023 for board members, alongside guidance for Chairs and a directory of board level learning and development opportunities.[2] The framework was developed in response to the Tom Kark KC review of 2019 which made recommendations to revise the existing FPPT process which was originally introduced in 2014.

3. The revised FPPT framework introduces additional background checks for board members on an annual basis. The FPPT Framework will be reviewed after 18 months to access its impact and whether it has been effectively embedded across NHS organisations. Elements of the framework are expected to be used from 30 September 2023 with full implementation by 31 March 2024.

4. In light of the Lucy Letby trial verdict, all NHS organisations were reminded via a letter from NHS England (NHSE) of their obligations under the FPPT not to appoint any individual into a board role unless they fully satisfy all the requirements in the FPPT requirement. This includes ensuring that persons have not been privy to, contributed to, been responsible for or facilitated any serious misconduct or mismanagement whether lawful or not.

5. The Framework applies to all board members including interim appointments, non-voting members i.e. Associate Non-Executive Directors (NEDs), those acting in the capacity of directors for a period of more than six weeks, temporary appointments including secondments and existing board members of NHS organisation who move to another NHS organisation for a board member role. The framework can also be extended to individuals within the NHS organisation whom, though not board members, have significant influence on board decisions but this is not proposed at the Trust.

New Requirements

6. A new starter/annual self-attestation form has been developed in line with the FPPT framework (Appendix 1).

7. A standardised board member reference form has been produced in line with the FPPT framework to ensure that board members satisfy regulatory requirements and promote good governance (Appendix 2). The form is to be completed by the Chair whenever a board member leaves, resigns or retires, irrespective of if they were seeking new employment elsewhere and a copy of this should be retained locally until the individuals 75th birthday.

[1] NHS England Fit and Proper Person Test Framework for board members
[2] NHS England » Directory of board level learning and development opportunities

8. A new FPPT checklist is introduced and includes the requirement for the following checks: Employment Judgement Tribunal, Social Media, Disqualification from being a Charity Trustee and triennial Disclosure and Barring Service (DBS) checks. (Appendix 3). This is in addition to the current annual checks against director insolvency and disqualification registers. Arrangements will be made for these checks to be made annually by HR and triennial checks against the DBS for Board members will be made for those who are not currently signed up to the update service.

Further Developments

Leadership Competency Framework

9. A new Leadership Competency Framework (LCF) for board level roles is being developed by NHSE. It is to be implemented alongside the revised FPPT Framework and will be made available by the end of September 2023. The LCF is aimed at supporting the development of a diverse range of highly skilled professional and proficient leaders who are focused on delivering the best outcomes for patients, workforce, and the public. It takes into account the NHS People Promise, the NHS Long Term Workforce Plan and Integrated Care Board (ICB) formation.

New Board Appraisal Framework

10. It is expected that the annual FPPT for all board members would be conducted at the same time the board appraisals and the appraisal process should incorporate the competency review that will be described in the LCF.

11. A new Board Appraisal Framework will be published by NHSE in March 2024 to be used for all board members annual appraisals. The new appraisal framework will incorporate provisions in the LCF and will be in use from April 2024.

12. The Corporate Secretary shall submit to the NHSE Regional Director an annual FPPT completion form containing records of the outcome of the FPPT for each board member which will be reviewed and signed by the chair before submission (Appendix 4).

Chair's FPPT

13. The annual FPPT for the chair will be conducted and signed off within the Electronic Staff Record (ESR) by the Senior Independent Director (SID) or the Deputy Chair. If the SID and Deputy Chair are the same individual, another NED should be nominated to review the chair's FPPT on a rotational basis.

Electronic Staff Record

14. New data fields will be created on ESR to hold individual FPPT information for all board members operating in the NHS and will be used to support recruitment referencing and ongoing development of board members. This information will be transferred to other NHS organisations as part of their recruitment processes. The information will only be accessible within the employing Trust. Access will be limited to the Chair, Chief Executive, SID/Deputy Chair, Corporate Secretary, Chief People Officer and their deputy and any other specifically authorised senior staff.

Application of FPPT

15. Currently the Trust interprets the FPPT regulations as applying to Deputy Directors as well as this was left to local interpretation in the original guidance. The new guidance is more specific in that these enhanced checks are only required for Board Members or those who have significant influence on board decisions. Due to the increase in resource required for the new checks it is recommended that Deputy Directors are no longer included in the checks unless formally acting up into the Director role for a period of more than six weeks.

Oversight of FPPT

16. The Chair is accountable for ensuring that FPPT checks are carried out and that the information held in ESR is up to date. Within the Trust, the Audit Committee will maintain oversight of the FPPT process through the annual FPPT report.

17. There are no new responsibilities for the Council of Governors (CoG) in relation to the FPPT. It is however recommended that the CoG receive summary outcomes of the FPPT for the Chair and NEDs as part of their involvement in Chair and NED appraisals.

18. Confirmation of the completion of the FPPT will be reported back to the Board through the Chair's key issues report.

19. The Chair will be supported in this annual process by the Corporate Secretary who will work with HR to ensure checklists are completed and submitted as required.

Conclusion and Recommendations

20. To ensure compliance with the new framework the following recommendations are made:
    - FPPT policy will be updated in line with the new FPPT Framework - once all elements are published
    - The new annual checklist (Appendix 3) will be updated ready to be used for 2024/25 checks
    - A reference form will be completed and held for all departing directors from 1 October 2023 and details will be added to ESR when the system has been updated
    - The new Leadership Competency Framework will be reviewed and reported to the Board once published
    - FPPT will be applied to Board members only and not to Deputy Directors as currently applies at the Trust.
    - Triennial DBS checks will be undertaken by HR for all Board Members (utilising the update service where individuals have signed up for this service).

The Board will have an oversight on the FPPT Framework and ESR monitoring through the Audit, Nominations and Renumerations Committee.

Recommendation

To approve the recommendations set out in the paper.

Author: Jennifer Ezeogu, Deputy Corporate Secretary
Date: 23 August 2023

Appendix 1 – New starter/annual self-attestation form

Appendix 2 – Board Reference Template
Appendix 3 – Annual Checklist for FPPT
Appendix 4 – Summary Form of Annual Checks for Submission

Appendix 3: New starter/annual NHS FPPT self-attestation

Every board member should complete the template (over the page) annually and this attestation should be submitted to [complete as applicable, eg the company secretary] on behalf of the chair.

Fit and Proper Person Test annual/new starter* self-attestation

[NAME OF NHS ORGANISATION]

I declare that I am a fit and proper person to carry out my role. I:

- am of good character
- have the qualifications, competence, skills and experience which are necessary for me to carry out my duties
- where applicable, have not been erased, removed or struck-off a register of professionals maintained by a regulator of healthcare or social work professionals
- am capable by reason of health of properly performing tasks which are intrinsic to the position
- am not prohibited from holding office (eg directors disqualification order)
- within the last five years:
  - I have not been convicted of a criminal offence and sentenced to imprisonment of three months or more
  - been un-discharged bankrupt nor have been subject to bankruptcy restrictions, or have made arrangement/compositions with creditors and has not discharged
  - nor is on any 'barred' list.
- have not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether unlawful or not) in the course of carrying on a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.

The legislation states: if you are required to hold a registration with a relevant professional body to carry out your role, you must hold such registration and must have the entitlement to use any professional titles associated with this registration. Where you no longer meet the requirement to hold the registration, any if you are a healthcare professional, social worker or other professional registered with a healthcare or social care regulator, you must inform the regulator in question.

Should my circumstances change, and I can no longer comply with the Fit and Proper Person Test (as described above), I acknowledge that it is my duty to inform the chair.

Name and job title/role:	
Professional registrations held (ref no):	
Date of DBS check/re-check (ref no):	
Signature:	
Date of last appraisal, by whom:	
Signature of board member:	
Date of signature of board member:	
For chair to complete	
Signature of chair to confirm receipt:	
Date of signature of chair:	

*Delete as appropriate

Appendix 2: The board member reference template

Board Member Reference

STANDARD REQUEST: To be used only AFTER a conditional offer of appointment has been made.

[Date]

Human resources officer/name of referee

Recruitment officer

External/NHS organisation receiving request

HR department initiating request

Dear [HR officer's/referee's name]

Re: [applicant's name] - [ref. number] – [Board Member position]

The above-named person has been offered the board member position of [post title] at the [name of the NHS organisation initiating request]. This is a high-profile and public facing role which carries a high level of responsibility. The purpose of NHS boards is to govern effectively, and in so doing build patient, staff, public and stakeholder confidence that the public's health and the provision of healthcare are in safe hands.

Taking this into account, I would be grateful if you could complete the attached confirmation of employment request as comprehensively as possible and return it to me as soon as practically possible to ensure timely recruitment.

Please note that under data protection laws and other access regimes, applicants may be entitled to information that is held on them.

Thank you in advance for your assistance in this matter.

Yours sincerely

[Recruitment officer's name]

Board Member Reference request for NHS Applicants:

To be used only AFTER a conditional offer of appointment has been made.
Information provided in this reference reflects the most up to date information available at the time the request was fulfilled.

1. Name of the applicant (1)	
2. National Insurance number or date of birth	

3. Please confirm employment start and termination dates in each previous role

A:(if you are completing this reference for pre-employment request for someone currently employed outside the NHS, you may not have this information, please state if this is the case and provide relevant dates of all roles within your organisation)

B: (As part of exit reference and all relevant information held in ESR under Employment History to be entered)

Job Title:
From:
To:

Job Title
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

Job Title:
From:
To:

4. Please confirm the applicant's current/most recent job title and essential job functions (if possible, please attach the Job Description or Person Specification as Appendix A):

(This is for Executive Director board positions only, for a Non-Executive Director, please just confirm current job title)

5. Please confirm Applicant remuneration in current role (*this question only applies to Executive Director board positions applied for)*	Starting:	Current:
6. Please confirm all Learning and Development undertaken during employment: *(this question only applies to Executive Director board positions applied for)*		
7. How many days absence (other than annual leave) has the applicant had over the last two years of their employment, and in how many episodes? ***(only applicable if being requested after a conditional offer of employment)***	Days Absent:	Absence Episodes:
8. Confirmation of reason for leaving:		

9. Please provide details of when you last completed a check with the Disclosure and Barring Service (DBS)

(This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)

Date DBS check was last completed.	Date
Please indicate the level of DBS check undertaken (basic/standard/enhanced without barred list/or enhanced with barred list)	Level
If an enhanced with barred list check was undertaken, please indicate which barred list this applies to	Adults □ Children □ Both □

10. Did the check return any information that required further investigation?	Yes □	No □

If yes, please provide a summary of any follow up actions that need to/are still being actioned:

11. Please confirm if all annual appraisals have been undertaken and completed (This question is for Executive Director appointments and non-Executive Director appointments where they are already a current member of an NHS Board)	Yes □	No □

Please provide a summary of the outcome and actions to be undertaken for the last 3 appraisals:		
12. Is there any relevant information regarding any outstanding, upheld or discontinued complaint(s) or other matters tantamount to gross misconduct or serious misconduct or mismanagement including grievances or complaint(s) under any of the Trust's policies and procedures (for example under the Trust's Equal Opportunities Policy)? (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)	Yes □	No □
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
13. Is there any outstanding, upheld or discontinued disciplinary action under the Trust's Disciplinary Procedures including the issue of a formal written warning, disciplinary suspension, or dismissal tantamount to gross or serious misconduct that can include but not be limited to: • **Criminal convictions for offences leading to a sentence of imprisonment or incompatible with service in the NHS**	Yes □	No □

• **Dishonesty** • **Bullying** • **Discrimination, harassment, or victimisation** • **Sexual harassment** • **Suppression of speaking up** • **Accumulative misconduct** (For applicants from outside the NHS please complete as far as possible considering the arrangements and policy within the applicant's current organisation and position)		
If yes, please provide a summary of the position and **(where relevant)** any findings and any remedial actions and resolution of those actions:		
14. Please provide any further information and concerns about the applicant's fitness and propriety, not previously covered, relevant to the Fit and Proper Person Test to fulfil the role as a director, be it executive or non-executive. Alternatively state Not Applicable. (Please visit links below for the CQC definition of good characteristics as a reference point) (7)(12) **Regulation 5: Fit and proper persons: directors - Care Quality Commission (cqc.org.uk)** **The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (legislation.gov.uk)**		

15. The facts and dates referred to in the answers above have been provided in good faith and are correct and true to the best of our knowledge and belief.

Referee name (please print): …….. Signature: ……

Referee Position Held:

Email address: Telephone number:

Date:

Data Protection:

This form contains personal data as defined by the Data Protection Act 2018 and UK implementation of the General Data Protection Regulation). This data has been requested by the Human Resources/ Workforce Department for the purpose of recruitment and compliance with the Fit and Proper Person requirements applicable to healthcare bodies. It must not be used for any incompatible purposes. The Human Resources/Workforce Department must protect any information disclosed within this form and ensure that it is not passed to anyone who is not authorised to have this information.

Appendix 7: FPPT checklist

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
First Name	✓	✓	✓	x – unless change	✓	✓	Application and recruitment process.	Recruitment team to populate ESR. For NHS-to-NHS moves via ESR / Inter-Authority Transfer/ NHS Jobs. For non-NHS – from application – whether recruited by NHS England, in-house or through a recruitment agency.
Second Name/Surname	✓	✓	✓	x – unless change	✓	✓		
Organisation (ie current employer)	✓	x	✓	N/A	✓	✓		
Staff Group	✓	x	✓	x – unless change	✓	✓		
Job Title Current Job Description	✓	✓	✓	x – unless change	✓	✓		
Occupation Code	✓	x	✓	x – unless change	✓	✓		
Position Title	✓	x	✓	x – unless change	✓	✓		
Employment History Including: • job titles • organisation/ departments • dates and role descriptions • gaps in employment	✓	x	✓	x	✓	✓	Application and recruitment process, CV, etc.	Any gaps that are because of any protected characteristics, as defined in the Equality Act 2010, do not need to be explained. The period for which information should be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that a career history of no less than six years and covering at least two roles would be the minimum. Where there have been gaps in employment, this period should be extended accordingly.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Training and Development	✓	✓	✓	✓	✓	*	Relevant training and development from the application and recruitment process; that is, evidence of training (and development) to meet the requirements of the role as set out in the person specification. Annually updated records of training and development completed/ongoing progress.	* NED recruitment often refers to a particular skillset/experience preferred, eg clinical, financial, etc, but a general appointment letter for NEDs may not then reference the skills/experience requested. Some NEDs may be retired and do not have a current professional registration. At recruitment, organisations should assure themselves that the information provided by the applicant is correct and reasonable for the requirements of the role. For all board members: the period for which qualifications and training should look back and be recorded is for local determination, taking into account relevance to the person and the role. It is suggested that key qualifications required for the role and noted in the person specification (eg professional qualifications) and dates are recorded however far back that may be. Otherwise, it is suggested that a history of no less than six years should be the minimum. Where there have been gaps in employment, this period should be extended accordingly.
References Available references from previous employers	✓	✓	✓	x	✓	✓	Recruitment process	Including references where the individual resigned or retired from a previous role
Last Appraisal and Date	✓	✓	✓	✓	✓	*	Recruitment process and annual update following appraisal	* For NEDs, information about appraisals is only required from their appointment date forward. No information about appraisals in previous roles is required.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Disciplinary Findings That is, any upheld finding pursuant to any NHS organisation policies or procedures concerning employee behaviour, such as misconduct or mismanagement	✓	✓	✓	✓	✓	✓	Reference request (question on the new Board Member Reference). ESR record (high level)/ local case management system as appropriate.	The new BMR includes a request for information relating to investigations into disciplinary matters/ complaints/ grievances and speak-ups against the board member. This includes information in relation to open/ ongoing investigations, upheld findings and discontinued investigations that are relevant to FPPT. This question is applicable to board members recruited both from inside and outside the NHS.
Grievance against the board member	✓	✓	✓	✓	✓	✓		
Whistleblowing claim(s) against the board member	✓	✓	✓	✓	✓	✓		
Behaviour not in accordance with organisational values and behaviours or related local policies	✓	✓	✓	✓	✓	✓		
Type of DBS Disclosed	✓	✓	✓	✓	✓	✓	ESR and DBS response.	Frequency and level of DBS in accordance with local policy for board members. Check annually whether the DBS needs to be reapplied for. Maintain a confidential local file note on any matters applicable to FPPT where a finding from the DBS needed further discussion with the board member and the resulting conclusion and any actions taken/required.
Date DBS Received	✓	✓	✓	✓	✓	✓	ESR	
Date of Medical Clearance* (including confirmation of OHA)	✓	x	✓	x – unless change	✓	✓	Local arrangements	
Date of Professional Register Check (eg membership of professional bodies)	✓	x	✓	✓	✓	x	Eg NMC, GMC, accountancy bodies.	

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Insolvency Check	✓	✓	✓	✓	✓	✓	Bankruptcy and Insolvency register	Keep a screenshot of check as local evidence of check completed.
Disqualified Directors Register Check	✓	✓	✓	✓	✓	✓	Companies House	
Disqualification from being a Charity Trustee Check	✓	✓	✓	✓	✓	✓	Charities Commission	
Employment Tribunal Judgement Check	✓	✓	✓	✓	✓	✓	Employment Tribunal Decisions	
Social Media Check	✓	✓	✓	✓	✓	✓	Various – Google, Facebook, Instagram, etc.	
Self-Attestation Form Signed	✓	✓	✓	✓	✓	✓	Template self-attestation form	Appendix 3 in Framework
Sign-off by Chair/CEO	✓	x	✓	✓	✓	✓	ESR	Includes free text to conclude in ESR fit and proper or not. Any mitigations should be evidence locally.
Other Templates to be Completed								
Board Member Reference	✓	✓	x	x	✓	✓	Template BMR	To be completed when any board member leaves for whatever reason and retained career-long or 75th birthday whichever latest. Appendix 2 in Framework.
Letter of Confirmation	x	✓	✓	✓	✓	✓	Template	For joint appointments only - Appendix 4 in Framework.
Annual Submission Form	x	✓	✓	✓	✓	✓	Template	Annual summary to Regional Director - Appendix 5 in Framework.

FPPT Area	Record in ESR	Local evidence folder	Recruitment Test	Annual Test	ED	NED	Source	Notes
Privacy Notice	x	✓	x	x	✓	✓	Template	Board members should be made aware of the proposed use of their data for FPPT – Example in Appendix 6.
Settlement Agreements	x	✓	✓	✓	✓	✓	Board member reference at recruitment and any other information that comes to light on an ongoing basis.	Chair guidance describes this in more detail. It is acknowledged that details may not be known/disclosed where there are confidentiality clauses.

Appendix 5: Annual NHS FPPT submission reporting template

NAME OF ORGANISATION	NAME OF CHAIR	FIT AND PROPER PERSON TEST PERIOD / DATE OF AD HOC TEST:

Part 1: FPPT outcome for board members including starters and leavers in period

Name	Date of appointment	Position	Confirmed as fit and proper?		Leavers only	
			Yes/No	Add 'Yes' only if issues have been identified and an action plan and timescale to complete it has been agreed	Date of leaving and reason	Board member reference completed and retained? Yes/No

Add additional lines as needed

Part 2: FPPT reviews / inspections

Use this section to record any reviews or inspections of the FPPT process, including CQC, internal audit, board effectiveness reviews, etc.

Reviewer / inspector	Date	Outcome	Outline of key actions required	Date actions completed
CQC				
Other, eg internal audit, review board, etc.				

Add additional lines as needed

Part 3: Declarations

DECLARATION FOR [name of organisation] [year]				
For the SID/deputy chair to complete:				
FPPT for the chair (as board member)	Completed by (role)	Name	Date	Fit and proper? Yes/No
For the chair to complete:				
Have all board members been tested and concluded as being fit and proper?	Yes/No	If 'no', provide detail:		
Are any issues arising from the FPPT being managed for any board member who is considered fit and proper?	Yes/No	If 'yes', provide detail:		
As Chair of [organisation], I declare that the FPPT submission is complete, and the conclusion drawn is based on testing as detailed in the FPPT framework.				
Chair signature:				
Date signed:				

For the regional director to complete:	
Name:	
Signature:	
Date:	

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	External Well Led Recommendations Action Plan
Executive Lead	Jan Ross, Chief Executive
Author (s)	Katharine Dowson, Corporate Secretary Jennifer Ezeogu, Deputy Corporate Secretary
Action Required	To decide

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

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

Key Messages

- Action plan for discussion following the External Well Led Review

Next Steps

- Complete the actions or agree where no further action is to be taken
- Report on progress to the Board in a further six months

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

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

All Risks	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Executive Directors	19 July 2023	K Dowson Corporate Secretary	Updates provided and actions and timescales agreed.

External Well Led Review Recommendations Action Plan

Background and Analysis

1. The External Well Led Review reported to the Board in May 2023 setting out the findings of a comprehensive review led by an external supplier Audit One against the NHS England Well Led Framework.[1]

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

3. Between January and March 2023, the assessment team observed all the major Board meetings and Committees, Council of Governors and divisional governance meetings. Interviews were conducted with the Board and senior managers and a series of focus groups were held with patients, Governors and staff. Surveys were also sent out to key external stakeholders.

4. The report was initially fed back to the Board at a Board Development Day before being reported to the public Board in May. At this point it was agreed that an action plan picking up all the recommendations would be developed and progressed by Executives before reporting back to the Board in September. This is attached as Appendix 1.

Conclusion

5. There are a number of actions, many of which tie into existing plans and Substrategies. A number of actions have already been resolved and closed. All others are underway. A further update will be provided to the Board in March 2024.

Recommendation

To agree

Author: Katharine Dowson
Date: September 2023

Appendix 1 Action Plan

[1] NHS England » Well-led framework

Appendix 1

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
Quality Statement 1: Shared Direction and Culture						
QS 1	As part of the roll out of the Trust refreshed strategy and suite of enabling strategies the Trust should ensure that the new strategic framework is well socialised with staff and stakeholders (including governors) including sufficient detail of implementation plans to make the strategies meaningful to all.	• Initial presentations and communications for launch including corridor displays and e-comms • June 2023 updates sent out via Walton Weekly and Team Brief about progress so far • All of the Substrategies have now been approved through the relevant forums and committees. The SPMO will lead on the action plans behind the strategies and will update the executive team on further developments.		• Ongoing roll out of activities to effectively socialise the Trust Strategy and Sub-strategies to staff, internally and externally. Information should be easy to comprehend and should not be limited to only digital platforms. Communications planed for 12 month point • Consider how to help staff understand what it means to them individually, what is their role in achieving it, the 'golden thread' through shared team objectives etc • Board Development Session on first 12 months of strategy • SPMO Strategy KPI Dashboard to be finalised	September 2023 September 2023 October 2023	Chief Operating Officer
QS 1	The Trust should ensure that it retains appropriate oversight over the delivery of the refreshed strategic ambitions and enabling strategies.	• The Board and CoG receive Bi-annual progress updates (incl. workplans) on the Trust Strategy and Substrategies. Board Committees receive updates on the Substrategies (x2 per year)		• Strategy KPIs to be agreed and reported against • The strategy dashboard has been developed with the Business Intelligence team and will include the strategic KPIs (being finalised)		Chief Operating Officer
QS 1	The Trust should review its approach of incorporating numerous strategic elements within the People Strategy in terms of appropriateness of profile and oversight	• Emerging process. Now the Substrategies are all being implemented, further detail is being developed through Strategic Implementation plans which will be specific to areas such as Research. • Research aligned with innovation and Medical Education within the RIME committee agenda. • Effectiveness of RIME committee reviewed annually • RIME committee extended to 3 hours to ensure appropriate profile and oversight of all three strategic ambitions				Chief People Officer
QS1	The Standing Financial Instructions state that the CEO will submit to the Board and CoG the annual operational plan. The Constitution also states that the Board must give regard to the views of the CoG in preparing the document. The CoG have not been involved in this in recent years and consideration needs to be given to engagement with Governors on this matter.	• The annual planning process has changed significantly in the last few years and this aspect has been overlooked as there is no longer a written operational plan • Executives have agreed that the views of the Governors on the annual plan should be sought before plans are made		• Session to be added to Council of Governors (December) to review the past year and strategic direction for and their view sought. Presentation to CoG.	December 2023	Chief Finance Officer/ Chief Operating Officer
QS1	Culture of modesty identified from internal and external stakeholders. Need to better promote and demonstrate the worth of small, specialist trusts within the system	• Ongoing focus for the last 12 months • High profile visits and TV segments • Documentary filming June/July 2023 for broadcast in September 2023		• Stakeholder review meeting to take place with Chair, CEO, Deputy CEO and Head of Communications and agree next steps	August 2023	Chief Executive

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
		• Nominated for Trust of the Year HSJ Award in 2023				
Quality Statement 2: Capable, Compassionate and Inclusive Leaders						
QS 2	The Trust should consider ways in which it can effectively re-energise the Trust's focus on its embedded values as staff felt that management did not focus on these as much as in the past.	• The values are embedded within all Trust policies and are also form part of the appraisal process. • Review of values is being picked up as part of rebranding focus group work • Values and 'The Walton Way' are well liked by staff • Building Rapport course enforces values with managers		• Review of values is being picked up as part of rebranding focus group work and to be aligned to the ICS values. To report to Board in September and agree next steps.	September 2023	Chief Executive
QS 2	The Trust should consider how it increases the contribution from executives at board and committee meetings and create more of a unitary board feel to proceedings. This was also noted by Board members in the 2022/23 Board Annual Self-effectiveness review.	• Chair has responded to this feedback and is ensuring all views are sought at Board meetings		• Sessions on Board roles to be added into Board Development plan and an away day planned.	November 2023	Chair
QS 2	The Trust should consider ways in which it can create additional executive/senior level capacity given the forward agenda i.e., digital leadership,	• Gap in digital leadership has been highlighted from a number of different sources • NHS does not currently offer aspiring director training in the field of Digital. • The Trust's Digital Substrategy sets out plans to seek specific skills from the market as required. • External review conducted through July/August to identify resource required for digital today and in the future		• Remuneration Committee to consider recommendations for digital leadership • Post-digital review the trust will be in a position to explore collaboration opportunities at a system level.	September 2023 April 2024	Chief People Officer
QS2	The Executive should ensure effective succession planning arrangements are in place below executive level.	• Although all executive leads have deputies, not all deputies aspire to be executive leads. • A number of senior managers have completed or are in the process of completing Nye Bevan Aspiring Executive course. • Board recognises the tension between succession planning and open competition in creating a positive impact on the diversity of the senior leadership team. • Current succession planning processed paper-based - exploring digital solution with NW NHSE. • Strong track record of internal appointments.		• Succession planning process has been established with all heads of service trained and in the process of developing plans for each area. To be reported to Business and Performance Committee • Recruitment and career progression policies to be reviewed to be more inclusive as part of ED&I plan including Key Performance Indicators (KPIs) • Board ED&I objectives to be agreed	September 2023 January 2024 August 2024	Chief People Officer
QS 2	The Trust should consider ways in which to create more formal divisional autonomy arrangements and generate effective accountability.	• Divisional performance review is now undertaken quarterly, and the triumvirate have a paper for HMG monthly to share their future plans for the divisions and areas for improvements. • Monthly triumvirate sessions added to executive team meetings		• New Accountability Framework to be developed (Corporate Secretary)	March 2024	Chief Operating Officer

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
		• Increased sign off levels for senior managers agreed at Audit July 2023				
QS 2	In a small Trust and one so compact as The Walton Centre it is not surprising that executives are so visible but there is a need to remain mindful of adopting a coaching style approach and allow divisional management to flourish.	• Significant change in senior divisional teams since March 2023 which is still being embedded. • Triumvirate sessions added to Exec meetings once per month to improve communications • HMG agenda has been reviewed to provide more opportunities to hold to account • New Assistant Chief Nurse role will have clear corporate responsibilities as well		• Refresh and review visibility programme and set expectations as part of Board Development • Back to the floor programme for all Executives.	December 2023	Chief Executive
QS 2	There had been two whistleblowing concerns raised directly to the Care Quality Commission (CQC) regarding staffing levels and skills mix.	• No further action was taken by CQC • Paper was taken to Board to provide assurance that levels of staffing are appropriate and safe • Two external reviews took place and have been developed into an action plan		• Action plan to be finalised and developed into ED&I plan	September 2023	Chief People Officer
Quality Statement 3: Freedom to Speak Up						
QS 3	The Trust should consider the appropriateness of the FTSU Guardian presenting their own papers at board meetings to increase their visibility and connection with all board members.	• The FTSU Guardian would normally present but had missed two meetings due to other commitments • FTSU Guardian also has a regular 1:1 meeting with the Chair and CEO. • Quarterly FTSU NED, Guardian, CN and CPO meeting to review trends and themes set up which links into annual report to Audit Committee.		No further action required.	Complete	Chief Nurse
Quality Statement 4: Workforce Equality, Diversity and Inclusion						
QS 4	The Trust should focus more effort on improving its appraisal and mandatory training performance in line with agreed Trust targets.	• Mandatory training target met in May 2023 • The HR team sends out monthly training compliance data to line-mangers • Appraisal process has been simplified and detailed reporting shared at People Group and Execs on a regular basis. Appraisal target met in June and maintained in July 2023. • Staff survey evidences that appraisals are of good quality; quality appraisal audits have been started • Mandatory training compliance is just below target		• Detailed report to be shared with Divisional managers going forward • Regular discussions at BPC and recovery plan agreed • Focus on achievement on compliance with 90% Safeguarding training target	September 2023	Chief People Officer

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 4	Whilst we recognise the Trust's estates constraints and lack of meeting rooms, the Trust should consider how it can better support the above recommendation by providing increased access to suitable rooms to hold 1:1 confidential discussions	• Several 'Pods' have been created this year on the second floor of Sid Watkins Building to create space for 1to1 confidential discussions • Positive responses in this area in staff survey.		• Ongoing work to provide more rest areas for clinical staff • Medical records project has commenced and vacated space has been allocated as a staff rest area - to be progressed within the next 6-12 months. • Policy on flexible and agile working policies to be updated and communications on the difference between the two to be sent out	April 2024 December 2023	Chief Operating Officer Chief People Officer
QS4	Difficulties of digesting information (Governor) due to dyslexia. Support should be provided in interactions with Trust.	• Despite best efforts we have been unable to identify this individual and therefore have not been able to put any mitigations or support in place		• Guidance is being developed on supporting staff with conditions such as dyslexia and providing resources where required	December 2023	Chief People Officer
QS4	The experience of staff in accessing information is mixed and we heard from staff that there are not enough computers compared to the number of staff and information are not received in a timely manner.	• No request for a computer has ever been turned down. Well led review shared in full with Public Digital to inform review of Digital Services. Business Intelligence and staff access included within scope of review • Screens added with scrolling information in staff rest areas • Communications Team have 12 months of engagement data from email communications and can respond to areas where staff are not opening internal communications		• IPads to be provided in staff rest areas	December 2023	Chief People Officer
Quality Statement 5: Governance, Management and Sustainability						
QS 5	The Trust should continue to support governors to discharge their statutory duty to represent members.	• The Trust provides governors with an induction at the start of their tenure and governors are part of various groups within the Trust. • There is ongoing governor development and networks available • Membership Strategic Plan in place and this is reviewed by Membership and Engagement Group quarterly • Membership events are held but not well attended by Governors • Membership stall held in outpatients in June as part of volunteers week		• Review of Trust engagement with Governors underway with Chair, Deputy Chair, Lead Governor and Corporate Secretary	September 2023	Corporate Secretary
QS 5	The Trust should consider its approach to digital and information leadership to maximise the benefit from its investments and ensure an aligned approach to secure greater value from its analytical and reporting capabilities to better scrutinise performance and help deliver current and future productivity and efficiency challenges.	• The Trust recognises there are challenges around digital and information leadership. • Digital Substrategy now in place • External review was conducted through July/August to identify resource required for digital today and in the future, Includes information in scope • Interim staffing arrangements in place pending external review recommendations		• Post-review the trust will be in a position to explore collaboration opportunities at a system level. • Outcomes of external review to be considered and investment requirements determined	April 2024 October 2023	Chief People Officer

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
		• Funding model being adapted following the reduction of external grant opportunities.				
QS 5	The IT team was described as 'disconnected' from the organisation and interviewees referenced inadequate provision of computers for the number of people needing them and a reduction in IT support. Beyond IT issues interviewees also made reference to the adequate availability of information but that staff cannot easily access it and the lack of interoperability between them which is causing operational inefficiencies and potential risks.	• Digital Substrategy in place • Drop in engagement and problem solving sessions running between IT team and staff in June/July/ August • No request for a computer ever turned down by the Digital team • JIRA Service Desk launched in 2023 to aid access and updates on issues • External review of resource required for digital and information now and in future completed in August 2023		• Outcomes of external review to be considered and investment requirements determined	October 2023	Chief People Officer
QS 5	The Trust should review the effectiveness of the Quality Committee in terms of the sub-group structure and effectiveness of reporting to support required improvements.	• Paper to Executives 28 June 2023 and Quality Committee 20 July on overall approach to revised subgroup structure		• Second phase of review focused on engagement with group attendees during second half of 2023/24	April 2024	Chief Nurse
QS 5	The Trust should consider reviewing its accountability and performance management arrangements to better formalise and improve accountability to support delivery of required targets via suitably devolved arrangements. Described as 'very gentle'. Senior leaders felt that they were more held to account by the non-executives at committee meetings as opposed to executives via operational performance review meetings.	• Divisional performance reviews held periodically • Role of challenge strengthened within Hospital Management Group • The COO and the DOF have now implemented a weekly operations and performance meetings to hold the divisional teams to account this is also attended by finance and BI and weekly performance data is reviewed and the finance for each division is also reviewed including CIP				Chief Operating Officer
QS 5	We noted in our observed operational level meetings that the absence of a key individual often meant that the agenda item was deferred to the next meeting. This inevitably causes delays and can weaken oversight of key matters.	• A new weekly operational / finance meeting has been introduced with terms of reference and if the key individuals cannot attend a deputy has to attend • Development of meeting etiquette guide will support this		• Continue to monitor attendance at the weekly performance meetings and the monthly HMG meeting		Chief Operating Officer
QS 5	Review of the Hospital Management Group meeting minutes demonstrate an operational focus with little time spent on oversight of strategic objective implementation despite the explicit reference to this within the terms of reference.	• Regular strategy updates have now been added to the cycle of business • The HMG group has had a committee review undertaken and the agenda and work plan has been reviewed also to ensure the strategic objectives have been maintained the meeting has now been moved to bimonthly with a bimonthly Senior managers development session		• Continue to monitor attendance at the weekly HMG meeting		Chief Operating Officer

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 5	There are not always clear outcomes from discussions and clear agreed actions which are followed through.	• The Chair and Committee Chairs to be reminded to ensure that actions are clearly noted with a date for completion and action owner assigned		• Learning for Committee /Group Chairs to be compiled and circulated to them and minute takers as part of a meeting etiquette guide; CS to support chairs in meetings.	December 2023	Corporate Secretary
QS 5	The operation of the action log in meetings appears a little 'clunky' at times and might benefit from prior population of the update section in advance of the meeting to aid review and the efficient running of meetings.	• This is supposed to happen but is not always done in advance.		• Learning for Committee /Group Chairs to be compiled and circulated to them and minute takers as part of a meeting etiquette guide; CS to support chairs in meetings.	December 2023	Corporate Secretary
QS 5	There were a number of examples where the chair of the forum did not seek explicit agreement to the recommendation of the paper and agreement was assumed.			• Learning for Committee /Group Chairs to be compiled and circulated to them and minute takers as part of a meeting etiquette guide; CS to support chairs in meetings.	December 2023	Corporate Secretary
QS 5	There were a number of Board agenda items where the rationale for a private discussion was unclear.	• The given example was the Referral to Treatment/ Average wait report which was part of a national trial and as part of this had to be reported in private board.		No further action required	Complete	Corporate Secretary
QS 5	The Scheme of Reservation and Delegation states that the Chief Operating Officer is responsible for the Risk Management Strategy and ensuring there is a programme of risk management, however, in practice we understand that this is under the Chief Nurse's portfolio.	• Updated SoRD will ensure that Chief Nurse is shown as the lead executive for Risk Management Framework				Chief Finance Officer
QS 5	We also noted that the Risk Management Policy does not make reference to the Audit Committee, which should be responsible for scrutinising 'the organisation's overarching framework of governance, risk and control' (NHS Audit Committee Handbook).	Risk Management Policy amended			July 2023	Chief Nurse
QS 5	The Trust should consider reviewing ownership and responsibilities associated with **risk** to ensure they are represented consistently across all relevant documents and match what is stated in the Annual Governance Statement	• High Assurance in recent MIAA – 2023 • Risk Management Policy updated regarding roles and responsibilities			July 2023	Chief Nurse
QS 5	The Trust should consider how it demonstrates fulfilment of the Audit Committees role in overseeing the effectiveness of risk management arrangements.	• New Risk Management Framework was reviewed by Audit Committee in 2023 and is on cycle of business for annual review • Internal Audit report on Risk Controls reviewed by Committee annually			Complete	Chief Nurse
QS 5	The Trust should consider ways to operationalise its risk appetite approach and improve alignment with target risk scores and risk-based discussions and decision making.	• Risk Appetite Statement established for 2023/24 and approved by Audit and Board.		Further Board Development Session on Risk Appetite to be planned in 2023/24	April 2024	Chief Nurse

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 5	It is unclear what benefit the Trust gains from the Audit Committee signing off the clinical audit plan as opposed to the Quality Committee whose membership and reporting appears better suited to this role.	• Audit Committee reviews the plan from the perspective of how the internal system of control is working as previously there were a large number of overdue and outstanding clinical audits which required more focus from the Committee to make improvements • Quality Committee receive the same report but focus on the impact and outcomes of the clinical audits		No further action required		Medical Director
QS 5	We note within the Audit Committee minutes that the Financial Accountant is a regular attendee at each meeting. The terms of reference for this committee include a list of regular attendees and the Financial Accountant is not identified as a required regular attendee.	• Updated in draft ToR pending next review of Audit Committee ToR			March 2024	Chief Finance Officer
QS 5	It was evident from reviewing the CoG minutes that challenges are made by the governors, which have not always been fully responded to.	• Pre-CoG meeting allows Governors to discuss areas of challenge and receive support to do this • Ongoing development /induction available to support Governors to understand their role in challenging		• Chair to be reminded to encourage follow up questioning and ensure Governors are happy with the responses received • Committee Etiquette guide to be developed and shared with all Chairs	December 2023	Corporate Secretary
QS 5	CoG minutes should distinguish between governors and others who are invited to attend the meeting	• Historic, this had already been identified and changed		No further action required	Complete	Corporate Secretary
QS 5	Despite the wide coverage and obvious overlap of operational, workforce and quality discussions we note the lack of clinical membership of the Business Performance Committee.	• This was identified when the membership was changed and at the 6 month review it was agreed that the current executive members were sufficiently representing the clinical voice but that this would be kept under review		No further action required	Complete	Chief Operating Officer
QS 5	Within the July 2022 Audit Committee minutes it was noted that fewer than half of all invoices were accompanied by a purchase order. This is at odds with many trusts who operate a 'no purchase order, no pay' policy approach to enforcing the use of purchase order discipline within the Trust.	• Plans have been put into place to improve BPPC which includes more rigorous requirements around POs being raised etc.'		• Work is being planned by the Finance and Procurement team to ensure that a 'no purchase order, no pay' policy approach is implemented across the Trust. This is part of the Finance and Commercial Development Substrategy.	2024/25	Chief Finance Officer
QS 5	We observed some lengthy presentations of papers at meetings. More could be done to ensure that introductions are succinct and focus on the cover sheet (i.e., why is the paper here, what are the key issues, what does the presenter want the forum to do with the paper). We noticed a tendance to tick the assurance boxes even when the paper is not for assurance which could give the impression that assurance has been provided when it has not.	• The paper template provides the required focus but there is a lack of compliance and insufficient challenge from meeting administrators and Executive leads. Exec leads are not always sent the paper or given sufficient time to review in advance of papers • Due to a change in jobs there is now more consistency across the Board Committees which should lead to improvement		• Meeting administrators to be reminded of importance of quality checks • Committee Chairs to be reminded to challenge where papers are not up to standard • Papers to be rejected if not approved by executive leads • Committee Etiquette guide to be developed and shared with all Chairs	Ongoing December 2023	Corporate Secretary

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 5	There was high proportion of 'to follow' papers, particularly at BPC	• This has been addressed through the year and has improved although there remain examples		• Establish zero tolerance for late papers unless there are exceptional circumstances and deferral to the next meeting would create significant issues • Committee Etiquette guide to be developed and shared with all Chairs	December 2023	Chief Executive
QS 5	We noted numerous examples of slippage in action dates with minimal recourse or challenge. It is important that realistic timelines are agreed from the outset and where slippage occurs the reasons and impacts of each instance is understood. We also noted a tendency sometimes to close actions when the course of action has been agreed as opposed to when it is actually actioned.	• Focus on this, starting to pre-populate action logs		• Corporate Governance team to support in meetings • Chairs to be asked to ensure that action logs are issued following the meeting and responses are pre-populated prior to the meeting – included in new Committee Etiquette guide	July 2023 December 2023	Corporate Secretary
QS 5	There are a number of policies that the Board has retained authority for approval in (Scheme of Reservation) which do not appear on the board forward plan. FTSU, Health, Safety and Welfare and Learning from Deaths	• FTSU Policy approved by Staff Partnership committee in January 2023 • Health and Safety Policy approved by Health and Safety Group May 2022 • Mortality Review Policy approved by Quality Committee in November 2017 (overdue) 3 month extension given by Quality and Patient Safety Group June 2021. • Risk team have been asked to transfer the ownership of these policies to the Board		• Scheme of Reservation to be reviewed by Corporate Secretary and included in new Trust assurance framework • Mortality Review Policy to be reviewed and approved asap • Policies to be added to Board Cycle of Business	March 2024 Sept 2023 Sept 2023	Chief Executive Medical Director Corporate Secretary
QS 5	It is noted that recent practice has been to include information on the performance of the shortlisted candidates (non-executive directors) including whether they were appointable or not. We would suggest that it is not appropriate to report this in the part 1 (public) CoG and is perhaps better reported in part 2 (private).			This will be implemented in the next NED appointment process.	Complete	Corporate Secretary
Quality Statement 6: Partnerships and Communities						
QS 6	The Trust should consider ways in which the Trust can continue to proactively raise its profile and demonstrate the wider added value that the Trust offers to system partners.	• Communications and Marketing Substrategy approved which includes this • Liverpool Citizens and Anchor Institution work • Nominated as Trust of the Year in HSJ Awards 2023 (winner to be announced November 2023)		• Documentary underway with channel 5 to air in September	ongoing	Chief Executive

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 6	The Trust should consider ways in which the Trust Board increases the voice of its stakeholders (qualitative feedback) at board and committee level.	Plan is within the Communications and Marketing Substrategy 2022-25		• Plan for stakeholder engagement to be developed with Head of Communications	September 2023	Chief Executive
QS 6	From our interactions with the Trust, we noted some concerns regarding the current status of the third-party contracts register and in particular concerns regarding how up to date some of the service level agreements are.	• Regular (quarterly) reporting to Executives on upcoming contract and SLA renewals has been put into place		The Trust will carry out an overview of third-party service level agreements.	2025	Chief Finance Officer
Quality Statement 7: Learning, Improvement and Innovation						
QS 7	The Trust should consider ways in which it can increase the added value from its clinical audit activities in terms of follow through of lessons learned, impact and embeddedness of changes. Learning opportunities would be enhanced by the provision of greater analysis within papers to bring insight to board and committee discussions rather than merely reporting performance. This is also true of quality reports where the primary focus of papers appears to be compliance against timelines and volume of instances rather than the learning and changes in practice that these have brought about.	• Medical Director provides progress and annual reports on Clinical Audit at the Audit and Quality committee meetings • Staff alerts and newsletters on patient safety incidents • Minerva dashboard in place for all patient safety incidents		• Highlighted Clinical Audit activities to be presented at the Hospital Management Group to share lessons learn • Implementation of new PSIRF framework • Audit Team and Risk and Governance Team need to work with divisions and corporate nurses to develop an agreed process and plan for developing clinical audit and ensure it is linked to patient safety priorities • Review wither Minerva can be linked to complaints and concerns generated through patient experience	September 2023 September 2023 March 2024 March 2024	Chief Medical Officer
QS 7	The Trust should consider ways in which it can strengthen the focus on learning lessons and dissemination of these lessons across the Trust including patient feedback, clinical audit and other sources of feedback as well as the more well-established learning from incidents. Not all areas (during mock CQC) were able to articulate lessons learned from complaints or incidents. In addition, not all staff were able to explain what had happened once an incident had been reported i.e. the absence of an effective feedback loop.	• Sharing and Learning Forum • Complaints quarterly reports to Executives, Quality Committee. Annual report to CoG • Staff alerts and newsletters on patient safety incidents.		• Quarterly learning event to be established for Nursing, Allied Health Professionals and Clinicians and linked to audit days	December 2023	Chief Nurse/ Medical Director
QS 7	How are local Clinical Audits identified as no clear driver in reports as to why these have been chosen and whether it links to identified concerns from incidents, complaints etc	• Local clinical audits are identified through a range of methods which include clinician interest but also from incidents, risks and complaints. This is through links with the divisional risk and governance process.		• Links to complaints, concerns. Incidents to be added to regular reports • As above	September 2023 March 2024	Medical Director

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 7	Evidence of discussion of clinical audit plans at divisional meetings, however no evidence of follow up once completed or focus on the implementation and impact of any recommendations from the findings.	• This has not been documented as clearly previously as required but has been agreed to be a focus		• Evidence required from Divisional Groups as new process is now in place • As above	December 2023	Medical Director
QS 7	Relatively large number of outstanding and abandoned clinical audits due to lack of response from services - this included NICE guidance assessments. 74% of requests in audit identified missing essential information and the recommendation was to implement an electronic short order system but no short term actions identified or any evidence of tackling the cause of this	• Major improvement in most recent clinical audit and NICE reports. Now no significant backlog. • Process for escalation of concern when projects are delayed is now established		Link to recommendations above		Medical Director
QS 7	End to end ownership of complaints resides with the central patient experience team who provide active support to divisions to respond to complaints in an appropriate and timely manner and also ensure learning actions are implemented. The Trust may wish to explore how it shifts ownership of complaints to the divisions with the central team facilitating co-ordination	• Neurosurgery division are compliant		Neurology need to establish the same processes in division as Neurosurgery	December 2023	Chief Nurse
QS2 &5	The Trust needs to be mindful that the informal mechanisms for resolving complaints and concerns do not become established 'workarounds' for Trust formal processes.	• Increasing numbers of concerns – monitored in the same way as complaints trends and terms.		• Need to understand why actions are not having sufficient impact and driving down complaints	December 2023	Chief Nurse
QS 7	The Trust should consider as part of the roll out of the 6i quality improvement methodology how this best aligns and provides value into the Trust's transformation and innovation activities.	• The 6i quality improvement methodology has now been rolled out and included as part of the Quality Substrategy to ensure this is included in all activities. • AQuA have now undertaken training with all the key members and leaders in the trust on the 6i methodology (July 2023)				Chief Operating Officer
QS 7	The Trust should continue to focus on increasing the research profile and level of activity within the Trust commensurate with being a national specialist Trust. The Research strategy sits within the People Strategy which may reduce its profile and focus in this area.	• Research is one of the five strategic ambitions in the Trust Strategy • Research has its own strategic implementation plan to achieve the Trust Strategy Ambition • Research sits with Innovation and Medical Education within the People function as part of the response to the independent external review of Research conducted by Kings.		• Developed joint strategic research ambitions with the University of Liverpool. • Developing a new joint Research Strategy with the University of Liverpool. • Developing appropriate resource to underpin strategy. • Neuroscience away day scheduled to include infection, neurodegeneration, epilepsy, pain and Neuro-oncology	July 2023 October 2023 November 2023 October 2023	Medical Director
QS 7	We note that the executive lead for research is the Chief People Officer, not the Medical Director, which is unusual.	There have been HR / people challenges historically within the research dept which have been managed by the CPO. However, the MD works closely with the CPO and clinical lead for		• Under review • Recent review by CEO agreed Medical Educations is to be moved to Medical		Chief Executive

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
		research on this agenda and is a core member of the RIME committee also.		Director. Research to remain as is, with input from Med Director		
Quality Statement 8: Environmental Sustainability - Sustainable Development						
QS 8	The Trust should consider the appropriateness of the governance and oversight arrangements surrounding delivery of the Trust's Sustainability Plan. Reporting has been sporadic and lacking in clear measurable objectives and measures against which BPC can effectively oversee delivery in the first 12 months of the plan.	• This forms part of the focus of the Estates, Facilities and Sustainability Substrategy. • Trust has established a sustainability steering group to support the implementation of the Trust's Sustainability plan. • Reporting line has been established to BPC and first update report has been received • A monthly sustainability meeting report is now included in the BPC monthly agenda and a quarterly update report has also been included into the work plan				Chief Operating Officer

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
Quality Statement 1: Shared Direction and Culture						
QS 1	As part of the roll out of the Trust refreshed strategy and suite of enabling strategies the Trust should ensure that the new strategic framework is well socialised with staff and stakeholders (including governors) including sufficient detail of implementation plans to make the strategies meaningful to all.	• Initial presentations and communications for launch including corridor displays and e-comms • June 2023 updates sent out via Walton Weekly and Team Brief about progress so far • All of the Substrategies have now been approved through the relevant forums and committees. The SPMO will lead on the action plans behind the strategies and will update the executive team on further developments.		• Ongoing roll out of activities to effectively socialise the Trust Strategy and Sub-strategies to staff, internally and externally. Information should be easy to comprehend and should not be limited to only digital platforms. Communications planned for 12 month point • Consider how to help staff understand what it means to them individually, what is their role in achieving it, the 'golden thread' through shared team objectives etc • Board Development Session on first 12 months of strategy • SPMO Strategy KPI Dashboard to be finalised	September 2023 September 2023 October 2023	Chief Operating Officer
QS 1	The Trust should ensure that it retains appropriate oversight over the delivery of the refreshed strategic ambitions and enabling strategies.	• The Board and CoG receive Bi-annual progress updates (incl. workplans) on the Trust Strategy and Substrategies. Board Committees receive updates on the Substrategies (x2 per year)		• Strategy KPIs to be agreed and reported against • The strategy dashboard has been developed with the Business Intelligence team and will include the strategic KPIs (being finalised)		Chief Operating Officer
QS 1	The Trust should review its approach of incorporating numerous strategic elements within the People Strategy in terms of appropriateness of profile and oversight	• Emerging process.Now the Substrategies are all being implemented, further detail is being developed through Strategic Implementation plans which will be specific to areas such as Research. • Research aligned with innovation and Medical Education within the RIME committee agenda. • Effectiveness of RIME committee reviewed annually • RIME committee extended to 3 hours to ensure appropriate profile and oversight of all three strategic ambitions				Chief People Officer
QS1	The Standing Financial Instructions state that the CEO will submit to the Board and CoG the annual operational plan. The Constitution also states that the Board must give regard to the views of the CoG in preparing the document. The CoG have not been involved in this in recent years and consideration needs to be given to engagement with Governors on this matter.	• The annual planning process has changed significantly in the last few years and this aspect has been overlooked as there is no longer a written operational plan • Executives have agreed that the views of the Governors on the annual plan should be sought before plans are made		• Session to be added to Council of Governors (December) to review the past year and strategic direction for and their view sought. Presentation to CoG.	December 2023	Chief Finance Officer/ Chief Operating Officer
QS1	Culture of modesty identified from internal and external stakeholders. Need to better promote and demonstrate the worth of small, specialist trusts within the system	• Ongoing focus for the last 12 months • High profile visits and TV segments • Documentary filming June/July 2023 for broadcast in September 2023 • Nominated for Trust of the Year HSJ Award in 2023		• Stakeholder review meeting to take place with Chair, CEO, Deputy CEO and Head of Communications and agree next steps.	August 2023	Chief Executive
Quality Statement 2: Capable, Compassionate and Inclusive Leaders						
QS 2	The Trust should consider ways in which it can effectively re-energise the Trust's focus on its embedded values as staff felt that management did not focus on these as much as in the past.	• The values are embedded within all Trust policies and are also form part of the appraisal process. • Review of values is being picked up as part of rebranding focus group work • Values and 'The Walton Way' are well liked by staff • Building Rapport course enforces values with managers		• Review of values is being picked up as part of rebranding focus group work and to be aligned to the ICS values. Will report to Board in September 2023 with next steps	September 2023	Chief Executive

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 2	The Trust should consider how it increases the contribution from executives at board and committee meetings and create more of a unitary board feel to proceedings. This was also noted by Board members in the 2022/23 Board Annual Self-effectiveness review.	• Chair has responded to this feedback and is ensuring all views are sought at Board meetings		• Sessions on Board roles to be added into Board Development plan and an away day planned.	November 2023	Chair
QS 2	The Trust should consider ways in which it can create additional executive/senior level capacity given the forward agenda i.e., digital leadership,	• Gap in digital leadership has been highlighted from a number of different sources • NHS does not currently offer aspiring director training in the field of Digital. • The Trust's Digital Substrategy sets out plans to seek specific skills from the market as required. • External review conducted through July/August to identify resource required for digital today and in the future		• Remuneration Committee to consider recommendations for digital leadership • Post-digital review the trust will be in a position to explore collaboration opportunities at a system level.	September 2023 April 2024	Chief People Officer
QS2	The Executive should ensure effective succession planning arrangements are in place below executive level.	• Although all executive leads have deputies, not all deputies aspire to be executive leads. • A number of senior managers have completed or are in the process of completing Nye Bevan Aspiring Executive course. • Board recognises the tension between succession planning and open competition in creating a positive impact on the diversity of the senior leadership team. • Current succession planning processed paper-based - exploring digital solution with NW NHSE. • Strong track record of internal appointments.		• Succession planning process has been established with all heads of service trained and in the process of developing plans for each area. To be reported to Business and Performance Committee • Recruitment and career progression policies to be reviewed to be more inclusive as part of ED&I plan including Key Performance Indicators (KPIs) • Board ED&I objectives to be agreed	September 2023 January 2024 March 2023	Chief People Officer
QS 2	The Trust should consider ways in which to create more formal divisional autonomy arrangements and generate effective accountability.	• Divisional performance review is now undertaken quarterly, and the triumvirate have a paper for HMG monthly to share their future plans for the divisions and areas for improvements. • Monthly triumvirate sessions added to executive team meetings • Increased sign off levels for senior managers agreed at Audit July 2023		• New Accountability Framework to be developed (Corporate Secretary)	March 2024	Chief Operating Officer
QS 2	In a small Trust and one so compact as The Walton Centre it is not surprising that executives are so visible but there is a need to remain mindful of adopting a coaching style approach and allow divisional management to flourish.	• Significant change in senior divisional teams since March 2023 which is still being embedded. • Triumvirate sessions added to Exec meetings once per month to improve communications • HMG agenda has been reviewed to provide more opportunities to hold to account • New Assistant Chief Nurse role will have clear corporate responsibilities as well		• Refresh and review visibility programme and set expectations as part of Board Development • Back to the floor programme for all Executives.	December 2023	Chief Executive
QS 2	There had been two whistleblowing concerns raised directly to the Care Quality Commission (CQC) regarding staffing levels and skills mix.	• No further action was taken by CQC • Paper was taken to Board to provide assurance that levels of staffing are appropriate and safe • Two external reviews took place and have been developed into an action plan		• Action plan to be finalised and developed into ED&I plan	September 2023	Chief People Officer
Quality Statement 3: Freedom to Speak Up						
QS 3	The Trust should consider the appropriateness of the FTSU Guardian presenting their own papers at board meetings to increase their visibility and connection with all board members.	• The FTSU Guardian would normally present but had missed two meetings due to other commitments • FTSU Guardian also has a regular 1:1 meeting with the Chair and CEO.		No further action required.	Complete	Chief Nurse

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
		• Quarterly FTSU NED, Guardian, CN and CPO meeting to review trends and themes set up which links into annual report to Audit Committee.				
Quality Statement 4: Workforce Equality, Diversity and Inclusion						
QS 4	The Trust should focus more effort on improving its appraisal and mandatory training performance in line with agreed Trust targets.	• Mandatory training target met in May 2023 • The HR team sends out monthly training compliance data to line-mangers • Appraisal process has been simplified and detailed reporting shared at People Group and Execs on a regular basis. Appraisal target met in June and maintained in July 2023. • Staff survey evidences that appraisals are of good quality; quality appraisal audits have been started • Mandatory training compliance is just below target		• Detailed report to be shared with Divisional managers going forward • Regular discussions at BPC and recovery plan agreed • Focus on achievement on compliance with 90% Safeguarding training target	September 2023	Chief People Officer
QS 4	Whilst we recognise the Trust's estates constraints and lack of meeting rooms, the Trust should consider how it can better support the above recommendation by providing increased access to suitable rooms to hold 1:1 confidential discussions	• Several 'Pods' have been created this year on the second floor of Sid Watkins Building to create space for 1to1 confidential discussions • Positive responses in this area in staff survey.		• Ongoing work to provide more rest areas for clinical staff • Medical records project has commenced and vacated space has been allocated as a staff rest area - to be progressed within the next 6-12 months. • Policy on flexible and agile working policies to be updated and communications on the difference between the two to be sent out	April 2024 December 2023	Chief Operating Officer Chief People Officer
QS4	Difficulties of digesting information (Governor) due to dyslexia. Support should be provided in interactions with Trust.	• Despite best efforts we have been unable to identify this individual and therefore have not been able to put any mitigations or support in place		• Guidance is being developed on supporting staff with conditions such as dyslexia and providing resources where required	December 2023	Chief People Officer
QS4	The experience of staff in accessing information is mixed and we heard from staff that there are not enough computers compared to the number of staff and information are not received in a timely manner.	• No request for a computer has ever been turned down. Well led review shared in full with Public Digital to inform review of Digital Services. Business Intelligence and staff access included within scope of review • Screens added with scrolling information in staff rest areas • Communications Team have 12 months of engagement data from email communications and can respond to areas where staff are not opening internal communications		• IPads to be provided in staff rest areas	December 2023	Chief People Officer
Quality Statement 5: Governance, Management and Sustainability						
QS 5	The Trust should continue to support governors to discharge their statutory duty to represent members.	• The Trust provides governors with an induction at the start of their tenure and governors are part of various groups within the Trust. • There is ongoing governor development and networks available • Membership Strategic Plan in place and this is reviewed by Membership and Engagement Group quarterly • Membership events are held but not well attended by Governors • Membership stall held in outpatients in June as part of volunteers week		• Review of Trust engagement with Governors underway with Chair, Deputy Chair, Lead Governor and Corporate Secretary	September 2023	Corporate Secretary

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 5	The Trust should consider its approach to digital and information leadership to maximise the benefit from its investments and ensure an aligned approach to secure greater value from its analytical and reporting capabilities to better scrutinise performance and help deliver current and future productivity and efficiency challenges.	• The Trust recognises there are challenges around digital and information leadership. • Digital Substrategy now in place • External review was conducted through July/August to identify resource required for digital today and in the future, Includes information in scope • Interim staffing arrangements in place pending external review recommendations • Funding model being adapted following the reduction of external grant opportunities.		• Post-review the trust will be in a position to explore collaboration opportunities at a system level. • Outcomes of external review to be considered and investment requirements determined	April 2024 October 2023	Chief People Officer
QS 5	The IT team was described as 'disconnected' from the organisation and interviewees referenced inadequate provision of computers for the number of people needing them and a reduction in IT support. Beyond IT issues interviewees also made reference to the adequate availability of information but that staff cannot easily access it and the lack of interoperability between them which is causing operational inefficiencies and potential risks.	• Digital Substrategy in place • Drop in engagement and problem solving sessions running between IT team and staff in June/July/ August • No request for a computer ever turned down by the Digital team • JIRA Service Desk launched in 2023 to aid access and updates on issues • External review of resource required for digital and information now and in future completed in August 2023		• Outcomes of external review to be considered and investment requirements determined	October 2023	Chief People Officer
QS 5	The Trust should review the effectiveness of the Quality Committee in terms of the sub-group structure and effectiveness of reporting to support required improvements.	• Paper to Executives 28 June 2023 and Quality Committee 20 July on overall approach to revised subgroup structure		• Second phase of review focused on engagement with group attendees during second half of 2023/24	April 2024	Chief Nurse
QS 5	The Trust should consider reviewing its accountability and performance management arrangements to better formalise and improve accountability to support delivery of required targets via suitably devolved arrangements. Described as 'very gentle'. Senior leaders felt that they were more held to account by the non-executives at committee meetings as opposed to executives via operational performance review meetings.	• Divisional performance reviews held periodically • Role of challenge strengthened within Hospital Management Group • The COO and the DOF have now implemented a weekly operations and performance meetings to hold the divisional teams to account this is also attended by finance and BI and weekly performance data is reviewed and the finance for each division is also reviewed including CIP				Chief Operating Officer
QS 5	We noted in our observed operational level meetings that the absence of a key individual often meant that the agenda item was deferred to the next meeting. This inevitably causes delays and can weaken oversight of key matters.	• A new weekly operational / finance meeting has been introduced with terms of reference and if the key individuals cannot attend a deputy has to attend • Development of meeting etiquette guide will support this		• Continue to monitor attendance at the weekly performance meetings and the monthly HMG meeting		Chief Operating Officer
QS 5	Review of the Hospital Management Group meeting minutes demonstrate an operational focus with little time spent on oversight of strategic objective implementation despite the explicit reference to this within the terms of reference.	• Regular strategy updates have now been added to the cycle of business • The HMG group has had a committee review undertaken and the agenda and work plan has been reviewed also to ensure the strategic objectives have been maintained the meeting has now been moved to bimonthly with a bimonthly Senior managers development session		• Continue to monitor attendance at the weekly HMG meeting		Chief Operating Officer
QS 5	There are not always clear outcomes from discussions and clear agreed actions which are followed through.	• The Chair and Committee Chairs to be reminded to ensure that actions are clearly noted with a date for completion and action owner assigned		• Learning for Committee /Group Chairs to be compiled and circulated to them and minute takers as part of a meeting etiquette guide; CS to support chairs in meetings.	December 2023	Corporate Secretary

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 5	The operation of the action log in meetings appears a little 'clunky' at times and might benefit from prior population of the update section in advance of the meeting to aid review and the efficient running of meetings.	• This is supposed to happen but is not always done in advance.		• Learning for Committee /Group Chairs to be compiled and circulated to them and minute takers as part of a meeting etiquette guide; CS to support chairs in meetings.	December 2023	Corporate Secretary
QS 5	There were a number of examples where the chair of the forum did not seek explicit agreement to the recommendation of the paper and agreement was assumed.			• Learning for Committee /Group Chairs to be compiled and circulated to them and minute takers as part of a meeting etiquette guide; CS to support chairs in meetings.	December 2023	Corporate Secretary
QS 5	There were a number of Board agenda items where the rationale for a private discussion was unclear.	• The given example was the Referral to Treatment/ Average wait report which was part of a national trial and as part of this had to be reported in private board.		No further action required	Complete	Corporate Secretary
QS 5	The Scheme of Reservation and Delegation states that the Chief Operating Officer is responsible for the Risk Management Strategy and ensuring there is a programme of risk management, however, in practice we understand that this is under the Chief Nurse's portfolio.	• Updated SoRD will ensure that Chief Nurse is shown as the lead executive for Risk Management Framework				Chief Finance Officer
QS 5	We also noted that the Risk Management Policy does not make reference to the Audit Committee, which should be responsible for scrutinising 'the organisation's overarching framework of governance, risk and control' (NHS Audit Committee Handbook).	Risk Management Policy amended			July 2023	Chief Nurse
QS 5	The Trust should consider reviewing ownership and responsibilities associated with **risk** to ensure they are represented consistently across all relevant documents and match what is stated in the Annual Governance Statement	• High Assurance in recent MIAA – 2023 • Risk Management Policy updated regarding roles and responsibilities			July 2023	Chief Nurse
QS 5	The Trust should consider how it demonstrates fulfilment of the Audit Committees role in overseeing the effectiveness of risk management arrangements.	• New Risk Management Framework was reviewed by Audit Committee in 2023 and is on cycle of business for annual review • Internal Audit report on Risk Controls reviewed by Committee annually			Complete	Chief Nurse
QS 5	The Trust should consider ways to operationalise its risk appetite approach and improve alignment with target risk scores and risk-based discussions and decision making.	• Risk Appetite Statement established for 2023/24 and approved by Audit and Board.		Further Board Development Session on Risk Appetite to be planned in 2023/24	April 2024	Chief Nurse
QS 5	It is unclear what benefit the Trust gains from the Audit Committee signing off the clinical audit plan as opposed to the Quality Committee whose membership and reporting appears better suited to this role.	• Audit Committee reviews the plan from the perspective of how the internal system of control is working as previously there were a large number of overdue and outstanding clinical audits which required more focus from the Committee to make improvements • Quality Committee receive the same report but focus on the impact and outcomes of the clinical audits		No further action required		Medical Director
QS 5	We note within the Audit Committee minutes that the Financial Accountant is a regular attendee at each meeting. The terms of reference for this committee include a list of regular attendees and the Financial Accountant is not identified as a required regular attendee.	• Updated in draft ToR pending next review of Audit Committee ToR			March 2024	Chief Finance Officer
QS 5	It was evident from reviewing the CoG minutes that challenges are made by the governors, which have not always been fully responded to.	• Pre-CoG meeting allows Governors to discuss areas of challenge and receive support to do this		• Chair to be reminded to encourage follow up questioning and ensure Governors are happy with the responses received	December 2023	Corporate Secretary

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
		• Ongoing development /induction available to support Governors to understand their role in challenging		• Committee Etiquette guide to be developed and shared with all Chairs		
QS 5	CoG minutes should distinguish between governors and others who are invited to attend the meeting	• Historic, this had already been identified and changed		No further action required	Complete	Corporate Secretary
QS 5	Despite the wide coverage and obvious overlap of operational, workforce and quality discussions we note the lack of clinical membership of the Business Performance Committee.	• This was identified when the membership was changed and at the 6 month review it was agreed that the current executive members were sufficiently representing the clinical voice but that this would be kept under review		No further action required	Complete	Chief Operating Officer
QS 5	Within the July 2022 Audit Committee minutes it was noted that fewer than half of all invoices were accompanied by a purchase order. This is at odds with many trusts who operate a 'no purchase order, no pay' policy approach to enforcing the use of purchase order discipline within the Trust.	• Plans have been put into place to improve BPPC which includes more rigorous requirements around POs being raised etc.'		• Work is being planned by the Finance and Procurement team to ensure that a 'no purchase order, no pay' policy approach is implemented across the Trust. This is part of the Finance and Commercial Development Substrategy.	2024/25	Chief Finance Officer
QS 5	We observed some lengthy presentations of papers at meetings. More could be done to ensure that introductions are succinct and focus on the cover sheet (i.e., why is the paper here, what are the key issues, what does the presenter want the forum to do with the paper). We noticed a tendance to tick the assurance boxes even when the paper is not for assurance which could give the impression that assurance has been provided when it has not.	• The paper template provides the required focus but there is a lack of compliance and insufficient challenge from meeting administrators and Executive leads. Exec leads are not always sent the paper or given sufficient time to review in advance of papers • Due to a change in jobs there is now more consistency across the Board Committees which should lead to improvement		• Meeting administrators to be reminded of importance of quality checks • Committee Chairs to be reminded to challenge where papers are not up to standard • Papers to be rejected if not approved by executive leads • Committee Etiquette guide to be developed and shared with all Chairs	Ongoing December 2023	Corporate Secretary
QS 5	There was high proportion of 'to follow' papers, particularly at BPC	• This has been addressed through the year and has improved although there remain examples		• Establish zero tolerance for late papers unless there are exceptional circumstances and deferral to the next meeting would create significant issues • Committee Etiquette guide to be developed and shared with all Chairs	December 2023	Chief Executive
QS 5	We noted numerous examples of slippage in action dates with minimal recourse or challenge. It is important that realistic timelines are agreed from the outset and where slippage occurs the reasons and impacts of each instance is understood. We also noted a tendency sometimes to close actions when the course of action has been agreed as opposed to when it is actually actioned.	• Focus on this, starting to pre-populate action logs		• Corporate Governance team to support in meetings • Chairs to be asked to ensure that action logs are issued following the meeting and responses are pre-populated prior to the meeting – included in new Committee Etiquette guide	July 2023 December 2023	Corporate Secretary
QS 5	There are a number of policies that the Board has retained authority for approval in (Scheme of Reservation) which do not appear on the board forward plan. FTSU, Health, Safety and Welfare and Learning from Deaths	• FTSU Policy approved by Staff Partnership committee in January 2023 • Health and Safety Policy approved by Health and Safety Group May 2022 • Mortality Review Policy approved by Quality Committee in November 2017 (overdue) 3 month extension given by Quality and Patient Safety Group June 2021. • Risk team have been asked to transfer the ownership of these policies to the Board		• Scheme of Reservation to be reviewed by Corporate Secretary and included in new Trust assurance framework • Mortality Review Policy to be reviewed and approved asap • Policies to be added to Board Cycle of Business	March 2024 Sept 2023 Sept 2023	Chief Executive Medical Director Corporate Secretary

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 5	It is noted that recent practice has been to include information on the performance of the shortlisted candidates (non-executive directors) including whether they were appointable or not. We would suggest that it is not appropriate to report this in the part 1 (public) CoG and is perhaps better reported in part 2 (private).			This will be implemented in the next NED appointment process.	Complete	Corporate Secretary
Quality Statement 6: Partnerships and Communities						
QS 6	The Trust should consider ways in which the Trust can continue to proactively raise its profile and demonstrate the wider added value that the Trust offers to system partners.	• Communications and Marketing Substrategy approved which includes this • Liverpool Citizens and Anchor Institution work • Nominated as Trust of the Year in HSJ Awards 2023 (winner announced November 2023)		• Documentary underway with channel 5 to air in September	ongoing	Chief Executive
QS 6	The Trust should consider ways in which the Trust Board increases the voice of its stakeholders (qualitative feedback) at board and committee level.	Plan is within the Communications and Marketing Substrategy 2022-25		• Plan for stakeholder engagement to be developed with Head of Communications	September 2023	Chief Executive
QS 6	From our interactions with the Trust, we noted some concerns regarding the current status of the third-party contracts register and in particular concerns regarding how up to date some of the service level agreements are.	• Regular (quarterly) reporting to Executives on upcoming contract and SLA renewals has been put into place		The Trust will carry out an overview of third-party service level agreements.	2025	Chief Finance Officer
Quality Statement 7: Learning, Improvement and Innovation						
QS 7	The Trust should consider ways in which it can increase the added value from its clinical audit activities in terms of follow through of lessons learned, impact and embeddedness of changes. Learning opportunities would be enhanced by the provision of greater analysis within papers to bring insight to board and committee discussions rather than merely reporting performance. This is also true of quality reports where the primary focus of papers appears to be compliance against timelines and volume of instances rather than the learning and changes in practice that these have brought about.	• Medical Director provides progress and annual reports on Clinical Audit at the Audit and Quality committee meetings • Staff alerts and newsletters on patient safety incidents • Minerva dashboard in place for all patient safety incidents		• Highlighted Clinical Audit activities to be presented at the Hospital Management Group to share lessons learn • Implementation of new PSIRF framework • Audit Team and Risk and Governance Team need to work with divisions and corporate nurses to develop an agreed process and plan for developing clinical audit and ensure it is linked to patient safety priorities • Review wither Minerva can be linked to complaints and concerns generated through patient experience	September 2023 September 2023 March 2024 March 2024	Chief Medical Officer
QS 7	The Trust should consider ways in which it can strengthen the focus on learning lessons and dissemination of these lessons across the Trust including patient feedback, clinical audit and other sources of feedback as well as the more well-established learning from incidents. Not all areas (during mock CQC) were able to articulate lessons learned from complaints or incidents. In addition, not all staff were able to explain what had happened once an incident had been reported i.e. the absence of an effective feedback loop.	• Sharing and Learning Forum • Complaints quarterly reports to Executives, Quality Committee. Annual report to CoG • Staff alerts and newsletters on patient safety incidents.		• Quarterly learning event to be established for Nursing, Allied Health Professionals and Clinicians and linked to audit days	December 2023	Chief Nurse/ Medical Director

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
QS 7	How are local Clinical Audits identified as no clear driver in reports as to why these have been chosen and whether it links to identified concerns from incidents, complaints etc	• Local clinical audits are identified through a range of methods which include clinician interest but also from incidents, risks and complaints. This is through links with the divisional risk and governance process.		• Links to complaints, concerns. Incidents to be added to regular reports • As above	September 2023 March 2024	Medical Director
QS 7	Evidence of discussion of clinical audit plans at divisional meetings, however no evidence of follow up once completed or focus on the implementation and impact of any recommendations from the findings.	• This has not been documented as clearly previously as required but has been agreed to be a focus		• Evidence required from Divisional Groups as new process is now in place • As above	December 2023	Medical Director
QS 7	Relatively large number of outstanding and abandoned clinical audits due to lack of response from services - this included NICE guidance assessments. 74% of requests in audit identified missing essential information and the recommendation was to implement an electronic short order system but no short term actions identified or any evidence of tackling the cause of this	• Major improvement in most recent clinical audit and NICE reports. Now no significant backlog. • Process for escalation of concern when projects are delayed is now established		Link to recommendations above		Medical Director
QS 7	End to end ownership of complaints resides with the central patient experience team who provide active support to divisions to respond to complaints in an appropriate and timely manner and also ensure learning actions are implemented. The Trust may wish to explore how it shifts ownership of complaints to the divisions with the central team facilitating co-ordination	• Neurosurgery division are compliant		Neurology need to establish the same processes in division as Neurosurgery	December 2023	Chief Nurse
QS2 &5	The Trust needs to be mindful that the informal mechanisms for resolving complaints and concerns do not become established 'workarounds' for Trust formal processes.	• Increasing numbers of concerns – monitored in the same way as complaints trends and terms.		• Need to understand why actions are not having sufficient impact and driving down complaints	December 2023	Chief Nurse
QS 7	The Trust should consider as part of the roll out of the 6i quality improvement methodology how this best aligns and provides value into the Trust's transformation and innovation activities.	• The 6i quality improvement methodology has now been rolled out and included as part of the Quality Substrategy to ensure this is included in all activities. • AQuA have now undertaken training with all the key members and leaders in the trust on the 6i methodology (July 2023)				Chief Operating Officer
QS 7	The Trust should continue to focus on increasing the research profile and level of activity within the Trust commensurate with being a national specialist Trust. The Research strategy sits within the People Strategy which may reduce its profile and focus in this area.	• Research is one of the five strategic ambitions in the Trust Strategy • Research has its own strategic implementation plan to achieve the Trust Strategy Ambition • Research sits with Innovation and Medical Education within the People function as part of the response to the independent external review of Research conducted by Kings.		• Developed joint strategic research ambitions with the University of Liverpool. • Developing a new joint Research Strategy with the University of Liverpool. • Developing appropriate resource to underpin strategy. • Neuroscience away day scheduled to include infection, neurodegeneration, epilepsy, pain and Neuro-oncology	July 2023 October 2023 November 2023 October 2023	Medical Director
QS 7	We note that the executive lead for research is the Chief People Officer, not the Medical Director, which is unusual.	There have been HR / people challenges historically within the research dept which have been managed by the CPO. However, the MD works closely with the CPO and clinical lead for research on this agenda and is a core member of the RIME committee also.		• Under review • Recent review by CEO agreed Medical Educations is to be moved to Medical Director. Research to remain as is, with input from Med Director		Chief Executive
Quality Statement 8: Environmental Sustainability - Sustainable Development						
QS 8	The Trust should consider the appropriateness of the governance and oversight arrangements surrounding delivery of the Trust's Sustainability Plan. Reporting has been sporadic and lacking in clear measurable objectives and measures against which BPC can	• This forms part of the focus of the Estates, Facilities and Sustainability Substrategy. • Trust has established a sustainability steering group to support the implementation of the Trust's Sustainability plan.				Chief Operating Officer

Quality Statement	Recommendation	Current Position/ Evidence	Rating	Actions	Date for Completion	Executive Lead
	effectively oversee delivery in the first 12 months of the plan	• Reporting line has been established to BPC and first update report has been received • A monthly sustainability meeting report is now included in the BPC monthly agenda and a quarterly update report has also been included into the work plan				

The Walton Centre NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	Emergency Planning Resilience & Response (EPRR) Self-assessment against NHS England Core Standards
Executive Lead	Lindsey Vlasman – Chief Operating Officer
Author (s)	Sally Butler-Rice – Health, Safety and EPRR Manager
Action Required	To approve

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

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

Key Messages

- Overview of compliance against EPRR self-assessment core standards. The deadline for submission to NHS England is 29th September.
- After a self-assessment, the Trust is fully compliant with 47 out of 59 applicable standards for specialist Trusts. Resulting in a compliance score of 80%, Partially Compliant.

Next Steps

- DPRR Annual Workplan has been amended to address the areas identified through this exercise

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

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

	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Emergency Planning Resilience & Response (EPRR) self-assessment against NHS England Core Standards

Executive Summary

1. Provider organisations are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness.

2. The total number of EPRR Core standards for 2023 is 73. However, only 59 standards are applicable to Specialist Trusts, this is an increase from 56 in 2022.

3. Based on the assessment, the Trust is fully compliant with 47 of the 59 applicable standards, partially compliant with 10 and non-compliant with 1. Therefore, will be submitting a score of 80% compliance, this equates to a rating of partially compliant. See appendix 1, dashboard of compliance against each standard.

4. The 2023 submission of the core standards is being assessed by NHS England. This includes a requirement to submit evidence into a repository to show compliance against each standard. This may cause the self-assessment score to change depending on whether the evidence supplied is sufficient.

Background and Analysis

5. Compliant standards

The Trust is fully compliant with 47 of the 59 applicable standards.

6. Non-compliant standards

The Trust is non-compliant with 1 of the 59 applicable standards. Key Performance Indicators need to be established to monitor compliance against the organisation's Business Continuity Management System (BCMS). Reports on these and the outcome of any exercises / status of any corrective action should be annually reported to Trust Board. This standard will be included within the 2023/24 EPRR action plan and be monitored by the Resilience Planning Group.

7. Partially compliant standards

The Trust is partially compliant with 10 of the 56 applicable standards. Remedial actions to ensure these are fully compliant will be included within the EPRR action plan. This includes as follows:

Standard 7 – Risk Assessment

EPRR risks are included on the Trust corporate risk register. They are however out of date for review. These will be reviewed at the earliest opportunity.

Standard 8 – Risk Management

The way in which EPRR specific risks are managed within the Trust requires improvement. This is how EPRR risks held on the corporate risk register have become out of date.

Standard 17 – Lockdown
The Trust's Lockdown Plan is held within the Major Incident Plan. This needs to be its own standalone plan with more details on lockdown arrangements. This is especially important post the installation of the new access control system within the Trust.

Standard 21 – Trained on call staff
On call staff within the Trust have completed the Principles of Health Command Course. There is an additional requirement to ensure on call staff maintain a portfolio of competence. NHS England have recently rolled out the portfolio template which staff will need to complete to ensure full compliance with this standard.

Standard 22 – EPRR training
EPRR training is established within the Trust. Examples of portfolios of competence are required for on call staff to evidence full compliance against this standard.

Standard 24 – Responder training
On call staff portfolios are required to show evidence against this standard.

Standard 46 – Business Impact Analysis / Assessment (BIA)
Business continuity plans within the Trust are based on a BIA. The BIA needs updating as it is out of date for review.

Standard 51 – Business Continuity Audit
The business continuity audit process requires improvement. An annual report on the progress of business continuity should be reported to Trust Board on an annual basis.

Standard 52 – Business Continuity Management System Continuous Improvement Process
Business continuity plans have been exercised and lessons learned will be reported to the next Resilience Planning Group. To satisfy this standard fully, the process needs to be reported to Trust Board on an annual basis.

Standard 66 – Hazmat / CBRN exercising
A CBRN exercise is included in the EPRR training programme. The production of the exercise report with lessons learned will satisfy the completion of this standard.

8. Deep dive

As part of the self-assessment, there is a deep dive on training and exercising. This does not form part of the annual declaration or impact the overall compliance score. Out of 11 standards relating to deep dive, the Trust is fully compliant with 8, non-compliant with 2 and partially compliant with 1.

9. Statement of compliance

Organisations are required to complete a Statement of Compliance and report this via the relevant group/committee to a public Board meeting.

The statement of compliance (appendix 2) has been signed by Lindsey Vlasman, the organisation's Accountable Emergency Office. Due to time constraints, this will be presented to the BPC post Trust Board, for information purposes. This report will also be submitted to the Resilience Planning Group (RPG) on the 19th September 2023.

This report, along with the Core Standards assurance rating and evidence displaying compliance against each standard, will be submitted to NHS England on 29th September 2023. Please not that due to this year's assessment method, the compliance score could change if NHS England are not satisfied with the evidence provided.

Conclusion

10. The annual assurance self-assessment has highlighted one area of non-compliance. This is because Key Performance Indicators need establishing to monitor compliance against the organisation's BCMS.

11. Areas of partial compliance are predominantly due to EPRR risks being out of date for review on the Trusts corporate risk register, on call staff portfolios not being completed and required improvements to be made to the BCMS.

12. It should be noted that this year's self-assessment is more stringent than previous years with NHS England requiring evidence to be submitted against each standard.

13. The EPRR Annual work plan has been updated to address the aforementioned areas of non and partial compliance, which will be overseen by the Resilience Planning Group.

Recommendation

- To approve

Author: Sally Butler-Rice

Date: 29th August 2023

Appendix 1 – Dashboard of compliance

NHS

Version Control
2.1 28/07/23

Please choose your organisation type

Specialist Providers

Generate Action Plan

Percentage Compliance	80%
Overall Assessment	**Partially Compliant**

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	0	2	0	0
Duty to maintain plans	11	10	1	0	0
Command and control	2	1	1	0	0
Training and exercising	4	2	2	0	0
Response	6	5	0	2	1
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	3	3
Business continuity	10	6	3	2	1
Hazmat/CBRN	10	9	1	9	9
Total	**59**	**47**	**10**	**16**	**14**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	7	1	2	0
Total	**10**	**7**	**1**	**2**	**0**

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core Standards.

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non Compliant' standards

Appendix 2 – Statement of Compliance

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

The Walton Centre NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, the Walton centre NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Partial (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____Lindsey Vlasman_____

Signed by the organisation's Accountable Emergency Officer

29/08/2023

Date signed

07/09/2023		
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 07/09/23		**Report of:** Audit Committee
Date of last meeting: 18/07/23		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Internal Audit Progress Report • Internal Audit Recommendations Report • Data Protection and Security Toolkit Audit Report • IT Infrastructure Housekeeping Audit Report • Counter Fraud Progress Report • Tender and Quotations Waivers Q1 Report 2023/24 • Finance Compliance Report • Proposal for Updates to the Standing Financial Instructions and Scheme of Reservation and Delegation • Managing Conflicts of Interests Annual Report 2022/23 • Board Committees Annual Review and Terms of Reference • Cyber Security Plan 2023/24 • Clinical Audit Plan Progress Report Q1 2023/24 • External Visits & Inspections Update Report
2.	**Alert**	• None
	Assurance	• The internal audits of Health Procurement Liverpool, Accounts Payable and Corporate Credit Card and the Data Security and Protection Toolkit Self-Assessment had provided substantial assurance. • The internal audit of the Risk Management Core Controls had provided High Assurance. • An internal audit of the National Data Guardian Standards had provided Moderate Assurance against two of the ten national standard levels with substantial assurance provided for the remaining eight national standard levels. • The Committee considered the Internal Audit Progress Report and noted that the following audits were underway: o Infection Prevention and Control (reporting stage) o Fire Safety (fieldwork stage) o Data Quality – IPR (fieldwork stage) o Medical Validation (scoping stage) o Safe Staffing (scoping stage) o Cyber Staffing (scoping stage)

		• The Internal Audit Recommendation Report was received by the committee, and it was highlighted that the Trust had closed thirteen out of the twenty recommendations previously made and continued to make positive progress against the implementation of the open recommendations. • The Committee received the Counter Fraud Progress Report and it was noted that no new fraud referrals had been made. One case was investigated during 2022/23 however, this had since been closed. • Mandatory fraud training was reported to be below target and work was underway to improve in this area. • The 2023/24 Q1 Tender Waivers Report was received and noted by the committee. • The 2023/24 Financial Compliance Report was received by the committee and the Committee noted the recovered debts and measures in place to recover aged debts. • The Committee received the annual report of managing conflicts of interest and it was highlighted that there had been 100% compliance rate for declaring interests. • The 2023/24 Q1 Clinical Audit Plan Progress Report was received by the Committee and it was highlighted that there were no outstanding audits within Neurosurgery and eight audits that had recently passed their estimated completion date and escalation processes were underway regarding these. It was recognised that significant work had been completed to significantly improve the number of outstanding audits. • The Committee received and noted an update on work undertaken against the 2023/24 Cyber-Security Annual Plan including completed initiatives and updates on ongoing and planned initiatives.		
	Advise	• The Committee endorsed the proposed amendments to the Standing Financial Instructions (SFI) and Scheme of Reservation and Delegation (SoRD) for Board approval.		
2.	**Risks Identified**	No new risks had been 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

Date of meeting: 22/07/23		**Report of:** The Walton Centre Charity Committee Meeting
		Membership Numbers: Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Finance Report as at 30 June 2023 • CCLA and Ruffer Quarterly Investment Reports • Fundraising Activity Report • Charity Risk Register • Cycle of Business 2023/24 • Application to Support a Band 7 Research Physiotherapist • Application for Bursary to Undertake Research Project • Application for the Purchase of Two Probes for Laser Interstitial Thermal Therapy • Draft Annual Report and Accounts 2022/23 • Pipeline of Potential Projects • Revised Committee Terms of Reference
2	**Alert**	• The committee received the quarterly investment reports from CCLA and Ruffer which highlighted the potential impacts on the investments portfolios due to the interest rate changes and cost of living crisis.
3	**Assurance**	• The Head of Fundraising presented the Charity Risk Register, no new risks were identified, and the Committee assessed appropriateness of risk ratings. • The Fundraising activities were progressing well and going back to pre-covid levels. Good progress was being made towards the Jan Fairclough (JF) Ball in November. • The committee would continue to monitor the impact of the Digital Fundraiser through the Fundraising Activity Reports. • The committee received and noted the Cycle of Business for 2023/24. • The pipeline of potential projects was presented to the committee, and the OCT machine project had been identified as a potential project for the JF Ball.
4	**Advise**	• The Finance Report as at 30 June was presented to the Committee which showed that the fund balances had increased from £1,373,910 to £1,426,808 as at 30 June 2023. • The Committee received and ratified the application to support a Band 7 Research Physiotherapist. • The Committee received and ratified the application of two bursaries for two students to undertake a research project at the Trust. • The Committee gave formal approval to an application from the Sid Watkins Innovation Fund for two more probes for the Laser Interstitial Thermal Therapy (LITT).

		• The Walton Centre Charity Draft Annual Report and Accounts 2022/23 was presented to the Committee and it was agreed that the Draft Annual Report and Accounts be sent to the independent examiner for a fee quotation and audit. • The committee received the Revised Terms of Reference (ToR) and recommended the ToR to the Board for approval.		
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: 11/05/23		**Report of: Neuroscience Network Programme Board**
Date of last meeting: 11/05/23		**Membership Numbers: 15 (Quorate)**
1.	**Agenda**	The Neuroscience Programme Board considered the agenda below:- • Getting it Right First Time (GiRFT) cranial update • Cheshire & Mersey Rehab review update • Rehab data presentation • NHS Right Care Data • Continence & Neurological Conditions • Patient Representative updates
2.	**Alert**	**Cheshire and Mersey Rehab Network Review** It was noted that the relevant teams are finalising working groups to ensure that membership was relevant and up to date. Representation for ICB is still required and this is being taken forward.
	Assurance	**Rehab Data Information** Comprehensive data, with regards to the services delivered by the Cheshire & Merseyside Rehabilitation Network for the past ten years, was presented. The Rehabilitation team are able to provide extensive data to describe the aetiology of patients admitted, length of stay, clinical requirements and expected outcomes for patients. The Rehabilitation Network are making a difference for patients, the community and regional health. A cost effectiveness analysis conducted in 2016 demonstrated that rehabilitation is the most cost-effective method of delivering healthcare for this group of patients. Further areas to be considered relate to those patients not admitted to the network as they do not meet the specified criteria.
	Advise	**Cranial Getting it Right First Time (GiRFT) Update** The majority of actions are on track. For emergency referrals, the ORION system is used. An update was made to the system to allow a two-way conversation between the referring provider and WCFT. Unfortunately, not all providers can access the two-way chat which has led to an increase in the number of referrals. The Surgical division were working closely with ORION for this to be rectified.

		Work is also on-going with regards to same day discharge for cranial patients. Once there is a robust system in place for spinal patients, the focus will move to cranial patients. **Continence & Neurological Conditions** The Head of Infection Prevention & Control for NHS England provided details of the work being undertaken with regards to the prevention of Urinary Tract Infections (UTIs) and subsequent reduction of antibiotic use. The update highlighted that continence can be an issue for those living with neurological conditions and that continence services within the community are not easily access. It is hoped that various teams will be able to work together so that this group of patients is not missed. **NHS Right Care Data** The Right Care Data highlighted particular areas in which Cheshire & Merseyside were outliers nationally and in comparison to peer PLACE groups. The areas discussed related to the high rates of neurology referrals and discharges after the first attendance and high rates of neurosurgical referrals. In addition the Right Care Data demonstrated that costs for pain medications (Pregabalin and Gabapentin) were notably higher within Cheshire & Merseyside in comparison to Greater Manchester and Lancs / South Cumbria. Use of Co-careldopa (a Parkinsonian medication) was also higher within Cheshire & Merseyside. The Programme Board discussed the difficulties with regards to pain management and alternative pathways. It was also noted how the Right Care data provided robust information for possible cost saving opportunities. **Patient Representatives at Neurosciences Programme Board** Following feedback from patient representatives a number of recommendations were received in order to fully utilise the valuable input from patients.		
3	**Risks Identified**	None		
4.	**Report Compiled by**	Medical Director	Minutes available from:	Corporate Secretary

The Walton Centre
NHS Foundation Trust

Report to Board of Directors
7 September 2023

Report Title	The Walton Centre Charity Committee Terms of Reference (ToR)
Executive Lead	Mike Burns, Chief Finance Officer
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To agree

Level of Assurance Provided

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

Key Messages

- Terms of Reference were approved in May 2023 by the Board but have since been queried by the Committee
- Quoracy requirement now includes a preference for a clinical representative to always be present for a meeting to take place
- Update to Data Privacy paragraph

Next Steps

N/A

Report Development

Committee/ Group Name	Date	Lead Officer (name and title)	Brief Summary of issues raised and actions agreed
Charity Committee	21 July 2023	Mike Burns Chief Finance Officer	Change to quoracy description agreed.
Trust Board	4 May 2023	Mike Burns Chief Finance Officer	Terms of Reference approved
Charity Committee	21 April 2023	Mike Burns Chief Finance Officer	Review requested of Quoracy to include non-Board Members. No further comments were received
Charity Committee	21 January 2023	Mike Burns Chief Finance Officer	Terms of Reference not agreed as quoracy queried

Terms of Reference (ToR) Review of The Walton Centre Charity Committee

Summary

1. The Terms of Reference for the Charity Committee have been reviewed following questions raised at regarding the quoracy of the Committee which stated:
   10. The Committee will be deemed quorate when two voting members, including at least one Executive and one Non-Executive Director are present

2. The Corporate Secretary was asked to review how this could be amended to reflect the contribution of the clinical representatives after the ToR were submitted to the January meeting in order to increase the number of Non-Executive Directors on the Committee.

3. On 14 February the Corporate Secretary sent an email to all member following a similar query raised at the January meeting which explained why the quoracy of a Board authorised Committee could only include Board members. There were no responses to this email and therefore the ToR was taken to the Board meeting in May for approval.

4. Following further debate at the Committee the Corporate Secretary reviewed again the options and has proposed a caveat to the paragraph which recognises the collaborative approach of the Committee and the intention to include all Committee members in decision-making and debate. The new paragraph included in the ToR attached at Appendix 1 is as follows.

   10. The Committee will be deemed quorate when two voting members, including at least one Executive and one Non-Executive Director are present. However, the Chair would need to authorise this for exceptional circumstances only, as at least one clinical representative would normally need to be present for a meeting to take place.

5. The Committee agreed that this was an acceptable compromise.

6. Paragraph 21 has also been updated on the recommendation of the Information Governance Manager to reflect the most recent legislation.

Recommendation

To agree.

Author: Katharine Dowson – Corporate Secretary

Date: September 2023

Appendix 1 – Terms of Reference

Appendix 1

THE WALTON CENTRE CHARITY COMMITTEE
TERMS OF REFERENCE

Authority/Constitution

1. The Walton Centre Charity Committee (WCC) (the Committee) is authorised by the Board of Directors of The Walton Centre NHS Foundation Trust, to exercise the Trust's functions as sole corporate trustee of The Walton Centre Charity, registered charity number 1050050.

2. The Committee has no executive powers other than those specifically delegated in these Terms of Reference.

3. The Committee has the authority to oversee and take decisions relating to the Trust's charitable activities which also support the achievement of the organisation's objectives.

4. The Committee is authorised to request specific reports from individual functions within the organisation and to seek any information it requires from any member of staff in order to perform its duties.

5. The Committee is authorised to create operational sub-groups, forum, advisory or working groups as are necessary to fulfil its responsibilities within its terms of reference. The Committee may not delegate executive powers and remains accountable for the work of any such group.

6. 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.

Purpose

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

Membership

8. The Committee shall be comprised of the following voting members:
   - At least two Non-Executive Directors, one of whom will be the Committee Chair
   - Chief People Officer
   - Chief Finance Officer

9. The following are required to attend in a non-voting capacity:
   - Clinical Representative from the Division of Neurosurgery
   - Clinical Representative from the Division of Neurology

- Deputy Medical Director
- Deputy Chief Nurse
- Head of Fundraising

10. The Committee will be deemed quorate when two voting members, including at least one Executive and one Non-Executive Director are present. However, the Chair would need to authorise this for exceptional circumstances only, as at least one clinical representative would normally need to be present for a meeting to take place.

11. In the event that the Chair of the Committee is unable to attend a meeting, the other Non-Executive Director shall be Chair for that meeting. The Chair shall have a casting vote in the event of a vote.

12. Members may only nominate a deputy to attend on their behalf if they have sufficient understanding of the area they are representing to be able to contribute effectively to the Committee/Group's business; however, this should only be in exceptional circumstances. There is no provision for deputies to represent voting members at meetings of the Committee unless they are formally acting-up in accordance with the Trust's Constitution.

13. Clinical Divisional representatives are invited on to the Committee for a period of three years at which point other clinical staff members will be invited to submit submissions of interest. If there is no further interest, then the divisional representative can be asked to serve a further three years.

14. Other staff or external advisers may be co-opted or requested to attend for specific agenda items as necessary.

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

Requirements of Membership

16. Members must attend at least 75% of all meetings each financial year but should aim to attend all scheduled meetings. Attendance will be recorded and monitored.

17. Conflicts of Interest – the Companies Act 2006 defines a conflict of interest as arising when the interests of directors or 'connected persons' are incompatible or in competition with the interests of the organisation. Committee/Group members are required to exercise judgement and to declare such interests as there is a risk of implied improper conduct. The relevant interest, once declared, will be recorded in a register of interests, maintained by the Company Secretary.

Duties

18. In order to fulfil its role and obtain the necessary assurance, the Committee will:
    - inform the development of the Charity and Fundraising Substrategy and objectives for the Charity's work for consideration by the Board and oversee their delivery

- monitor the performance of the fundraising and marketing activity, ensuring that the return on investment is satisfactory and that income targets are met
- receive reports detailing balances of the Charity's Funds
- receive reports on all individual charitable non-pay transactions in excess of £1,000
- approve expenditure of all individual charitable non-pay transactions valued from £5,000 up to £100k
- in line with charity law establish the strategy, policies, budget, spending priorities and criteria for spending decisions for each fund
- appoint appropriate Investment Managers to provide investment advice and manage the Charity's investment portfolio
- 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.

i) keep investment performance under review
j) 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
k) ensure compliance with the Trust's Standing Financial Instructions, Financial Control Procedures and Scheme of Delegation
l) receive audit reports on the charity controls
m) approve new fundraising appeals and monitor fundraising targets
n) consider the Charity's annual report and accounts prior to approval by Trust Board.

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

20. The Committee will also keep under review any risks relevant to its remit in order to provide assurance to the Board that risks are being effectively controlled and managed.

Data Privacy

21. The Group is committed to protecting and respecting data privacy. The Group will have regard and demonstrate, where applicable, compliance with data protection legislation, in particular the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (GDPR).

Equality, Diversity & Inclusion

22. In conducting its business, the Committee will at all times seek to meet its obligations under the Equality Act 2010 and promote its commitment to equality and diversity by the creation of an environment that is inclusive for both our workforce, patients and service

users, including those who have protected characteristics and vulnerable members of our community.

Reporting

23. The Committee will be accountable to the Trust Board of Directors. The Board of Directors will be informed of the Committee's work through an assurance report from the Chair submitted following each meeting.

24. The Committee will agree a cycle of business which will be reviewed at each meeting to ensure the Committee is meeting its duties.

25. The Committee will annually assess its performance against the Charity and Fundraising Substrategy.

26. Reports including regular assurance reports will be received from any subgroups established by the Committee and the Committee will approve their Terms of Reference and annual work programme and keep their effectiveness under review.

Administration of Meetings

27. Meetings shall be held quarterly with additional meetings held on an exception basis at the request of the Chair or any three voting members of the Committee. There shall be a minimum of four meetings per year.

28. The Corporate Secretary will make arrangements to ensure that the Committee is supported administratively. Duties in this respect will include development and monitoring of a workplan, agenda setting, collation of papers, taking minutes of the meeting and providing appropriate support to the Chair and Committee members.

29. Agendas and papers will be circulated at least four working days in advance of the meeting.

30. Minutes will be circulated to members for comment as soon as is reasonably practicable.

31. An annual workplan will be agreed which will be reviewed at least quarterly by the Committee to ensure it is meeting its duties.

Review

32. The Terms of Reference shall be reviewed annually and approved by the Board of Directors.

33. The Committee will undertake an annual review of its performance and effectiveness against its work plan and the Trust Strategy in order to evaluate the achievement of its duties.

Agreed by WCC: ~~January 2023~~ ~~April 2023~~ July 2023
Approved by Board of Directors: ~~May 2023~~ September 2023
Review Date: April ~~2023~~ 2024