The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Account

2020 – 2021

Part 3 Trust Overview of Quality 2020/21

Annex 1 Statements from Commissioners and Local Healthwatch Organisations

Glossary of Terms

Part 1 Statement on Quality from the Interim Chief Executive

We are delighted to share the Quality Account 2020/2021 for The Walton Centre NHS Foundation Trust which demonstrates our continual drive and commitment to delivering excellent standards of quality care to our patients and their families, enabling, “Excellence in Neuroscience”. This report details our performance over the last year whilst also highlighting our key priorities for 2021/2022.

2020/2021 was a difficult year across the NHS due to the covid 19 pandemic. We are extremely proud of how staff have managed in the last year at The Walton Centre and how they have continued to deliver outstanding patient care.

The Quality Strategy which encompasses our priority for patient and family centred care has continued to be worked on through the year and whilst covid has impacted on the hospital, the staff have continued to strive to ensure high quality care continues to be delivered. The Executive Team have worked closely with the teams across the hospital to provide care for patients in line with government guidelines and ensure that staff have the support required to undertake their role. A command and control way of working was established to support staff in all wards and departments during the pandemic, at a time when national guidance and advice was changing daily and at times felt confusing, the aim was to ensure staff were clear how to undertake their role in the correct PPE (personal protective equipment).

Despite the pandemic, the Walton Centre prioritised patient and staff safety however this meant that not all of the quality priorities could be achieved. Further information is detailed within this Quality Account.

In addition, this year we have achieved:

- Consultants Lead Research into Neurological Effects of Covid-19
- Rated Sixth in the Country for Overall Experience – National Inpatient Survey
- Project Wingman Open a ‘First Class Lounge’
- Procurement Team Shortlisted for Excellence in Supply Awards
- Walton Centre Neurologist to Co-Lead National Study
- Network Lead Nurse Recognised in New Year’s Honours List
- Spinal Improvement Partnership Set to Enhance Patient Safety
- NHSX Digital Aspirant Funding
- Walton Black, Asian and Minority Ethnic (BAME) Strategic Committee Created
- Creation of an Operational Management Board
- Supported LUHFT in delivering care to patients following a stroke at The Walton Centre
- Supported LUHFT in enabling them to operate in the theatres at The Walton Centre
- Expanded our critical care capacity to support the Cheshire and Merseyside system

Quality initiatives are usually discussed and debated through various Committees including the Audit Committee, Quality Committee and Business & Performance Committee in order to ensure that quality assurance is achieved. These Committees report to Trust Board to ensure that patient safety is a priority and is progressed. During the pandemic however, some committees and meetings were postponed (in line with NHSE guidance) and actions were taken through the command and control way of working to ensure good governance was in place and decisions and actions were logged.

The daily Trust Safety Huddle continued during the pandemic and moved onto MS Teams which enabled a greater number of staff to attend. This allowed for excellent communication and support to various staff disciplines.

In detailing our achievements and forthcoming priorities, I confirm that the information provided in this quality account is accurate and to the best of my knowledge.

Jan Ross, Interim Chief Executive

Part 2 Priorities for Improvement and Statements of Assurance from the Board

Towards the end of each financial year, the Trust worked closely with various stakeholders to identify areas of focus for improvement for the forthcoming year. At this time it also allowed the Trust to reflect on the year's previous performance against the identified quality improvement priorities. The NHS has seen a very different year in 2020/21 due to the pandemic however in spite of this; the hospital remained focussed on delivering outstanding care and supporting patients from other organisations during the difficult times.

The delivery of the quality improvement priorities are monitored through meetings of the Quality Committee, chaired by a Non-Executive Director, with sub groups focussing on the 3 domains of quality: patient safety, clinical effectiveness and patient experience. The Director of Nursing and Governance is the Executive Lead responsible for delivering the plan and designates duties to operational leads for each of the priorities.

All of the priorities were identified following a review by Trust Board on the domains of quality reported in 2019/20. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focussing our priorities for 2020/21.

The Trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care. The following section includes a report on progress against the three improvement priority areas for 2020/21.

2.1 Update on Improvement Priorities for 2020–2021

In February 2021, the Board of Directors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each priority was on target. At this review, quality priorities were identified and agreed for 2021/22. The improvement priorities all contained specific indicators which have been monitored over the last twelve months to provide evidence of sustainable improvement.

Performance has been managed through subcommittees to Trust Board. Operational groups within the Trust have been responsible for the implementation of the quality priorities and reporting to committees as required. Merseyside Internal Audit Agency (MIAA) has not been engaged in the year due to the pandemic. As the government guidance eases, moving forwards, MIAA will re-engage with the Trust to fulfil the requirements as set out by NHSEI.

2.1.1 Patient Safety

Priority: Improve the number of staff trained in Immediate Life Support (ILS)

Reason for Prioritising:
To ensure all clinical staff (band 4 and above) will be trained in ILS, and the training will be delivered on site by the SMART and Resuscitation team.

Outcome: Postponed
The training was not delivered due to social distancing measures during the COVID-19 pandemic.

Priority: FOCUS – Free of Criticism for Universal Safety

Reason for Prioritising:
FOCUS will provide the opportunity in the Theatre Department to pause practice if they feel the need to do so and if staff feel there is a safety risk to both staff and patients.

Outcome: Postponed
The introduction of FOCUS was not completed due to the outbreak of COVID-19 and staff focusing on the delivery of safe patient care.

Priority: Introduction of MITEL System

Reason for Prioritising:
Upgrading the telephone system in the Patient Access Centre (PAC) will ensure patients are able to leave a message and receive a call back. Patients will also be given their queue position and estimated wait time.

Outcome: Achieved
The MITEL phone system has been introduced within the Patient Access Centre.

2.1.2 Clinical Effectiveness

Priority: Introduce Multitom Rax 3D Imaging

Reason for Prioritising:
There will be no requirement for patients to attend another hospital to undergo 3D spinal imaging as it would be in-house. Less positioning and transfers are required as these images are undertaken in one room**.**

Outcome: Partially Achieved

The Multitom Rax machine has been introduced in the X-Ray Department. The 3D imaging software is due to be installed during quarter one 2021/22.

Priority: HCA Apprenticeship Training

Reason for Prioritising:
The training will develop the Health Care Assistant (HCA) workforce and offer career progression. The training will support the Trust with retention of HCAs and also to progress with recruitment of our Trainee Nurse Associates.

Outcome: Achieved
The Health Care Assistant Apprenticeship training has been launched.

Priority: Bespoke Spinal Module

Reason for Prioritising:
Offering a spinal module for the Trust will enhance the knowledge and expertise of clinical staff to be able to support spinal patients. This will also support retention and recruitment within the Trust.

Outcome: Achieved

The spinal module has been introduced.

2.1.3 Patient Experience

Priority: Introduce the Road to Recovery

Reason for Prioritising:

Patients who have had a subarachnoid haemorrhage are currently not able to attend the Trust to take part in a pathway as they live in Wales and are unable to travel to the classes.

Outcome: Postponed

The road to recovery has been postponed due to social distancing requirements during the COVID-19 pandemic.

Priority: LASTLAP – Looking After Staff That Look After People

Reason for Prioritising:

Introducing the LASTLAP will improve the health and wellbeing of staff. All staff members will be invited to a huddle to discuss their shift/work day and reflect on any issues or concerns which may have affected them.

Outcome: Achieved

LASTLAP has been launched and is widely used. The information is readily accessible across the Trust. An audit and survey will be undertaken to ascertain how effective this is.

Priority: Outsourcing Mail

Reason for Prioritising:

Introducing the outsourcing of mail to an external company for large volumes or clinical correspondence will reduce the need for a significant amount of manual work and reduce the number of incidents due to human error. Outsourcing will provide greater control and traceability of documents.

Outcome: Postponed

The outsourcing of mail has been postponed due to the social distancing measures as the external company could not come on site.

2.2 What are our priorities for 2021 – 2022?

In December 2020, the Board of Governors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each indicator was successfully implemented and monitored. After this review, quality priorities were identified and agreed for 2021/22 with the Quality Committee, Health watch and Specialist Commissioners identifying the final priorities from those initially identified.

How progress to achieve these priorities will be monitored and measured:

Each of the priorities has identified lead/s who has agreed milestones throughout the year. Monthly meetings are held to review progress and support is given as required.

How progress to achieve these priorities will be reported:

Committees have been reinstated at The Walton Centre (following the pandemic) and updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Quarterly quality meetings are now held with the commissioners (via MS Teams) to review quality assurance and provide external scrutiny and performance management. Due to Covid, Merseyside Internal Audit Agency (MIAA) did not undertake audits or provide assurance on the Quality Account via the Audit Committee.

2.2.1 Patient Safety

Priority: Reduce pressure ulcers

Reason for Prioritising:
Pressure ulcers are preventable and there is a need to ensure patient harm is reduced and nursing standards of care are improved. During 2020/21 there were a total of 13 hospital acquired pressure ulcers.

Outcome Required:
To have an overall 10% reduction in the number of hospital acquired pressure ulcers compared with the 2020/21 year end position and to have maintained zero tolerance of category 4 pressure ulcers across the Trust.

Priority: Redevelop Pain Management Programme (PMP)

Reason for Prioritising:

Due to the Covid pandemic and the need to work differently and restart services, an online PMP programme was designed

Outcome Required:

To support the delivery of the Pain Management Programme in the current climate, the programme will be reviewed and re-developed and provide video conferencing and an interactive online group course.

Priority: Improve Patient Flow Across the Trust

Reason for Prioritising:

Optimisation of the patient's journey to remove any unnecessary steps from the pathway will allow us to deliver care in the right place, at the right time and enable patients to return to their usual place of care in a timely manner.

Outcome Required:

Explore different ways to improve patient flow across the Trust. Streamline how bed and staff meetings are held and allow proactive management of any delays or issues.

2.2.2 Clinical Effectiveness

Priority: Introduce Patient Initiated Follow Up (PIFU)

Reason for Prioritising:

To give patients and their carers the flexibility to arrange their follow-up appointments as and when they need them. NHS England and NHS Improvement are supporting providers to roll out patient initiated follow-up (PIFU). PIFU can be used with patients with long or short-term conditions and following treatment or surgery. Adopting this approach makes it easier and more convenient for patients to receive care and support when they need it, whilst avoiding unnecessary trips to hospitals and clinics, saving time, money and stress. The approach helps empower patients to manage their own condition and plays a key role in enabling shared decision making and supported self-management in line with the personalised care agenda.

Outcome Required:

Implement PIFU for people with long term conditions or following surgery.

Work with NHSE/I to roll the priority out to provide the opportunity for patients and their carers to initiate their own appointments.

Priority: Increase Outpatient Appointment Slot Utilisation

Reason for Prioritising:
This will help ensure effective use of resources, by increasing slot utilisation. This will increase the number of patient appointments for both new and follow up slots and ensure the most appropriate use of clinicians time.

Outcome Required:
Increase outpatient slot utilisation by 5% during 2021/22. This will improve efficiency and aid the reduction in waiting times.

Priority: Implement Inventory Management System

Reason for Prioritising:
To provide Trusts with improved patient level costing information. eDC Gold enables products to be tracked to the patient and also provides greater operational inventory visibility on stock holding and expiry for Trusts.

Outcome Required:
Implement the Electronic Demand Capture (EDC) and EDC Gold inventory management system.

EDC - primary means of demand capture and order creation and is typically used for low value, high volume products (standard ward/theatre consumables).

EDC Gold - module within EDC providing inventory management visibility and control and is used for high value, low volume products.

The outcome of effectively using the system will include improved patient safety and provide detailed patient costings.

Standardised approach across NHS organisation - eDC is used in 90% of NHS trusts and eDC Gold is live in 30 NHS trusts.

2.2.3 Patient Experience

Priority: Improve Wellbeing and Equality of Black and Asian Minority Ethnicity (BAME) Staff and Patients

Reason for Prioritising:
Workforce Race Equality Standards data shows that Black and Asian Minority Ethnic staff experience higher rates of discrimination, harassment and bullying. National data on health inequalities relating to race consistently shows poorer outcomes for many Black, Asian and Minority Ethnic communities and patients. Trust patient monitoring indicates that fewer Black and Asian Minority Ethnic patients are referred to the Trust than we would expect given the racial demographics of North West England. In light of the disproportionate effect that COVID 19 has had on Black, Asian and Minority Ethnic communities, patients and staff, the Trust will prioritise the wellbeing of Black, Asian and Minority Ethnic patients and staff in relation to its COVID-19 response and post COVID-19 systems recovery.

Outcome Required:
Review progress/set stretch ambitions to improve wellbeing and equality of BAME staff and patients.

Set measurable ambitions and monitor progress at the Strategic BAME Advisory Committee which has recently been launched.

Demonstrate that there is no significant difference in the reported wellbeing of staff and patients in relation to COVID-19 and race and ethnicity. The Trust should also be able to demonstrate an increase in the percentage or Black, Asian and minority ethnic patients attending the hospital to a figure closer to the percentage for the Black, Asian and minority ethnic population in Cheshire and Merseyside which stand at 4.5%

Priority: Provide Mental Health First Aid (MHFA) Training

Reason for Prioritising:
A number of debrief sessions and supportive workshops have been held with staff across the Trust during the past 12 months. Without exception, staff have told us that they want a person to speak to rather than on line/remote support. MHFA is a nationally recognised training programme; the aim is to have a number of trained MHFA staff who will be able to provide advice and support to staff and patients as required.

Outcome Required:

Roll out Mental Health First Aid Training for 40 staff. Improving staff and patient access to direct personal support, improving mental health and wellbeing. Registered trained staff will be able to recognise if patients require support and can signpost more effectively.

Priority: Improve Start Time of Theatre Lists and Same Day Discharges

Reason for Prioritising:

To ensure we maximise the utilisation of our theatres and expertise of the staff who work there, which in turn will allow them to deliver outstanding patient treatment and care in an efficient and effective way.

Outcome Required:

Conduct a review of the Team Brief process to ensure theatre lists start on time.

Review the recovery process and time spent in recovery.

Review how the Trust can set up a designated area for same day discharges.

2.3 Statements of Assurance from the Board

During 2020/21, The Walton Centre provided and/or sub-contracted four relevant health services:

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation

The Walton Centre has reviewed all the data available to them on the quality of care in four of these relevant health services. We have interpreted this as services covered by our Quality Committee that are monitored by internal and external indicators and not necessarily a formal review.

The income generated by the relevant health services reviewed in 2020/21 represents 91.3% of the total income generated from the provision of the relevant health services by The Walton Centre for 2020/21.

2.3.1 Data Quality

The data reviewed covers three dimensions of quality – patient safety, clinical effectiveness and patient experience which are all encompassed within the Quality Committee Terms of Reference and Trust Board.

The Walton Centre takes the following actions to improve data quality:

- The Trust continues to develop internal data collection systems to provide assurance to the Quality Committee in relation to the accuracy of data quality.
- The Trust continuously reviews its internal processes in relation to the measurement and reporting of the quality indicators reported both to the Board and reported externally. This includes reviewing the quality indicators outlined within the Quality Accounts ensuring that there are standard operating procedures and data quality checks within each quality indicator process.

Ward to Board nursing quality indicator data has been collated over the last nine years which includes data collection of not only information to support progress against the Quality Accounts but additional nursing metrics to provide internal assurance and allow a clear focus for improving patient experience and delivery of quality care.

This information supports the Trust in building year on year metrics to show progress against important aspects of the patient journey.

2.3.2 Participation in Clinical Audit and National Confidential

During 2020/2021, 10 national clinical audits and 2 national confidential enquires covered relevant health services that The Walton Centre provides.

During that period The Walton Centre participated in 100% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that The Walton Centre was eligible to participate in during 2020/2021 are as follows:

2.3.3 National Audits

- Adult Critical Care (ICNARC / case mix programme)

- Severe Trauma – Trauma Audit & Research Network (TARN)
- National Emergency Laparotomy Audit (NELA)
- The Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Care at the End of Life (NACEL)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- National Comparative Audit of Blood Transfusion (NCABT)
- National Neurosurgery Audit Programme (NNAP)
- Perioperative Quality Improvement Programme
- British Spine Registry

2.3.4 National Confidential Enquiries

- Dysphagia in Parkinson's Disease
- Epilepsy

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2020/2021 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit	Participation	% Cases submitted
Acute care		
Adult Critical Care (ICNARC / Case Mix Programme)	Yes	100%
Severe Trauma (Trauma Audit & Research Network)	Yes	100%
National Emergency Laparotomy audit (NELA)	Yes	N/A – no eligible cases
The Sentinel Stroke National Audit Programme	Yes	98%
National Audit of Care at the End of Life (NACEL)	N/A	N/A postponed due to Covid-19
Perioperative Quality Improvement Programme	N/A	N/A - no eligible cases
British Spine Registry	Yes	65%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
National Comparative of Blood Transfusion (NCABT) – Audit of the management or perioperative paediatric anaemia	N/A	N/A
Older people		

Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	N/A	N/A – No WCFT cases met the inclusion criteria
National Confidential Enquiry into Patient Outcome and Death		
Dysphagia in Parkinson's Disease	Yes	100%

The reports of 3 national clinical audits were reviewed by the provider in 2020/21 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

National Audit	Actions
Adult Critical Care (ICNARC / Case Mix Programme)	• Findings are discussed quarterly • The Trust will continue participating in the ICNARC/Case Mix Programme by submitting data for all patients admitted to Critical Care
Severe Trauma - Trauma Audit & Research Network (TARN)	• The Trust will continue to submit data to TARN and will review individual cases as appropriate
The Sentinel Stroke National Audit programme (SSNAP)	• All WCFT thrombectomy cases are reviewed at the Regional Thrombectomy MDT group. • The regional MDT group identify and discuss potential areas for improvement across the patient pathway

2.3.5 Participation in Local Clinical Audits

The reports of 85 local clinical audits were reviewed by the Trust in 2020/21 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

Neurology Clinical Audits & Service Evaluations

Audit title	Actions
An evaluation of the Walton first seizure referral pathway (N 246)	• Vetting of all new referrals to first seizure clinic • New digital referral system that ensures that mandatory information fields
Re-audit of pre-counselling for women with epilepsy (N 294)	• Report to be discussed at health record group and audit presentation meetings
Assessment of efficacy of the woven endobridge (WEB) device in endovascular treatment of intracranial aneurysm (N 271)	• Completion of 5 year follow up for all patients
Re-audit of outpatient IV immunoglobulin use (N 292)	• Rapid access IVIg pre-assessment slots needed on Jefferson ward • Discussed at Neurology lunchtime lecture audit slot
Compliance with report writing standards for objectives swallowing assessments – FEES (fibreoptic endoscopic evaluation of swallowing) (N	• All trained FEES clinicians will need to ensure medical consent is sought and documented prior to carrying out FEES as well as a clinical rationale. The report format has recently been updated and adapted and is planned to be put on EP2 therefore it would be wise to add a

299)	tick box for medical consent and space for rationale of assessment to ensure this is not missed in future.
Compliance with report writing standards for objective swallowing assessments (N 300)	• An increase in reminders of all the Royal College Speech Language Therapist guidelines for all staff undergoing VFS procedures
Transforming MND care experience survey (N 214)	• <u>Cognitive assessments and Psychological support</u> Action: • To investigate the feasibility of more OT time to improve the potential to complete the ECAS tool on those patients that require it. • To discuss in house psychology provision with psychology department and MNDA to help with sourcing alternative services if necessary. *(Already in discussion, October 2019 Steering Group minutes)* • To investigate means of recording RCDA contact in clinic and Association Visitor referral in patient notes in order to capture this data for future audit. • Limitations: • *Staff availability, time, room availability, secretarial support, cost restrictions.* • <u>Cough effectiveness</u> Action: • Explore the potential for physiotherapy input in follow up clinics to encourage assessment and review of cough effectiveness and breathing exercises. • Consider the use of a peak cough flow assessment within existing clinical observations to enhance clinical decision making. • Limitations: • *Staff availability, time, room availability, training, secretarial support, cost restrictions.* • <u>Nutrition and Gastrostomy</u> Action: • To explore the potential for dietetic support within the MND service to discuss dietary requirements. Particularly for those who do not yet need a community dietitian but have concerns regarding weight loss due to changes in swallow. This could also be due to a change in people's dietary requirements, i.e. vegan and vegetarian and having difficulty deciding on suitable nutritional supplements. • Limitations: • *Staff availability, time, room availability, secretarial support, cost restrictions.* • <u>Planning for end of life</u> Action: • Consider the MND well-being day model working in more hospices within the locality to enable more patients' access to specialised palliative care. • Consider means of reporting referral to and attendance at wellbeing days. • Limitations:

	• *Cost, hospice engagement, patient engagement.*
Audit of the Neuroradiology brain tumour service (N 133)	• Advanced parameters have a role in non-enhancing brain tumours. Information gained from post-processing by research associate will optimise its utility. – Currently there is no funding source for this within neuroradiology
Audit of the accuracy of voice recognition software in radiology (NRP 09)	• Radiologists reminded to proof read reports and ensure correct placement of the microphone
Audit of comparison of dose of X-ray guided lumbar puncture between radiologist and advanced practitioner (NRP 17)	• Continue to audit to ensure radiation dose remains as low as reasonably practicable
Audit of outcomes of X-ray guided lumbar puncture between radiologist and advanced practitioner (NRP 19)	• No action necessary – continue to audit
Audit of multiple radiological examinations in line with Royal College of Radiologists guidelines (NRP 18)	• No action necessary – continue to audit
Audit of the standards of communication of urgent radiological reports and fail safe notifications in line with RCR guidelines (NRP 20)	• No action necessary – continue to audit
Audit of Tracheostomy care quality indicators (N 265)	• Re-commence service with service with new Royal College of Speech and Language Therapists guidance re COVID-19. Establish 5 day service. Commence using Tristell cleaning system. • Escalate to managers re lack of regular ENT inputs tracheostomy ward rounds and number of patients requiring this • Explore if tracheostomy if tracheostomy passport can be made available via Ep2
Is there a need for physiotherapy assistants to support the respiratory (N 295)	• When considering a 7 day rehabilitation service on critical care, consider the use of therapy assistants as part of uplift of staffing to support rehabilitation input as per GPICs guidance. Business case application has been started
Review of bowel management in neurorehabilitation (N 296)	• Issue – nil consistency in prescribing and administration of laxatives. • Action – present audit findings to nursing and medical teams, to generate discussion • Issue – Similar issues reported on acute wards. • Action – Share findings with dietetic team to allow consideration of similar project in acute teams • Update stool chart and present to team for consideration
Audit of CT Pulmonary angiograms (NRP 11)	• Encourage patients who are well enough to do so to position their arms above their head to improve scan

	quality • Reduce sub-optimal imaging – presentation/ education and monthly team brief • Re-audit to be undertaken April 2021
Audit of WHO surgical checklists in Radiologists (NRP 15)	• No actions necessary
Evaluation of the usability of an MS self-reported assessment tool for people with multiple sclerosis (N 266)	• Consideration of future use of the tool in WCFT service – MS team discussion
Review of cases of intracranial hypotension treated with IV caffeine – (N 267)	• This is an off license medication for which there is very little safety / efficacy data – audit results to be factored into IV caffeine pharmacy policy
Focus group testing of patient and family perception of rehabilitation goal setting meetings – (N 268)	• Issue: Ongoing need to critically examine goal setting processes in HARU/CRU, action: Will reconvene Goal Setting Meeting working party
Audit of blood results availability for MRI contrast radiology examinations (N 316)	• Radiology have updated the system so that a communication goes to the referrer advising them to organise the taking of blood on site for a contrast scan and if aged over 70 years • For planned patients radiology will request the blood results a month ahead of the planned appointment date to allow the time delay of requesting them from the GP and being carried out
Evaluation of long term EEG monitoring reports (N 284)	• Present data at departmental risk meeting, ensure this forms part of SOP / timescale for implementation September 2020
Audit of prescribed feed vs estimated nutritional requirements for energy in neurorehabilitation (N 313)	• Issue - PENG pocket guide not always effective at predicting energy requirements in neurorehabilitation population. Action - Present findings to dietetic team to inform practice
Clinical psychology 1:1 referrals after PMP assessment (N 277)	• Issue - Need to develop more consistency / clarity regarding 1:1 referrals for psychological work on the PMP and in outpatient work. Action - Psych team to develop appropriate documentation
Evaluation of medical interruptions to rehabilitation within CMRN that exceeded 14 days (N 318)	• Issue – Lack of information about what happens to the patients discharged during interruption / action – ongoing data collection
Audit of MRI exams confirming radiographer administration of contrast agent (N 336)	• Feedback results and the necessity to ensure documentation is completed
Audit of the number of MRI patients recalled for further imaging (NRP 6)	• Only mark in vetting as a recall if the patient is genuinely being recalled to complete the original examination • Case review meetings reinstated • Consultant Radiologist review MR recalls from list provided buy PACS manager
Review of MUST (malnutrition universal screening tool) assessments where a MUAC	• Issue – MUAC not always used appropriately / action – Feedback to nursing team /steering committee • Issue – Rationale for MUAC and value not documented

(mid upper arm circumference) is used (N 312)	/ action – Feedback to nursing team / steering committee • Issue – Patients not being weighed during admission / action – Feedback to nursing team / steering committee
Evaluation of long term EEG monitoring reports (N 284)	• Issue – Large error rate or missing data for DOB and hospital numbers on EEG system, particularly after day 1. Action – Present data at departmental risk meeting, ensure this forms part of SOP
Does the length of time for a speech and language therapy referral impact the length of hospital admission for patients with communication difficulties on acute wards (N 308)	• Issue - Delay in referring patients with communication difficulties, particularly cognitive communication difficulties, dysarthria and aphasia • Action - Discussion in SLT acute team meeting to identify whether training would be feasible to increase staff understanding of communication difficulties
Reducing risk of social isolation in people living with motor neurone disease (MND) (N 281)	• Issue - Patients diagnosed with MND are not consistently asked about their psychological wellbeing or signposted to appropriate support / action - To pilot the use of two measures (The measures Duke Social Support Index (DSSI) and The UCLA 3-Item Loneliness Scale) during the MND specialist nurse follow up clinic to identify those patients potential at greater risk of social isolation. Notes will then be re-audited to review the impact of the measures on improving the consistency of conversations around wellbeing • Issue - There audit has demonstrated that despite staff reporting that they have discussions about psychological problems and the support available it is not always clearly documented / Action – No action – Introduction of the above measures will minimise the likelihood of conversations around psychological wellbeing not being documented. The findings of this pilot will be reviewed in 12-18 months' time.
Psychoeducational videos (N 323)	• No actions necessary
Audit of feed prescribed vs estimated nutritional required for energy in neurosurgical patients (N 314)	• Issue:- Use of disease specific and consensus based guidelines for estimating nutritional requirements in neurosurgical/ vascular patients. – Action:- Present at Dietetic Team meeting for discussion on use of evidence to estimate energy requirements
Prolonged disorders of consciousness guideline (N 317)	• Issue:- Limited acute input from neuro-rehabilitation team for PDOC patients / Action:- Liaison with Major Trauma and Craniotrauma teams required to highlight clinical need for early rehab input • Issue:- There is no structured pathway to guide best interest meetings / timing of assessments / other medical or ethical / legal aspects of PDOC management / Action:- PDOC pathway needs to be created and put in place • Issue:- Best interest meetings not always formally documented / Action:- Best interests documentation to be reviewed
Antibiotic point prevalence	• Ongoing education to prescribers on education and

audit (NRP 4)	weekly antimicrobial ward rounds • Small patient numbers - plan to start collecting monthly spot data focusing on areas that can be improved • Include key points from the point prevalence audit at junior doctor and consultant induction. SD to liaise with IPC team to update induction talk. • Dissemination of key points to prescribers every quarter. SD to discuss at AMS meeting
Audit to assess the suitability of line algorithm for visualisation of NG tube (NRP 16)	• No actions necessary • Re-audit
Exploration of the use of apps (MHealth) to support inpatient therapy in the acute and rehab settings (N 161)	• No concerns identified to action • Potential to support other projects within the Trust – discuss with RD&I committee • Possible further research into implementation of app – discuss with tech group committee
Audit of standards for reporting and interpretation of ultrasound images in line with RCR and BMUS guidelines 2020 (NRP 2)	• No action necessary
Audit of evaluation of radiation dose for endovascular procedures (N 311)	• No actions necessary
To assess the impact of long days in the acute respiratory team on the number of total contacts, chest treatments, tracheostomy weaning and rehab sessions (N 327)	• Issue: Need for increased staffing at weekends to cover 7 day service in line with GPICS guidelines – Action: A business case for increased physiotherapy support to provide a 7 day rehabilitation service on critical care and out of hours on call respiratory physiotherapy service
Review of INNS service over the past year looking at case load and clinical activity (332)	• Increase NAL slots once team fully established (2 nurses currently in training) • Ask NAL admin staff to redirect HCP queries to our direct email. • Review the use of NAL slots for routine follow up i.e. not pre booking for follow up calls/meds change review. • Review job plans to increase nurse support in Southport, Ormskirk, South Sefton and Skelmersdale. • Increase Home visit and NAL availability in the above areas. • The Clatterbridge and Arrowe park hospital clinics have a large caseload of patients who could be seen more locally in the smaller community clinics. The nurse in this area will review the follow list and organise the caseload distribution more effectively.
Review of INNS service over the past year looking at case load and clinical activity (N 332)	• Increase NAL slots once team fully established (2 nurses currently in training) • Ask NAL admin staff to redirect HCP queries to our direct email. • Review the use of NAL slots for routine follow up i.e. not pre booking for follow up calls/meds change review. • Review job plans to increase nurse support in

	Southport, Ormskirk, South Sefton and Skelmersdale. • Increase Home visit and NAL availability in the above areas. • The Clatterbridge and Arrowe park hospital clinics have a large caseload of patients who could be seen more locally in the smaller community clinics. The nurse in this area will review the follow list and organise the caseload distribution more effectively.
Audit of non-medical referrers for radiology under IRMER guidelines 2020 data action plan (NRP 3)	• No actions necessary • Continue to audit annually
Contrast enhanced CT protocol adherence – EGFR documentation (NRP 10)	• Email to all CT requestors that clinical safety questions must be answered correctly • Email all radiographers to document if CT has been acquire without appropriate EGFR the reason for doing so
Audit of exam time to report availability in radiology (NRP 12)	• No action necessary • Re-audit 12 months

Neurosurgery Clinical Audits & Service Evaluations

Audit title	Actions
Anaesthesia in Theatres (NS 231)	• All Anaesthetic practitioners have not undertaken the IV medicines administration course. This has been highlighted and will be discussed to look at competency in accordance with the Trusts medicines policy.
Management of Specimens in Theatres (NS 229)	• Discuss with staff on Audit day that they ensure specimen trolley is checked weekly by weekend staff and sufficient size pots are ordered.
Audit of the accuracy of voice recognition software in Neuropathology 2019 (NRSP 3)	• Use of dictation templates where appropriate. • Simultaneous review of reports at the same time as dictation • Final review of reports before authorisation. • Re-audit
Managing Perioperative Normothermia (NS 228)	• Safety issued by MHRA re: Enflow fluid warmer; All Enflow systems (10) and cartridges have been removed from theatres and replaced with (3) Bair Hugger Fluid Warmers. • Fluid cabinets temperature found to be outside the recommended guidelines (>40 ° C)
VTE prophilaxis prescribing in neurosurgical patients – re-audit (NS 287)	• Maintenance of the current level of compliance. • Continuous insistence on the new VTE protocol, so that there are no non-compliant cases. • Familiarisation with the new VTE protocol for all

	staff remains to be essential. • Very important and continuous role of pharmacists, doctors and nurses in maintaining the required standards related to the VTE prophylaxis • Re-audit in 6-12 month to ensure new protocol is followed
Re-Audit Of Hypothermia Prevention & Management in Adult Surgical Patients (NS 237)	• Improved documentation of variable measured in theatre/recovery • Re-audit 2020-2021
Compliance of trust guidelines regarding transfusion related investigations for non-Instrumented lumbar spine surgery (NS 120)	• Establish local guidelines with respect to pre-operative need for group and save/crossmatch in patients undergoing single level decompressive surgery • Create awareness and educate ward staff and doctors about above agreed guidelines • Re-audit to confirm compliance
Medihoney HCS Surgical Dressing Evaluation (NS 267)	• That medihoney HCP dressing be used as per guidelines for all stimulator and pump patients as well as other difficult wounds or patients with a previous healing problem or infection as per manufacturer guidelines • Complete can compare comparison audit
Service Review of Post-Surgical Site Infections in the Community (NS 269)	• Follow up of patients in a timely manner by relevant team • Post op OPD appointments made and communicated to patients • Medical documentation completed in timely manner.
HTA 66 - Research Consent forms Audit 2019 (NRSP 14)	<u>Non-Conformances</u> • The importance of patient's initiating and signing the consent forms will be highlighted to both specialist nurses and theatre staff to avoid any invalidity of the consent forms by KS. • KS to check with HTA and REC committee for the validity of ticked consent forms <u>Observations</u> • The incomplete forms will be retrospectively completed (signed) by specialist nurses or respective individuals. • Incorrect colour of consent form to be raised with Theatre staff. Laboratory staff/Biobank manager will review forms upon receipt in the Neuroscience Laboratories.
Re-audit: Infection Rate in Gliadel Patients (NS 264)	• Clear documentation decolonisation therapy provided to patients at pre-op clinic, complete and

	recorded • Limit number of people in theatre to 5 • Antibiotics on induction (at least 15 minutes prior to knife to skin) • No evidence supporting x3 doses of antibiotics post-operatively • Standardise sample collection from theatre, microbiology have suggested a pot of pus or tissue rather than a swab • Removal of sutures by specialist nurse vs district nurse
Impact of BMI on CSF Leak following Pituitary Surgery (NS 155)	• Close observation for CSF leak in post-operative pituitary patients, particularly in those with an increased BMI given the associated increase in risk for this complication
BIOC 170 Significance of low numbers of oligoclonal bands (NS 263)	• No further recommendations; continue with current practice.
Outcomes for Vestibular Schwannomas treated with Radiotherapy (NS 212)	• N/A
IO diagnosis versus Final Diagnosis (including telepathology) Horizontal Audit 2019 (NS 298)	• No recommendations required as no issues identified.
HTA 67 - REC & RGC approvals Audit 2019 (NRSP 15)	• The process is going well no further actions are required.
HTA 64 - Research Request Form R2 & R3 Horizontal Audit 2019 (NRSP 13)	• The process running well, to be reviewed next year.
Traceability Audit of Blocks and Slides Horizontal Audit 2019 (NS 288)	• All Neuropathology staff reminded of importance to complete tracers and place in the file. • All Neuropathology staff reminded to check each individual slide number and not presume all slides in a slide tray are from the same case. • Slide file will not be so tightly filled and file drawers to be labelled annually when the majority of slides have been filed. • Process of refiling slides for NEQAS back with the original case rather than in a separate EQA file reinforced with staff. • Monitor return of slides from HODS in next audit following the service move earlier this year. • Neuropathology staff to add H&E to the LIMS if

	required as part of a molecular test. • Test panels will be created for molecular tests where required to ensure number of slides match.
Audit on Last Minute Cancellation of Elective Surgery (NS 146)	• The reason for cancellations should be recorded in the case notes for all cancelled surgeries. • Where possible, the cancelled surgeries should be rescheduled within 28 days. • All the interventional radiology patients who are posted for therapeutic interventions should have adequate pre op assessment. • Some anaesthetist felt that this audit should be conducted as a recurring audit, therefore decided to do re-audit in 2021
Neurobiochemistry vertical audit 2020 – Beta trace protein (NRSP 11)	• The laboratory internet page and assay finder need to be updated and conform. • The PAT testing and the servicing of the equipment needs to be carried out ASAP.
Review of patching Chiari malformations intra-operatively versus not patching (NS 278)	• That the project supports patching of Chiari patients routinely. One other surgeon has changed to this technique, the other who does Chiari decompressions, is considering it
Audit on pre-operative risk assessment using POSPOM scoring system (NS 160)	• POSPOM scoring system can be used for risk stratification in elective patients undergoing Interventional neuro radiology (INR) procedures. • POSPOM scoring is not suitable for emergency INR patients
Spine Tango Documentation Audit (NRSP 9)	• Re-iterate to staff the importance of accurate data entry
Coroner's and Hospital Post Mortems Horizontal Audit 2019 (NRSP 16)	• Staff were reminded of the 30 days disposal period. If the disposal is rescheduled due to any reason a note should be left on the NA sheet and order entry notes on LIMS stating the reasons. • A database is currently being updated to record when wet tissue has been retained – this data will be included in next year's audit.
Omission and delay of critical medicines in neurocritical care (NS 304)	• List of critical medicines to be incorporated into each patient's bedside folder • Pharmacy bulletin to be emailed to Horsley staff and included in Horsley internal newsletter summarising audit findings and outcomes • Pharmacy or medicines-related inductions for new nurses and doctors to be updated based on findings/concerns • Senior nurse for clinical governance currently recruiting nurse to undertake re-audit 6-monthly

	(pharmacists to contribute to data analysis) • ACCP previously agreed to undertake administration of intrathecal antibiotics on Horsley and are awaiting training and sign-off
rTMS for neuropathic pain: Patient Reported Outcomes about, Pain, Function and Quality of Life. (NS 218)	• View non-responders and responders in more detail. Brain connectome analysis in process as part of MRes project – 6 month timescale • Meeting with psychiatry and Alder Hey neurosurgeons to finalise potential service level agreement to make TMS financially viable. – 6 month time scale. To be discussed by the Clinical Effectiveness Services Group.
Anaesthetics and Critical Care audit by Deepa Laiju (NS 250)	• Pharmacy developing new eye care guidelines – in next 3-6 months • Staff training in eye care
Re-audit of molecular data obtained on gliomas reported at WCFT between June 2019 and May 2020. (NS 295)	• Since the revised 4th edition of WHO classification (2016), a lot has changed in CNS tumour diagnosis and pathologists at the Walton Centre have strived to keep up with the changes. Our data has now been audited twice against the NICE guidelines (2018). RCPath published a Molecular diagnostic algorithm for adult gliomas in March 2020 which is far more advanced than the NICE guidelines. Currently we follow the standards published by the RCPath. The 5th edition of the WHO classification of CNS tumours is overdue. It is expected to incorporate some important changes as outlined in cIMPACT recommendations. In view of this a fresh audit will be planned once all the recommended changes have been implemented in the department.
Re-audit of spinal deformity practice (NS 301)	• To be discussed within department – no actions directly from audit.
Laterality of ACDF (NS 297)	• Not formally discussed – my opinion is that no change of practice is needed as results very much reflect findings in the literature
Late Adverse Radiation Affects after cerebral radiosurgery for brain AVM (NS 217)	• The Late post radiotherapy adverse effects for b AVM are found within the reported bibliographic findings (6.9%)
Surgical Vertical Audit 2019 (NRSP 1)	• Although a Non Conformance was raised a root cause could not be determined as the clinicians in theatres had completed the request form. • An audit will not be performed to monitor the information missing from the request card as this has been an ongoing issue for several years whereby forms are not completed properly, and no significant

	improvement has been made. • Quality & Governance Manager in Theatres has been contacted. She will ask theatre staff to ensure that all forms are correctly completed.
Surgical Vertical Audit 2020 (NRSP 1)	• N/A
Caring for Mothers in WCFT – Service evaluation of enhanced maternal Care Guidelines (NS 176)	• Training for SMART - 1 session already held. Yearly/biennially • Separate out Day cases (for more simplified guidelines) and inpatients – apply full guideline. Re-audit 2021
Oral ketamine to support outpatient and inpatient opioid weaning. (NRSP 5)	• Patient information leaflet developed and completed. completed • Prospective data collection in addition to prescribing database - Key points for data collection on EP2 to be agreed. LFT and ketamine level on TD web. TBC • Present to the headache group - TBC
GlobalSurg/CovidSurg Week (NS 306)	• Where possible, surgery should be delayed for at least 7 weeks following SARS-CoV-2 infection. • Patients with ongoing symptoms ≥ 7 weeks from diagnosis may benefit from further delay. • No Actions to arise

Trust wide Clinical Audits & Service Evaluations

Audit title	Actions
Audit of patient preferences regarding sharing information with their partners, family members and / or carers – NICE CG 138 – Patient experience	• Feedback results to relevant groups and circulate findings, highlighting areas for improvement. • Continue to audit annually
Inpatient Health Records Documentation Audit	• Feedback and discuss results / disseminate findings • Circulate results summary sheet highlighting the areas for improvement • Inform medical records of the two instances of patients identifiable data and complete datix • Continue to audit health record documentation
Outpatient Health Records Documentation Audit	• Feedback and discuss results / disseminate findings • Circulate results summary sheet highlighting the areas for improvement • Continue to audit health record documentation

NB. If implementation is not deemed appropriate then outstanding actions are placed on the divisional risk registers.

Recommended actions resulting from clinical audit projects are reviewed and monitored monthly by the Clinical Audit Group.

The divisional clinical audit teams produce a monthly clinical audit activity progress report which includes registered audits, recommended actions from all completed projects for each division and the progress made towards implementation, these reports are discussed at the relevant Divisional Governance & Risk Group monthly meetings.

2.3.6 Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2020/21 that were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority was 580. Due to the impact of Covid19 no yearly target was set for this financial year. In total there are currently 82 clinical studies currently open to recruitment at The Walton Centre. The Trust has a research pipeline of new studies in the set-up phase that will be ready to open at different points throughout the coming year.

The Neuroscience Research Centre has secured new local collaborations which means that we are now able to offer our patients access to participation in Phase 1 clinical trials for the first time. The Phase 1 clinical trials are being offered to patients with Parkinsons Disease and Huntingdons Disease and will be conducted at a specialist clinical research facility within Liverpool Health Partners.

The Trust's participation in clinical research demonstrates our commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

Our clinical staff actively maintain their involvement in the latest possible treatments and as a Trust recognise that active participation in research leads to successful patient outcomes.

During 2020/21 the Trust has worked collaboratively with the following networks and organisations to attract NIHR funding to deliver and disseminate clinical research and innovation to inform service transformation and improvement:

- Clinical Research Network: North West Coast (CRN)
- Liverpool Health Partners (LHP)
- Innovation Agency, the North West Coast's Academic Health Science Network
- North West Coast Collaboration for Leadership in Applied Health Research and Care (NWC CLAHRC) now the ARC (Applied Research Collaboration)

- Local Higher Education Institutions
- Other NHS organisations
- Pharmaceutical companies (industry)

The collaboration with all members of Liverpool Health Partners has resulted in the set up of the Liverpool SPARK – Single Point of Access to Research and Knowledge. We are delighted to be part of such an innovative approach to offering wider access to clinical trials for our patients and look forward to the SPARK becoming embedded in all Trusts.

2.3.7 CQUIN Framework & Performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. Due to the COVID pandemic all CQUIN activity was suspended. To date no CQUINs for the forthcoming year have been agreed.

2.3.8 Care Quality Commission (CQC) Registration

The Walton Centre is required to register with the Care Quality Commission and its current registration status is registered without conditions. The CQC completed a review of the mental health services across the Trust in November / December 2020. The CQC were satisfied that no further monitoring was required and recommendations have been completed. The CQC has not taken enforcement action against The Walton Centre during 2020/21. The CQC undertook an inspection, including well led, during March and April 2019, which resulted in an Outstanding status for the second time.

During 2020/21 the Trust continued to self-assess against the CQC regulations. The self-assessment is supported by a governance process which enables oversight of findings and identification of areas for further review and includes a process to escalate exceptions to the Quality Committee which is a sub-committee of the Board.

Ratings for The Walton Centre

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Surgery	Good ➔➔ Aug 2019	Outstanding ↑ Aug 2019	Good ➔➔ Aug 2019	Good ➔➔ Aug 2019	Outstanding ↑ Aug 2019	Outstanding ↑ Aug 2019
Critical care	Good ➔➔ Aug 2019	Good ↓ Aug 2019	Outstanding ↑ Aug 2019	Good ➔➔ Aug 2019	Good ➔➔ Aug 2019	Good ➔➔ Aug 2019
Outpatients	Good Oct 2016	Not rated	Outstanding Oct 2016	Good Oct 2016	Good Oct 2016	Good Oct 2016
Rehabilitation services	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016	Good Oct 2016	Outstanding Oct 2016
Overall*	Good ➔➔ Aug 2019	Outstanding ➔➔ Aug 2019	Outstanding ➔➔ Aug 2019	Good ➔➔ Aug 2019	Good ➔➔ Aug 2019	Outstanding ➔➔ Aug 2019

2.3.9 Trust Data Quality

The Walton Centre submitted records during 2020/21 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data which included the patient's valid NHS Number was:

XX% TBC (due to COVID extension deadline) for admitted patient care

XX% TBC (due to COVID extension deadline) for outpatient care

The percentage of records in the published data which included the patient's valid General Practitioner Registration Code was:

XX% TBC (due to COVID extension deadline) for outpatient care

XX% TBC (due to COVID extension deadline) for admitted patient care

This year is the third year of the new Data Security and Protection Toolkit. The focus is now on the security of data, and incorporating the Network and Information Systems Regulation 2018 (NIS) and the 10 Data Security Standards and is very different to the old IG Toolkit. Within the Toolkit there are 42 assertions and 110 mandatory evidence items.

Completion of this requires compliance with all assertions and all mandatory evidence items. The methodology remains the same every year whereby a mandatory independent audit continues to be required as part of the evidence process.

The Trust is on target to meet all assertions and mandatory evidence items for the Data Security and Protection Toolkit, which is due to be submitted to NHS Digital on 30th June 2021. This deadline was extended in line with Covid19 and the delay to last years submission date.

The Trust has implemented action plans to achieve another high score on the new Data Security and Protection Toolkit and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessments undertaken as part of the mandated 19-20 DS&P audit requirements has been completed in May 2021 and the Trust is still awaiting the outcome of this review.

The latest figures from the NHS IC Indicator portal are for 2011/12 and the national readmission rate was 11.45%. The website link is https://indicators.ic.nhs.uk/webview/

The Walton Centre undertook a Clinical Coding Data Quality Audit during the reporting period. The following table reflects the results of an audit carried out by an Approved Clinical Coding Auditor and the error rates reported for this period for diagnoses and procedure coding (clinical coding) was as follows:

The Walton Centre Internal Clinical Coding Audit 2020/201

Coding Field	Percentage Correct	Mandatory	Advisory
Primary diagnosis	91%	90%	95%
Secondary diagnosis	86%	80%	90%
Primary procedure	97%	90%	95%
Secondary procedure	98%	80%	90%

Last year The Walton Centre took steps to improve data quality which is demonstrated in the improved scores above.

2.3.10 Learning from Deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendments Regulations 2017 in July 2017. These add new mandatory disclosure requirements relating to 'Learning from Deaths' to quality accounts from 2017/18 onwards.

2.3.10.1 During 2020/21, 111 of The Walton Centre patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

35 in the first quarter

23 in the second quarter

27 in the third quarter

26 in the fourth quarter

By 31st March 2021, 108 case record reviews have been carried out in relation to 111 of the deaths included in item 2.3.10.1. Three case records are awaiting review.

In 2 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 35 in the first quarter
- 23 in the second quarter
- 26 in the third quarter
- 24 in the fourth quarter

2.3.10.2 0 representing 100 % of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient. There were two patients that were referred to the coroner, one is awaiting an outcome from the Coroner and the second death was noted to be classed as misadventure and the Trust did not receive any recommendations as a consequence.

In relation to each quarter, this consisted of:

- 0 representing 100% for the first quarter
- 0 representing 100% for the second quarter
- 0 representing 100% for the third quarter
- 0 representing 100% for the fourth quarter

These numbers have been estimated using the structured judgement review methodology. Prior to the National Quality Board report on Learning from Deaths, The Walton Centre had

a robust mechanism of mortality review where all deaths were reviewed in detail and reviewed in the mortality review group.

Since the NQB report, WCFT have published an updated Mortality Review Policy, which encompasses the structured judgement review methodology for the mortality review, but also in cases where there are potential issues highlighted, a root cause analysis (RCA) is undertaken.

0 case record reviews and 0 investigations completed after 31.03.20 which related to deaths which took place before the start of the reporting period

0 representing 0 % of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the process embedded within the Trust including a full health record review of each death and discussion at the respective Divisional Mortality Meetings.

0 representing 0% of the patient deaths during 2020/21 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services

In the 7 day services framework, clinical standards (CS) 2,5,6 and 8 have been prioritised. We are fully compliant with clinical standards 5, 6 and 8.

The Trust continues to make progress with CS2. In the 7 day service audits from 2016-2019 the overall rate of compliance improved from 50% to 79%. The compliance rate at the weekends in the audits have consistently been high, demonstrating a Consultant presence for review throughout 7 days. As a specialist Trust there has been discussion with the 7 day services team regarding difficulties that arise for us with this standard. All patients who are transferred to The Walton Centre will have been seen and assessed in their local hospital, usually will have had investigations such as scans, and in neurosurgery admissions (which are the vast majority) the diagnosis will usually be clear. All admissions are discussed with a Consultant prior to transfer and a management plan is formulated. There is a two tier middle grade on-call system in neurosurgery so there is always a senior trainee on-call. In some cases there is a clear plan for the patient on arrival and assessment by a senior trainee is considered clinically appropriate. Also, all patients admitted as an emergency will be initially assessed by a member of our MDT SMART (Surgical and Medical Acute Response Team) team, which consists of medical staff and outreach /critical care trained nursing staff.

Therefore, the differences in the service will reflect some difficulty with compliance with this standard in all patients, but there remains the aim to reach the target of 90%. This has not been re-audited since 2019 due to the impact of the Covid pandemic. The mortality report continues to be reviewed quarterly at Quality Committee and Trust Board.

This has not shown any trends in deaths by day of the week and day of admission. In summary, the Trust continues to show an improvement in compliance with CS2 but due to being a tertiary centre, some patients may appropriately be treated on arrival by a senior trainee but are reviewed in a timely manner following this by a Consultant. In addition, there are the other clinical standards which the Trust continues to progress well with.

Feedback from local patient experience surveys and reports from listening events held by Healthwatch Sefton (e.g. covid vaccine feedback) and Healthwatch Liverpool continue to be excellent on the standard of medical care. There have been no concerns raised over quality of care / Consultant presence on weekday or weekends. This does not feature as a theme of patient and family complaints.

There is an MDT ward round for all neurosurgery and critical care patients. This comprises medical, nursing, Advanced Practitioners (AP) and pharmacy staff. The SMART team join the ward round at weekends. In neurology there is a weekday daily board round involving medical, nursing, pharmacy and therapy staff. This has been developed since 2015, particularly with the involvement of pharmacy and therapies.

Shift handovers - each morning at 8am there is a neurosurgical handover meeting led by the Consultant on-call - all patients referred overnight (whether transferred or not) are discussed and scans reviewed. This is an MDT meeting involving medical, AP staff, SMART team coordinator and bed management team. There is a formal handover meeting at 8pm each weekday, coordinated by the SMART coordinator and involving junior medical staff. There are well defined procedures for medical handover following each shift. At weekends at 8.30am there is a handover meeting attended by the Consultant neurosurgeon on-call, the trainee medical staff and SMART coordinator. In neurology there is a daily board round, including weekends. The role of SMART coordinator in safe handover is documented in the Trust policy 'Operational Guidelines for the Surgical and Medical Acute Response Team (SMART)'.

Transfer to community, primary and social care – There are daily Consultant reviews to support discharge. There is a complex discharge coordinator working during the week but not at weekends. This service is covered by the bed management team or bleep holder at weekends. Ward based pharmacists support the ward rounds and medications to take out

(TTO) are completed by the pharmacist or AP. There are referral pathways for community settings and access and referral systems in place for all providers, social care and continuing health care. There is pharmacy support for TTO at weekends.

There is a process in place for repatriation to other Trusts. There is a weekly delayed discharge meeting to discuss any patients with a long length of stay and these are escalated as appropriate.

Quality improvement - the Trust mortality report is reviewed quarterly by Quality Committee in detail and reported also to Trust Board. The Trust Board receives a quarterly report from the Guardian of safe working hours on junior doctor working hours. The Clinical Effectiveness and Services Group and Quality Committee regularly review clinical outcomes, with a view to driving continuous improvement. We collect robust clinical outcome data in 75% of all neurosurgical procedures, which is far higher than most neurosurgical units.

2.3.12 Speaking Up

The Trust's Freedom to Speak up Guardian (FTSUG) is proactive in ensuring staff members are given the opportunity to raise concerns. The FTSUG presents to clinical and non-clinical staff members during their induction. Each individual staff member receives a business card with specific contact details should they wish to raise a concern, arrange a meeting on/off site. Posters are displayed across the organisation and the Trust's intranet site also provides relevant information. Drop-in sessions are scheduled throughout the year across each of the areas within the Trust. There are also two FTSU Champions in post to support the guardian. There is a dedicated email address for those wishing to raise concerns. The FTSUG will agree the frequency of contact with the individual/s and following a meeting/investigation information will be gathered regarding speaking up, which has been positive to date. The FTSUG also undertakes exit interviews for those leaving the organisation in order to give staff the opportunity to raise any issues/concerns. The Trust has adopted the NHSI Raising Concerns Policy and has a Grievance Policy and Bullying and Harassment Policy which is readily available for all staff to access offering contact details such as email addresses, contact names and telephone numbers.

During the pandemic, the FTSUG was pivotal in supporting staff when they or their family were symptomatic of covid 19. The FTSUG was the first point of contact and in organising swabbing, they also offered support and questionned whether they had any concerns they wished to raise. This was important to ensure that staff had a voice, at a time where people were feeling vulnerable nationally due to the pandemic.

Part 3 Trust Overview of Quality 2020/21

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2020/21.

Presented are quantitative metrics, specific to aspects of safety, effectiveness and patient experience which are measured routinely to assure the Trust Board regarding the quality of care provided, having also been shared at a number of assurance committees within the hospital.

Patient Safety Indicators

Trust Acquired	2017/18	2018/19	2019/20	2020/21
C Difficile	7	7	5	3
MRSA Bacteraemia	1	0	0	0
Ecoli	11	9	13	7
Minor and Moderate Falls	35	31	37	19
Never Events	2	2	1	0

Clinical Effectiveness Indicators –

Mortality – Procedure	2017/18	2018/19	2019/20	2020/21
Tumour	8	8	11	7
Vascular	37	27	23	38
Cranial Trauma	21	14	32	21
Spinal	4	11	6	3
Other	14	17	20	41

Patient Experience Indicators

Patient Experience Questions	2017/18	2018/19	2019/20	2020/21
Were you involved as much as you wanted to be in decisions about your care and treatment?	91%	91%	95%	89%
Overall did you feel you were you treated with respect and dignity while you were in the hospital?	98%	99%	99%	99%
Were you given enough privacy when discussing your condition or treatment?	93%	96%	94%	84%
Did you find someone on the hospital staff to talk to about your worries and fears?	84%	85%	82%	93%

3.1 Complaints

3.1.1 Patient Experience, Complaints Handling and Patient & Family Centred Care

We recognise that attending hospital can be a difficult and frightening experience for all and particularly during a pandemic. The Patient & Family Experience Team provides a confidential support and advice service to patients and their families, as well as helping to resolve enquiries and concerns quickly on their behalf. This can be prior to, during or after their visit to the Trust and they can be contacted in various ways including telephone, email or in person whilst in the Trust.

Where concerns cannot be easily resolved or are of a more serious or sensitive nature, the team are responsible for supporting the patients and their families in managing and resolving the complaint. As staff, we pride ourselves on working together with patients and their families and carers to resolve complaints in a timely way, explaining our actions and learning, evidencing how services will be improved as a result of a complaint. We recognise that families are diverse and a family member is not always a blood relative of a patient and we respect this at all times.

Throughout the past year, the Patient Experience Team has:

- continued to listen to and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided support to families unable to visit their loved-ones during Covid-19 and for the families of the bereaved
- continued to support and engage with volunteers
- reviewed and enhanced the complaints management process including implementing a local resolution pro-forma and responded to all concerns and complaints within a timely manner
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meeting prior to discharge
- Purchased large screens to enable life size communication between patients and loved ones
- Introduced Letters to Loved Ones which enabled families to stay in touch with their loved ones during the pandemic whilst visiting was suspended. A dedicated email inbox was made available and upon receipt would be delivered to the patient.

3.1.2 Complaints Management and Lessons Learnt

The Patient Experience team work proactively in partnership with the Neurosurgical and Neurology Division in order to manage complaints to meet the needs of each individual patient or family member, this may involve meeting with patients in their preferred place, including their homes in order to reach the best outcome for them.

Every enquiry, informal concern and formal complaint is given careful consideration and review. Each concern and complaint is investigated and complainants receive their response in their preferred format. This can be in a telephone call or response from the Patient Experience team via email or letter or for a formal complaint, a detailed response from the Chief Executive or at a meeting with the senior staff from the respective division.

Over the last 12 months the complaints process has been robustly reviewed and embedded to ensure that complaints are addressed in a timely manner and that meaningful apologies are provided. All concerns and complaints are discussed by the Patient Experience Team and the divisional management teams at a weekly joint divisional meeting. This process ensures that all complaints are being carefully considered and investigated in a timely manner. Every effort is made to ensure that responses are comprehensive and that lessons are learnt. Outstanding actions from complaints are discussed weekly and shared at relevant divisional governance meetings until the Divisional Directors are assured that actions are fully implemented and closed.

Outcomes from complaints are reported monthly to the respective risk and governance committees and meetings within the Trust. Trends and actions taken are discussed in detail in the Governance, Risk and Patient Experience Quarterly report, the monthly divisional governance and risk group meetings and Quality Committee. Any trends in subject, operator or area are escalated in real time to the Executive team. Complaints are reported and discussed with the Executive Team bi-monthly to offer assurance that the management process is robust and actions managed in a timely way.

Complainants are kept informed and updated during the process by regular contact from members of the Patient & Family Experience Team. We use feedback from those who have used the complaints process to help us improve and shape the service we provide.

Examples of lessons learnt from complaints during 2020/21 include reviewed process to ensure that patients with enhanced needs are provided with information in their preferred format and improvements to the patient referral system/telephone system resulting in improved patient experience. In addition to this, complaints form part of the consultant

appraisal process and other individuals involved in complaints are required to personally reflect on the impact complaints have had on patients and families.

3.1.3 Complaints Activity

We use feedback from patients and families who have used the complaints process to help us improve the service we provide. We have developed a person centred approach so that complainants are kept informed during the investigation, with regular contact from members of the Patient Experience Team.

- there has been a dramatic reduction (48%) in formal complaints received and responded to during 2020/21 (67) compared to 2019/20 (129)
- there has been a significant increase in concerns and enquiries more than doubled but were effectively dealt with and responded to by PET before escalating in 2020/21 in comparison to 2019/20
- the response time for formal complaints has considerably reduced from an average of 57 working days in 2019/20 to an average of 23 working days in 2020/21, which is less than the required response time of 25 working days demonstrating a robust management process
- we aim to continue to reduce the numbers of formal complaints in 2021/22 by continuing to embed actions and lessons learnt and proactively resolving enquires and concerns at the very earliest opportunity – in addition we aim to maintain the improved response time

Complaints received 01 April 2020 – 31 March 2021

	Quarter 1 April–June 20	**Quarter 2** July–Sept 20	**Quarter 3** Oct– Dec 20	**Quarter 4** Jan–Mar 21
Number of complaints received	14	25	16	12

The Trust received 67 complaints during 2020/21 which was a 48% decrease compared to 129 complaints received during 2019/20.

A key element of the person centred approach is focusing on the individual outcomes patients and families are seeking when they raise concerns. The Patient Experience Team acknowledge all complaints and agree the best way of addressing their concerns. The Trust work in partnership to investigate any joint complaints with all other NHS organisations whereby care received within The Walton Centre is highlighted as a concern as part of any complaint they receive.

3.1.4 Duty of Candour

The Trust fully acknowledges its duty of candour which supports one of its core values of openness. Incidents which fall under the requirements of the regulation are identified through the weekly scrutiny of the Datix Risk Management system.

All patients (or relatives in the event of a patient lacking capacity) who are involved in an incident falling under the requirements of duty of candour will be offered an apology as soon as possible. The patient/relative will receive a follow up letter (if not declined) with a written apology signed on behalf of the Chief Executive by the Director of Nursing and Governance. The patient/relative will be offered a copy of the investigation or a face to face meeting if required.

3.2 Local Engagement – Quality Account

The Quality Account has evolved by actively engaging with stakeholders and using external feedback and opinion combined with thoughts and visions from staff within The Walton Centre. Trust Executives have also participated in discussions with the local health economy and sought views on the services provided by the Walton Centre. The Trust has developed strong stakeholder relationships with local Healthwatch organisations, who have conducted numerous engagement events with patients and visitors at our Trust. The hospital has further developed relationships with charities including, The Brain Charity and Headway.
The Trust has actively engaged with Governors through a forward planning event on all aspects of quality including choice of indicators for 2021/22 via MS Teams.

3.3 Quality Governance

A Quality Governance framework was designed as a tool to encourage and support current good practice for quality governance in healthcare organisations. The Trust developed a Quality Strategy to define the combination of structures and processes at and below Board level to lead on Trust-wide quality performance to ensure that required standards are achieved. This now forms part of the Quality Strategy which sets out key priorities and the principles that the Trust will continue to develop and apply to current and future planned services and patient and family experience.

The Quality Strategy is underpinned by the Trust Strategy work internally to further improve patient safety and quality, and learning from national work such as the Francis Report and Berwick Review.

The Quality Strategy is built on the ambitions of the Trust strategy:

- Deliver
- Invest
- Adopt
- Provide
- Lead
- Recognise

The Quality Strategy is monitored via Quality Committee, Patient and Family Experience Group and the Senior Nursing team. A risk has also been put on the Board Assurance Framework in regards to achieving the Quality Strategy ambitions to ensure this is monitored at Board level and an oversight of any risk is addressed.

3.4 Consultants Lead Research into Neurological Effects of Covid-19

Lead researcher, a consultant neurologist with the Trust, worked with the CoroNerve Studies Group, a collaboration between several universities to study 153 patients treated in UK hospitals during the acute phase of the COVID-19 pandemic.

3.5 Rated Sixth in the Country for Overall Experience – National Inpatient Survey

The Walton Centre scored top marks in the Care Quality Commission (CQC) National Inpatient Survey, ranking 6th in the country against other Trusts when asked about overall experience, published July 2020.

3.6 Project Wingman Opens a 'First Class Lounge'

Project Wingman was a group of airline crew from across every UK airline, united by their profession and dedication to serve NHS staff during the COVID-19 pandemic. The project provided a space for staff to unwind, relax and be pampered before, during and after a shift.

3.7 Procurement Team Shortlisted for Excellence in Supply Awards

The Trust was nominated in recognition of the procurement teams work during the early stages of the COVID-19 outbreak and their exceptional support throughout.

3.8 Walton Centre Neurologist to Co-lead National Study

Clinical Researchers from The Walton Centre have been awarded a grant to investigate the neurological impact and neuropsychiatric effects of COVID-19.

3.9 Network Lead Nurse Recognised in New Year's Honours List

Director and Lead Nurse for the Cheshire & Mersey (and the Isle of Man) Major Trauma & Adult Critical Care Networks (CMCCN) was awarded an MBE in the New Year's Honours List

3.10 Spinal Improvement Partnership Set to Enhance Patient Safety

The Trust became the first centre of excellence for spinal services to give surgeons and medical device manufacturers detailed insight into the long term effectiveness of spinal surgeries and implants through a new partnership with Northgate Public Services (NPS).

3.11 NHSX Digital Aspirant Funding

NHSX (a new joint organisation for digital, data and technology) announced The Walton Centre will be included in the second wave of the Digital Aspirant Programme – a project which helps trusts across the country digitise and progress towards paper-free patient record keeping.

3.12 Walton Strategic Committee Created

The Trust launched its first Black, Asian and Minority Ethnic (BAME) Strategic Committee to tackle racism head on

3.13 Creation of an Operational Management Board

This was created to enable better ways of working and communications across the hospital regarding operational services and developments.

3.14 Supported Liverpool University Hospital Foundation Trust (LUHFT) in delivering care to patients following a stroke at The Walton Centre

Stroke services transitioned to The Walton Centre to enable LUHFT to expand their wards with patients with covid, due to pressures in their Accident and Emergency department. The service was supported by both Walton and LUHFT staff as the patients had neurological conditions.

3.15 Supported Liverpool University Hospital Foundation Trust (LUHFT) in enabling them to operate in the theatres at The Walton Centre

LUHFT required patients with head and neck cancers to be treated within the theatres in the Walton Centre due to increased usage and pressures within their own operating departments.

3.16 Overview of Performance in 2020/21 against National Priorities from the Department of Health's Operating Framework

The following table outlines the Trust's performance in relation to the performance indicators as set out in the Department of Health's Operating Framework.

Performance Indicator	2019/20 Performance	2020/21 Target	2020/21 Performance
Incidence of MRSA	0	0	0
Screening all in-patients for MRSA	98.88%	95%	95.92%
Incidence of Clostridium difficile	5	5	3
All Cancers : Maximum wait time of 31 days for second or subsequent treatment: surgery	98.6%	94%	100%
All Cancers : 62 days wait for 1st treatment from urgent GP referral to treatment	100%	85%	100%
All Cancers : Maximum waiting time of 31 days from diagnosis to first treatment	100%	96%	100%
All Cancers : 2 week wait from referral date to date first seen	98.9%	93%	98.9%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	N/A	N/A	N/A
Maximum 6 week wait for diagnostic procedures	0.17%	1%	19.8%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Fully Compliant		

Note: The Trust is currently taking part in the NHSI Pilot to measure average wait and is not required to measure against 18 weeks from referral to treatment.

3.17 Overview of Performance in 2020/21 against NHS Outcomes Framework

The Department of Health and NHSI identified changes to Quality Account reporting requirements for 2012/13 and subsequent rounds of Quality Accounts, following consideration by the National Quality Board of introducing mandatory reporting against a small, core set of quality indicators.

The indicators are based on recommendations by the National Quality Board, are set out overleaf. They align closely with the NHS Outcomes Framework and are all based on data that trusts already report on nationally.

If the indicators are applicable to us the intention is that we will be required to report:

- Our performance against these indicators
- The national average
- A supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality.

The data within this report is local data that has not been validated nationally.

During 2020/21 The Walton Centre provided and/or sub-contracted four relevant health services. These were neurology, neurosurgery, pain management and rehabilitation.

3.18 Indicators

The indicators are listed below and a response is provided if they are deemed applicable to the Trust. If the indicators are deemed not applicable a rationale for this status is provided.

1. **Summary Hospital-Level Mortality Indicator (SHMI):**
   NOT APPLICABLE

Rationale: This indicator is not deemed applicable to the Trust, the technical specification states that Specialist Trusts are excluded from this measurement and that this decision was made by the CQC in June 2011

2. **Percentage of Patients on Care Programme Approach:**
   NOT APPLICABLE

Rationale: The Trust does not provide mental health services

3. **Category A Ambulance response times:**
   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

4. **Care Bundles - including myocardial infarction and stroke:**
   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

5. **Percentage of Admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as gatekeeper during the reporting period:**
   NOT APPLICABLE

Rationale: The Trust does not provide mental health acute ward services

6. **Patient reported outcome scores for (i) groin hernia surgery, (ii) varicose vein surgery, (iii) hip replacement surgery, and (iv) knee replacement surgery:**
   NOT APPLICABLE

Rationale: The Trust does not perform these procedures

7. Emergency readmissions to hospital within 28 days of discharge:
APPLICABLE

Response:

	No. of readmissions	% of Inpatient Discharges Readmitted
2019/20	244	4.82%
2020/21	142	4.34%
Change	-102	-0.48%

Calculation of readmission rates is based on the national standard as defined within the Compendium of clinical and Health Indicators. (https://indicators.ic.nhs.uk/webview/). The rates are for patients 16 years and over as The Walton Centre does not treat patients under the age of 16.

Actions to be taken

The Walton Centre considers that this data is as described for the following reasons:
The Trust recognises that the main causes for readmissions are due to infection and post-operative complications.

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- Consultant review of all readmissions to ensure any lessons learnt are embedded into future practice.

8. Responsiveness to inpatients' personal needs based on five questions in the CQC National Inpatient Survey:
APPLICABLE

Response:

- This year our designated company Picker carried out the CQC National Patients Survey, this was undertaken later in the year than usual due to the pandemic and as we had a wider sample period we were able to provide the required sample number. As the timeframe for submitting the sample was later in the year, we will not be provided with the result of this until later in 2021.

National Inpatient Survey Question	2017 Result	2018 National Comparison	2019 Result	2020 Result
1. Were you involved as much as you wanted to be in decisions about your care?	7.8	About the same	About the same	tbc
2. Did you find a member of hospital staff to talk to about your worries or fears?	6.0	About the same	About the same	tbc
3. Were you given enough privacy when discussing your condition or treatment?	8.6	About the same	Slightly worse	tbc
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.1	About the same	Better	tbc
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.7	Better	Better	tbc

To note: National Inpatient scores are out of a maximum score of ten

In addition, to the National Patient Survey, The Trust undertakes regular patient and family engagement through several methods including ward rounds to speak directly to patients and families in order to put any concerns right in real time. This was put on hold due to the pandemic but will be combined with the Matrons Rounds over the forthcoming twelve months to ensure that positive feedback is shared with staff and any negative feedback is actioned in a timely manner.

Friends and Family Test (FFT) was put on hold nationally due to the pandemic and Trusts were required to report results for Q4 2021 only. A total of 871 responses were received for Q4 with 93% of responses rating the service as very good, and 4.5% as good. To support this going forward the new digital platform for FFT has been implemented in addition to the postcards. This digital platform has been uploaded on to ipads and the Trust volunteers will support with this once they have been reintroduced into the Trust when this is safe to do so.

The digital platform is also shared with patients who have attended a virtual appointment via Attend Anywhere and they are able to provide real-time feedback following this appointment. This was successfully received by outpatients in Q4 with over 500 responses received; 88% of these respondents rated the service as very good or good. The digital platforms are also available in easy read.

Patient Experience Initiatives

In addition to the introduction of the digital platform for FFT to enhance patient experience, the team were successful in securing financial support from NHE/Improvement to help address Covid-19 related pressures. The criteria was met to support patient experience with the introduction of new technology with the aim to improve patient and family experience. The Trust commissioned three activity screens for use across the wards. These touch

screen devices (32”/43”) are cordless giant tablets. These tablets are highly adaptable to meet accessibility needs of all patients and can be used for life-size virtual visiting; the height and screen can be adjusted by an electric motor.

The devices are multi-purpose and are being used for interactive activities and games which can be supported by volunteers/staff to interact with patients. For games the tablets can be adjusted to table top-style to undertake two person activities for example, chess, word games, jigsaw puzzles, bingo with a volunteer opponent. Sensory games are also available to support neurorehabilitation and interaction. They can also be used for YouTube to reminisce and have the House of Memories App installed to support with cognitive impairment and patients with dementia. The plan is also to install FFT feedback onto this platform.

9. Percentage of staff who would recommend the provider to friends or family needing care:
APPLICABLE

Response:
The Trust had a response rate of 39% for the 2020 national staff survey; the national average for acute specialist trusts in England for 2020 was 56%.

Within the survey, the percentage of staff who would recommend the Trust as a place to work scored 78.9% against an average of 75% and the percentage of staff who would recommend the Trust as a place to receive treatment” scored 92% against an average 0f 91.7%.

The findings for 2020 are arranged under eleven themes across 49 questions,

- Equality, diversity and inclusion
- Health & wellbeing
- Immediate managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment- bullying and harassment
- Safe environment- violence
- Safety culture
- Staff engagement
- Team working

There has been no statistically significant change in ten themes, with the following five themes: Health & Wellbeing, Quality of Care, Safe Environment (Bullying and Harassment),

Safe Environment (Violence) and Safety Culture indicating that the 2020 score is slightly higher than the 2019 score. Three themes have remained the same: Equality, Diversity & Inclusion, Morale and Staff Engagement and two have decreased slightly: Immediate Managers and Team Working.

In the following 9 themes the Trust scored either better (in 8 themes) or the same (in 1 theme) as the average which is based on 14 Organisations in the group across the country:

- Equality, diversity and inclusion - better than benchmarking average
- Health & wellbeing - better than benchmarking average
- Immediate managers – same as benchmarking average
- Morale - better than benchmarking average
- Quality of care – better than benchmarking average
- Safe environment - bullying and harassment - better than benchmarking average
- Staff engagement – better than benchmarking average.
- Safety culture- better than benchmarking average
- Team working- better than benchmarking average

In the following 4 themes the Trust had the best score in its benchmarking group:

- Health & Wellbeing
- Quality of Care
- Staff Engagement
- Team Working

In the following theme the Trust's score was worse than the benchmarking average.

- Safe Environment (violence)

Some Key Highlights are as follows:

- Opportunities for flexible working patterns- increase from 60.4% in 2019 to 66.4% in 2020
- In the last 3 months have you come to work despite not feeling well enough- decrease form 55.7% in 2019 to 39.6% in 2020.
- I am able to deliver the care I aspire to – 75.5% in 2019 to 82% in 2020, best in benchmarking group
- Care of patients is my Organisations top priority- 87.4% in 2019 to 91.8% in 2020, best in benchmarking group

Covid 19 Pandemic

The 2020 staff survey asked a series of questions about staff experience during the Covid 19 pandemic.

Key Highlights:

- Health & Wellbeing for all staff had the highest score in the benchmarking group
- Morale had the best score in the benchmarking group for those staff working on a specific covid ward/area
- Staff engagement and team working for all staff had the highest score in the benchmarking group

In addition to the annual staff survey, a staff Friends and Family Test has also taken place on a quarterly basis this year. The purpose of these is to assess how likely employees are to recommend the Walton Centre as a place to work and also as a place to receive treatment. The results have been extremely positive.

In Quarter 1, (June 2020) the Friends and Family Test was issued to approximately 400 staff using an online survey and 170 surveys were returned. The results showed that 98% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 85% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

In Quarter 2, (September 2020) the Friends and Family Test was issued to a further circa 400 staff with 161 being returned. The results showed that 97% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 79% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

Quarter 4 (March 2021) results had 180 complete the survey, 95% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 80% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

Key staff survey questions:

Organisation and management interest in and action on health and wellbeing:

The Trust score for 2020 was 47%, with the national average being 37%; the Trust had the best score for an acute specialist trust for the 6th year.

Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse from patients:

The Trust score was 22% with the average score for acute specialist trusts being 17.1%.

The Trust has encouraged staff over the past year through various staff engagement events to raise concerns, we work closely with staff side to address any issues raised and have highlighted the role of the "Freedom to Speak Up Guardian" across the Trust.

Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months: (the lower the score the better)

The Trust score was 15.1% the average score for acute specialist trusts being 18.7%. This was a decrease from the 2019 score of 15.6%.

Percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard: (the higher the score the better)

The Trust score was 77% the same as 2019.

The Trust intends to continue to work with staff side and staff through various engagement sessions to increase the response rates and percentage scores for the 2021 survey. A Trust action plan and Divisional action plans will be formulated and approved by Board

Volunteers

Whilst volunteers have not been on site for the majority of 2020/21, we felt it important to continually engage and support them. This has been undertaken by the Volunteer Managers by:

- Regular welfare calls and virtual meetings
- Virtual Coffee Mornings and quizzes
- Newsletters
- Well-being gifts in Summer and Christmas personally delivered in line with covid-19 guidance
- Socially distanced safe park walks
- Engagement and staff/volunteer support with local foodbanks
- Introduction of Volunteer Befriending Service – volunteers specifically trained to undertake telephone befriending service for socially isolated patients being discharged from hospital. Although there has not been much update for this service this demonstrates the proactive approach taken and volunteer engagement
- Picnic in the park planned for volunteer week
- Developing a Volunteer recovery roadmap

In summary, although it has been a very difficult and challenging year for the Trust and NHS, despite working very differently we have overall successfully achieved positive patient and family experience outcomes and we aim to build on this further in 2021/22.

10. Patient Experience of Community Mental Health Services: NOT APPLICABLE

Rationale: The Trust does not provide community mental health services

11. Percentage of admitted patients risk-assessed for Venous Thromboembolism: APPLICABLE

Response: * To be updated once National data published

YEAR		Q1	Q2	Q3	Q4
2017/18	Walton Centre	99.09%	99.69%	98.34%	97.17%
	National Average	95.20%	95.25%	95.36%	95.21%
2018/19	Walton Centre	98.52%	99.00%	98.86%	96.78%
	National Average	95.63%	95.49%	95.65%	95.74%
2019/20	Walton Centre	98.79%	98.97%	98.85%	98.58%
	National Average	95.63%	95.47%	95.33%	Suspended due to COVID
2020/21	Walton Centre	95.35%	98.17%	98.08%	97.94%
	National Average	Suspended due to COVID	Suspended due to COVID	Suspended due to COVID	Suspended due to COVID

The Walton Centre considers that this data is as described for the following reasons:

The risk assessments are carried out by nursing staff within 6 hours of admission, mechanical VTE prevention interventions (use of anti-thrombolytic stockings) are carried out by nursing staff with a medical review regarding pharmacological interventions (medications).

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- All VTEs are subject to a full Root Cause analysis, where any lapses in care, processes or practice are identified. In keeping with the Duty of Candour, the patients are given details of how the reports can be shared with them.

12. Rate of C. difficile per 100,000 bed days amongst patients aged two years and over: APPLICABLE

Response:

Quality Accounts use the rate of cases of C. difficile infections rather than the incidence, because it provides a more helpful measure for the purpose of making comparisons between organisations and tracking improvements over time.

WCFT Clostridium difficile infections per 100,000 bed days:

	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21
The Walton Centre	20.4	15.6	21.0	21.6	15.7	14.5	13.3	13.7	9.5	7.81

The Walton Centre considers that this data is as described for the following reasons:

In 2020/21 The Walton Centre had a total of 3 Clostridium difficile infections against the trajectory set by NHSE/I of 5. To achieve such a reduction is a fantastic outcome which is a consequence of the outstanding work undertaken by all of the staff Trust wide.

The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- Setting clear objectives, implementation and monitoring of the Healthcare Associated Infection (HCAI) reduction plan
- Robust programme of infection prevention control audit
- Monitoring and reporting infection prevention outcomes to the Quality Committee
- Use of technology e.g. Hydrogen Peroxide Vapour (HPV) to enhance our cleaning programmes and investing in an additional UV machine.
- An Anti-microbial Pharmacist to support excellence in antibiotic prescribing and support education and training of clinical staff

The Trust will continually strive to review and improve the quality of its service and aims to reduce healthcare associated infection, including Clostridium difficile to ensure that all of our service users within the Trust, are not harmed by a preventable infection.

13. Rate of patient safety incidents per 100 admissions

Response:

In 2020/21 1384 incidents occurred against 10306 admissions (excluding OPD as per NLRS figures) this equals 13.43 per 100 admissions.

The Walton Centre considers that this data is as described for the following reasons:

- Increased patient acuity

- Increase in capacity and activity
- Improved incident reporting across the Organisation as a result of raised awareness

Walton Centre will take the following actions to improve this score, and so the quality of its services, by:

- Continuing to investigate all incidents ensuring any identified lessons learned are shared across all relevant staff groups. Where there are found to be gaps in care delivery, processes and policies will be updated and put in place to support the delivery of safe and quality care to ensure these incidents do not re-occur.
- Increase in Datix Incident reporting refresher training across the Organisation.

The Trust will continue to:

- Discuss all investigations at the relevant meetings to ensure the sharing of learning Trust wide
- Conduct rapid reviews when required
- Share lessons learnt via the Governance safety bulletin
- Improve the reporting of incidents through discussions at the Trust safety huddle and Trust wide incident training sessions
- Continue to develop the ERCA to support the Trusts reporting requirements

Annex 1

NHS South Sefton Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group
Quality Account Statement 2020-21
Walton Centre NHS Foundation Trust

Liverpool, South Sefton, Knowsley, St Helens CCGs, and NHSE/I Specialist Commissioners wish to thank the Walton Centre NHS Foundation Trust for the opportunity to jointly comment on their Quality Account for 2020/21. Commissioners are committed to working in partnership with the Walton Centre NHS Foundation Trust to provide safe, high quality care and services. Commissioners note that the account submitted is draft and that some sections will be subject to change. Commissioners look forward to receiving the Trusts final version of the Quality Account.

Commissioners have continued to work closely with the Walton Centre NHS Foundation Trust throughout 2020/21, in a challenging year where unprecedented demand has been placed upon services due to the Covid-19 pandemic. The Walton Centre NHS Foundation Trust have continued to deliver safe, effective, and quality driven services throughout the pandemic and supported health partners to continue to deliver care. This is important to note when reviewing the Quality Account for 2020/21 and commissioners would like to take this opportunity to thank the Trust and its staff for the work it has undertaken throughout the pandemic.

The account demonstrates a quality driven approach and continued partnership working with NHS commissioners, setting out achievements and key priorities. The account reflects good progress on the delivery of most indicators and provides detailed insight reflecting on achievements from last year. Commissioners share the fundamental aims of the Trust and support their strategy to deliver high quality, harm free care, which the account offers insight into.

This account shows a consistent drive for quality improvement and recognising that overall, despite pandemic impact good progress was made on the majority of set indicators, with the Trust acknowledging indicators requiring further improvement. The continued drive to achieve indicators fully supports the Walton Centre NHS Foundation Trusts commitment to improving the quality of the services it provides, with the organisation setting out key priorities for 2021/22 in the below areas:

- Patient Safety
- Clinical Effectiveness
- Patient Experience

The account presents a comprehensive picture of the Walton Centre NHS Foundation Trust, acknowledging partnership working and quality improvement plans across the Trust. The report provides key examples of developments and areas of improvement to support proactive safe preventative practice, which offers commissioning assurance. There is further insight detailed in the account with reference to quality improvement requirements and continuous review of required actions to ensure that goals are achieved.

The Trust places significant emphasis on safety, patient/staff engagement and demonstrating commitment to continuous evidence-based quality improvement, research, and audit. This is reflected in the work that the Trust has undertaken towards supporting staff wellbeing and workforce development. An example of this is Project Wingman and the opening of 'A First-Class Lounge' for staff which is both an innovative and excellent provision to support staff wellbeing. The Trust should additionally be commended for the mutual aid support that was offered across the system throughout the pandemic to help free up capacity, which commissioners have received excellent feedback on and would recommend further specific referencing from a Quality Account perspective.

The work that the Trust has undertaken to improve outcomes on the following work streams throughout 2020/21 are of particular note:

- Staff Wellbeing: Project Wingman – 'First- Class Lounge' as previously referenced as an excellent initiative for supporting staff wellbeing.
- Encouraging that a number of the quality aims were based on developing the workforce and staff experience which furthermore supports staff wellbeing.
- High achievement of staff satisfaction with the Trust being rated 6th in England in the national NHS Staff Survey.
- Recognition of the support requirement in the reduction of hospital acquired pressure ulcers.
- Positive introduction of Patient Initiated Follow Up appointments which offers patients more flexibility, in addition to wider work to improve both efficiency and patient experience.
- The Trusts progress in implementing clinical standards for seven-day hospital services and the requirement for ongoing review.

Commissioners acknowledge the significant work undertaken by the Trust in relation to improving quality and safety standards and the continued focus to strive for excellence. In supporting staff development, keeping patient needs central, improving learning from deaths and acknowledging support requirements in the reduction of hospital acquired pressure ulcers.

Commissioners are aspiring through strategic objectives and five year plans to develop an NHS that delivers great outcomes, now and for future generations. This means reflecting the government's objectives for the NHS set out in their mandate to us, adding our own stretching ambitions for improving health and delivering better services to go even further to tailor care to the local health economy. Providing high quality care and achieving excellent outcomes for our patients is the central focus of our work and is paramount to our success.

It is felt that the priorities for improvement identified for the coming year are challenging and reflective of the current issues across the health economy. We therefore commend the Trust in taking account of new opportunities to further improve the delivery of excellent, compassionate and safe care for every patient, every time.

Jane Lunt
Chief Nurse
NHS Liverpool CCG
25.06.2021
Signed on behalf of the chief Nurses for Liverpool, South Sefton, Southport &Formby and Knowsley CCGs

The Walton Centre NHS Foundation Trust

Healthwatch Sefton would like to thank the Trust for presenting the Quality Accounts in a report that is written in a clear and understandable format.

The Trust engaged with Healthwatch Sefton and other local Healthwatch to provide the opportunity for Healthwatch to be involved in selecting potential Quality objectives for the Trust.

The Trust has continued to work in partnership with Healthwatch Sefton and hold regular Patient Experience Group meetings that we are invited to attend.

The Trust reported that 2020/21 has been a very difficult year with specific reference to Covid-19 and that although not all the priorities they set themselves had been achieved they had supported staff, volunteers and patients and have identified opportunities to improve their service going forward.

Healthwatch Sefton would like to see the Road to Recovery programme for stroke patients which were put on hold during the pandemic to restart as soon as possible.

Despite Covid-19 the Trust were rated 6th in the country for overall patient experience which is impressive.

An achievement noted during 2020/21 was that the Trust participated in 100% of National clinical audits and 100% National confidential enquiries that it was eligible to participate in.

The Trust also reported that they have collaborated with other medical and academic networks to identify funding and are now able to offer Phase 1 clinical trials to patients with Parkinson's disease and Huntingdon's disease. We look forward to hearing how the trials progress over the coming year.

We are pleased to hear a BAME strategic committee has been set up in recognition of the fact that BAME communities are disproportionately effected by Covid 19 and the fact long recognised that fewer people from those communities are referred to the Walton centre than would be expected given the demographics of North West England.

It is reported that the patient experience team have continued to support patients and have reviewed the complaints process to ensure that complaints are carefully considered and investigated in a timely manner and that complaints have reduced over the year by (48%) and the response time reduced. An update on the Trusts complaints and concerns is provided by the team at each Patient Experience Group meeting.

Healthwatch Sefton will continue to work in partnership with the Trust by attending the Trust Patient Experience Group meetings and feeding in any emerging issues.

The Walton Centre Foundation Trust 2020-21 Quality Account commentary

Healthwatch Liverpool welcomes the opportunity to comment on this 2020-21 Quality Account for the Walton Centre.

We base our commentary on this report, feedback and enquiries that we receive throughout the year. Due to the Covid-19 pandemic we could not carry out our usual annual listening event at the Trust.

Firstly, we would like to congratulate the Trust in gaining 6th place for overall experience in the National Inpatient Survey published in July 2020, which is a great result. The survey was carried out in 2019, before the Covid-19 pandemic which brought lots of changes and challenges to the Trust. Not all quality priorities could be achieved this year, however the 2020-21 Quality Account highlights many successes, including the successful introduction of a new phone system in the Patient Access Centre which is certain to improve patient experience.

We are also aware that the Walton Centre took on additional responsibilities during the pandemic, for example taking in head- and neck cancer and stroke patients from Aintree hospital to free up space there, thus supporting other Trusts and wider local NHS systems.

We are pleased to see that Equality, Diversity and Inclusion initiatives have continued at the Trust, and that one of the priorities for the coming year focuses on improving the wellbeing and equality experienced by Black, Asian and Minority Ethnic staff and patients, especially after a year in which inequalities were starkly exacerbated. We will be interested to learn more about initiatives and outcomes from this.

We also welcome the other priorities the Trust has chosen for the coming year, in particular the Patient Initiated Follow Up (PIFU) which gives patients with long-term conditions or after surgery more control about future appointments. The increase of outpatient appointment slot utilisation is also a positive focus at a time where anything that can help to improve appointment backlogs and waiting times is to be encouraged.

Providing Mental Health First Aid training is another very welcome development, particularly after the additional and at times extreme pressures of the Covid-19 pandemic that many NHS staff and patients have experienced.

We were pleased to see the substantial reductions this year in Trust-acquired infections, minor and moderate falls and Never Events. Patient experience indicators show a positive picture overall, particularly the percentage rise in patients being able to find staff to talk to about worries and fears. However, we noted that the percentage given for privacy whilst discussing condition or treatment this year declined, and wondered if that has been further investigated to find out if this reflects particular wards or areas of the hospital?

During a large part of the pandemic inpatients could not receive visitors, which for patients who had to spend long periods of time in the hospital and their relatives and friends must have been particularly difficult. We were pleased to learn about some of the initiatives the Trust took to help ensure that patients, relatives and friends could stay connected, for example the large screens that were bought so that patients could have 'life-sized' video calls, and the 'Letters to Loved Ones' initiative.

That the Trust halved its response time to complaints is a positive step forward, and we hope that this will be sustained in the coming year.

Due to the pandemic we currently can't visit Trust sites and meet patients and visitors face to face to capture their feedback. We are working in different and new ways, for example by facilitating online focus groups. We look forward to working with the Walton Centre in 2021-22, helping to ensure that patients' voices continue to be central in celebrating good practice, and in feeding back if and where improvements could be made.

Glossary of Terms

ANTT	Aseptic Non Touch Technique
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
DOLS	Deprivation of Liberty Safeguards
EP2	Electronic Patient Record System
FFFAP	Falls and Fragility Fractures Audit Programme
FOCUS	Free of Criticism for Universal Safety
FTSUG	Freedom to Speak Up Guardian
GIRFT	Getting It Right First Time
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit & Research Centre
KPI	Key Performance Indicator
LASTLAP	Looking After Staff to Look After People
MDT	Multidisciplinary Team
MIAA	Mersey Internal Audit Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteraemia
NCABT	National Comparative Audit of Blood Transfusion
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Clinical Excellence
NIHR	National Institute of Health Research
NNAP	National Neurosurgery Audit Programme
NQB	National Quality Board
PACS	Picture Archiving Communication System
RCA	Root Cause Analysis
SJR	Structured Judgement Review
SIRO	Senior Information Risk Owner
SMART	Surgical and Medical Acute Response Team
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
VTE	Venous Thromboembolism
WCFT	Walton Centre Foundation Trust