The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Account

2021 – 2022

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Part 1 Statement on Quality from the Chief Executive

It gives me great pleasure to share the Quality Account for 2021/2022 which demonstrates how the Trust staff are determined to make positive changes for patients and families, continually going above and beyond. This report details our performance over the last year whilst also highlighting our key priorities for 2022/2023.

The Trust have fantastic staff across the whole organisation and I am extremely proud of our teams and how they have shown great resilience and commitment throughout the ongoing challenges brought to us by the Covid-19 pandemic. We are committed to working together to be even better and come out of the Covid-19 pandemic even stronger.

Whilst the last year has yet again brought considerable challenges The Walton Centre NHS Foundation Trust continued to innovate and lead the way to improve treatment and care for our patients and their families.

The Trust's Quality Strategy (2019-2024) aims to improve on the quality of care provided for patients and their families and reduce avoidable harm however Covid-19 has changed how we work and care for our patients. It is for this reason that we have been working with our staff to launch a new strategy for 2022 onwards to identify new ways to deliver outstanding care.

The Walton Centre have continued to prioritise patient and staff safety however this meant that some of the quality priorities could not be achieved. Further information is detailed within this Quality Account.

In addition, this year the Trust have achieved:

- NHSX Digital Aspirant funding will mean more integrated health care for patient of The Walton Centre
- MS Awareness Week – FACETS (Fatigue: Applying Cognitive Behavioural and Energy Effectiveness Techniques to LifeStyle) Programme
- New spinal clinic in North Wales bringing care closer to home
- Families continuing to save and improve lives through deceased organ donation
- Staff and supporters take a leap of faith for charity
- Making it to the Tokyo Olympic Games
- Patient drinks innovative 'pink drink' helping surgeon remove brain tumour
- International Nurses made The Walton Centre their home
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Quality initiatives are discussed and debated through various local meetings, reporting up to 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 in a timely way.

On a personal note I was delighted to be appointed Chief Executive of The Walton Centre in June 2021. Having worked at a number of NHS Trusts throughout my career, The Walton Centre felt like ‘home’ and the staff have made me very welcome. It has been a pleasure to lead the trust over the last year to enhance further the delivery of outstanding quality care to our patients and their families. This is an outstanding trust with a long history of providing highly specialist care.

We have all faced challenges we could not have imagined, both professionally and personally. I’d like to thank every single member of staff for their compassion, resilience and dedication, without which we would not be able to provide such wonderful treatment and care for all our patients and their families.

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, 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 2021/22 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 Chief Nurse 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 2020/21. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focussing our priorities for 2021/22.

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 2021/22.

2.1 Update on Improvement Priorities for 2021–2022

In December 2021 the Council of Governors and in February 2022 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 2022/23. 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) did not audit the priorities 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: 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 18 hospital acquired pressure ulcers. 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.

Outcome: Not Achieved
During 2021/22 the Trust has had 19 pressure ulcers. A new tissue viability specialist nurse is working with teams to provide enhanced education and support regarding pressure relieving equipment.

Priority: Redevelop Pain Management Programme (PMP)

Reason for Prioritising:
Due to the Covid-19 pandemic and the need to work differently and restart services, an online PMP programme was designed. 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.

Outcome: Achieved
The PMP have successfully responded to the Covid-19 pandemic and has operated an online programme meaning we have successfully delivered and continue to deliver our PMP group programme.

Patients outcomes data has revealed that the programme has been a resounding success and patients have reported a positive patient experience.

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. 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.

Outcome: Achieved
We have moved the writing of the discharge prescription, also referred to as To Take Out, TTO's to the day before discharge to improve patient flow and remove delays. We have conducted a review of the nurse & therapy handover of a morning to release time to care for staff at a critical time of the day. We are developing a standardised Ward Round Review in line with national guidelines. Daily morning bed meetings were introduced but we have since improved the process and moved this to the afternoon to look at the following day's position. Considering the expansion of Same Day Discharge and Same Day admissions going forward.

2.1.2 Clinical Effectiveness

Priority: Introduce Patient Initiated Follow Up (PIFU)

Reason for Prioritising:
To give patients, families 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. 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.

Outcome: Achieved
PIFU has been rolled out to the majority of specialities with Neurology and currently being rolled out across Neurosurgery. We are one of the leading Trusts in the region and were one of the early adopters for this programme of work in the country.

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

Outcome: **Achieved**
All of the afternoon clinics were changed from 3.5hrs to 4hrs where possible to increase slot utilisation

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. 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.

Outcome: **Not Achieved**
The service provider (NHSSC) could not support the Trust as they were focusing their attentions on the national roll out of Android PDA devices which meant all of their staff focused on that specific initiative.

The creation of Health Procurement Liverpool (HPL) to incorporate other neighbouring trusts as a single procurement function highlighted that other trusts were using a different inventory management system. Ideally the Trust would prefer all HPL trusts to use a single system. This project is currently on the work plan for HPL and the recruitment of a Supply Chain Lead will lead across all four Trusts.

2.1.3 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. 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%

Outcome: Achieved
The Trust prioritised the wellbeing of Black, Asian and Minority Ethnic patients and staff in relation to its Covid-19 response and post Covid-19 systems recovery and participated in the steering group for: Getting under the skin, the impact of Covid-19 on ethnic minority communities. This was a piece of research headed by the Cheshire and Merseyside Health and Care Partnership.

Risk assessments and risk mitigating actions were undertaken in response to health inequalities associated with Covid-19 e.g. a representative for BAME staff and patients/populations has been included as part of tactical planning for Covid-19 to ensure that the greater risk is considered and acted on by the Hospital Management Group.

The Trust consulted with NHS colleagues on how best to tackle health inequalities in relation to race and ethnicity. This will give the Trust a better understanding of areas where we are not performing so well and where we have the power to make improvements in a reasonable timeframe.

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.

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.

Outcome: Partially Achieved
29 staff have been trained as MHFA's and an additional 25 staff have attended a taster session, a further full course will run in Spring 2022; the MHFA have been advertised across the Trust.

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. 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.

Outcome: Partially Achieved
The Trust saw theatre start times improve however the impact of the Red, Amber and Green (RAG) pathways did hinder this at times. Theatre start times have improved and levelled out compared to 2020/21.

This outcome is only partially achieved. Progress in this area has been affected due to the pandemic and requirements to place our patients on 3 different pathways within theatres to maintain patient and staff safety. This has meant that start times of theatres have been protracted due to the requirements of stand down time following aerosol generating procedures, and the recovering of patients. The Trust has reviewed the patient pathways in the last couple of weeks, which should show an improvement on the theatre start time.
We currently are supporting the same day admission service for the appropriate patients through the bed repurposing project. One of the outcomes from this is to facilitate a same day admission and discharge area, and therefore this is partially achieved also.

2.2 What are our priorities for 2022 – 2023?

In December 2021, the Council 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 2022/23 with the Quality Committee, Health watch and Specialist Commissioners identifying the final priorities from those initially identified by the Council of Governors.

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

Each of the priorities has identified lead/s who have 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 held with the commissioners (via MS Teams) to review quality assurance and provide external scrutiny and performance management. Due to Covid-19, 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: 98% completion of MUST within 12hrs of ward admission and compliance with weekly MUST re-assessment

Reason for Prioritising:
Aim for 98% compliance of MUST risk assessment on ward admission and weekly MUST re-assessment.

This will improve patient outcomes by ensuring timely referrals to Dietitians and initiation of appropriate dietetic treatment plan.

Outcome Required:
98% compliance of MUST risk assessment on ward admission and weekly re-assessments.

Priority: Pilot the Whiston Project (initially Whiston Hospital patients)

Reason for Prioritising:
Improve the pathway for patients with a brain tumour deemed unsuitable for surgery and require best supportive care.

Significant unmet need identified for patient cohort resulting in patient not receiving right support/care.

Outcome Required:
Aim to provide enhanced responses and information for patients and reduce AED attendances.

Priority: Introduce Same Day Admission/ Discharge (surgery)

Reason for Prioritising:
Creating safer pathways and processes for patients to be admitted and discharged on the same day as their operation.

This will improve not only patient overall experience, but will also reduce length of stay and mitigate against hospital acquired infections.

Outcome Required:
Aim to ensure patients are not spending longer than is absolutely necessary in hospital.

2.2.2 Clinical Effectiveness

Priority: Introduce Nutrition Champion Training Programme

Reason for Prioritising:
This will improve patient outcomes through improvements to their nutritional care.

Outcome Required:
Increase staff training to support nursing teams to focus on nutrition and mealtimes.

Each area to have a nutritional champion lead

Priority: Implement Virtual Reality (VR) Simulator

Reason for Prioritising:
Training occurs under the watchful eye of consultant neurosurgeons. The VR allows junior neurosurgeons to practice major procedures such as craniotomies in a virtual, but realistic environment mitigating against any potential patient safety risks that could arise in a live environment.

Outcome Required:
Purchase a neuro VR simulator for teaching junior neurosurgeons. In addition we would offer training as an educational tool to the region and beyond.

Priority: Introduce Patient Initiated Follow Up (PIFU) – Surgery

Reason for Prioritising:
Rolling this project out in neurosurgery will see patients taking more control of how/when they are followed up.

Outcome Required:
Aim to reach 2% (trust wide) of our patient follow up cohort to be initiating their own follow up appointments.

2.2.3 Patient Experience

Priority: Develop Training Programme Cheshire and Mersey Rehabilitation Network

Reason for Prioritising:
Increase staff training to identify and undertake quality improvement initiatives and evaluate the impact on patients, staff and the service.

This will improve the experience of patients and service delivery.

Outcome Required:
Enable staff to develop knowledge and skills in undertaking and evaluating quality improvement projects.

Priority: Introduce Staff Training to Support People with Communication Difficulties

Reason for Prioritising:
Providing support to patients, carers, families and staff is paramount in improving experience by increasing the understanding of those with communication difficulties.

Outcome Required:
Ensure the trust is accredited to use the Communications Access Symbol.

Priority: Reduce the Number of Complaints

Reason for Prioritising:
Embed learning and actions to prevent re-occurrences.

Outcome Required:
Year on year reduction of complaints received by the divisional teams.

2.3 Statements of Assurance from the Board

During 2021/22, 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 2021/22 represents 92.9% of the total income generated from the provision of the relevant health services by The Walton Centre for 2021/22.

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 ten 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.

Quality reviews are undertaken across clinical areas to provide an overview of compliance against standards to provide a full picture of the care delivered within each area and the trust overall. The framework is designed around fifteen standards with each one subdivided into four categories including patient experience, observations, documentation and staff experience.

2.3.2 Participation in Clinical Audit and National Confidential

During 2021/22, 8 national clinical audits and 1 national confidential enquiry 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 2021/2022 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)

2.3.4 National Confidential Enquiries

- Epilepsy

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2021/2022 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	0% (1 eligible case)
The Sentinel Stroke National Audit Programme	Yes	93%
National Audit of Care at the End of Life (NACEL)	N/A	100%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
National Comparative of Blood Transfusion (NCABT) – 2021 Audit of patient blood management and NICE guidelines	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 which are those over 60 years of age and have fallen and fractured their hip
National Confidential Enquiry into Patient Outcome and Death		
Epilepsy	Yes	100%

The reports of 3 national clinical audits were reviewed by the provider in 2021/22 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 90 local clinical audits were reviewed by the Trust in 2021/22 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
The effect of deep brain stimulation on impulse control related disorders in Parkinson's disease (N 307)	• No actions necessary
Service evaluation to assess documentation of bowel movements (N 322)	• Consider developing educational resources for ward staff on the importance of documenting bowel movements • In view of findings that EP2 is most popular, it may be appropriate to discuss with nursing teams to determine if electronic is the place to document over stool charts/fluid charts. • Highlight that there is no access to EP2 for HCAs and is this a barrier to why documentation is incomplete • Discussions at the nutrition steering group to gain a consensus on where is best for documentation of bowel patterns
Evaluation of the acute occupational therapy service using the Australian Therapy Outcome Measure (AusTOM) for Occupational Therapy (N 319)	• No actions necessary
Enteral feed documentation service evaluation (acute wards) (N 346)	• Raise awareness of the issue of incomplete documentation of enteral feeds
Gastrostomy removal service evaluation (N 306)	• Develop standard operating procedure outlining best practice for implementing and managing gastrostomy removal • Develop gastrostomy removal tool to be used on wards to help manage gastrostomy removal trial period
Evaluation of NCS waveform data (N 334)	• Disseminated to line manager • Share with consultants in Governance and risk meeting • Encourage to make attempts to eliminate stimulus artefact to acquire a satisfactory baseline and ensure a clear waveform take off
Outcomes of ventilator weaning, tracheostomy weaning and level of	• No actions necessary

functional ability on ITU discharge in patients admitted with Covid-19 pneumonitis (N 345)	
Evaluating the adherence to guidelines for addressing palliative care needs of patients with advanced Parkinson's disease or Parkinson's plus syndromes (N 289)	• Issue - Lack of conversations regarding palliative care in PD. Action - Increase awareness and provide patients with information. Information booklet to be given to doctors. Update – Carried out with the movement disorders team and discussed at the grand round with the consultant neurologist • Issue - Increase awareness to consultants/registrars/nurses. Action - Discuss at local audit meeting • Issue - Lack of input from palliative care. Action - Talk from palliative care doctor (Aintree hospital)
Exploring the prognostic value of the electroencephalogram for patients Hypoxic ischaemic encephalopathy an out of hospital cardiac arrest (N 339)	• No actions necessary
Comparing the yield of sleep deprived EEG referral by neurophysiologists and neurologists following a non-diagnostic routine EEG (N 342)	• No actions necessary
Quality improvement project relating to weekly medical updates for families of inpatients (N 349)	• Issue – Improving the proportion of patients whose NOK receive a family update. Action – Checkbox on Ep2 Consultant Daily Ward Round Checks (Family Update provided Y/N?)
Compliance with Bowel protocol on Horsley ITU (N 356)	• Timely initiation of bowel protocol for patients admitted to ICU • Glycerine suppositories to be prescribed following BNO for 48 hours in line with protocol • Clear prescription of full suppository and enema pathway after 48 hours in case of BNO following glycerine suppository • Ensure stool sample taken and sent when clinically indicated as per bowel protocol
Long term monitoring record keeping audit (N 335)	• Encourage documenting time of the entry
An audit of current practice to evaluate the spasticity ward round against bets practice national guidelines (N 351)	• Presentation disseminated to the team which reviewed all the recommended outcome measures from the RCP guidelines and suggestions about repeating these at regular timeframes
Tracheostomy quality audit (N 350)	• SLT will pay particular attention in the interim period to ensuring that access to fiberoptic endoscopic evaluation of swallowing (FEES) is available as required. This will be escalated as required if it is noted that patients requiring this service are not able to receive it - Repeat audit in 2022/23

Duration of MUST completion on transfer from ICU to the ward (N 344)	• Dietitians to work on implementing refresher MUST training across the wards for nursing staff when nutrition champions are assigned
Review of bowel management in Neurorehabilitation (N 296) Review of Anthropometric measures in Horsley ICU (N 329)	• Present audit findings to nursing and medical teams, to generate discussion • Share findings with dietetic team to allow consideration of similar project in acute teams. • Update stool chart and present to team for consideration • Immobile patients not weighed on admission to ICU • Weight obtained – to be documented on daily monitoring form • Patients requiring weekly weights highlighted- weekly MDT • Dietitians provided training to ICU staff on transfer weighing scale for immobile patients • Presented to ICU Operational Group • Audit undertaken – all actions complete
Evaluation of medical interruptions to rehabilitation within CMRN that exceeded 14 days (N 318)	• Collecting more data on those patients discharged during their interruptions - The CMG continue to review all interruptions at the monthly meetings and report any issues or recommendations to our strategic board
Audit of MRI examinations confirming radiographer administration of contrast agent (N 336)	• Staff reminded to detail contrast agent information on radiology computer system
Exploring the prognostic value of electroencephalogram for patients with Hypoxic ischaemic encephalopathy out of hospital cardiac arrest (N 339)	• No actions necessary
Gastrostomy placement: are we meeting NICE guidelines? (N 315)	• Benchmark against referral times/processes in similar settings • Develop flow-chart to inform gastrostomy referral discussions/referrals • Gain consensus on pathway from wider clinical team • Implement flow chart/pathway at WCNN • Present this audit to wider clinical teams • Deliver training at Therapies CPD session • Discuss at CMRN Hub Op meeting • Discuss at SLT/Dietitian team meetings
Audit of acknowledgement of urgent reports (N 353)	• Email team responsible for signing the unsigned report • Audit results to be discussed at next audit meeting with the issue highlighted to clinical leads. Clinical leads to disseminate across their divisions. • Ensure signing off reports promptly is covered during junior doctor's induction either as part of radiology or other (e.g. IT/ep2) presentation.
Evaluating the management team of psychosis and cognitive decline in	• No actions identified

Parkinson's disease patients (N 249)	
Retrospective audit of the clinical use of DaT scan or Dopamine Transporter Scan (DaTscan) at WCFT (N192)	• No actions identified
Transforming MND care (N 363)	**Issue:** Cough effectiveness **Action:** Look into assessing cough peak flow within • clinic observations. • Explore physiotherapy time within follow up clinics to allow further assessment and supportive advice to promote chest clearance and cough effectiveness. • Liaise with the specialist respiratory services to encourage clear communication between our services so we can understand that these assessments have taken place **Issue:** Planning for end of life • **Action:** Identify and discuss referral to community palliative care services for symptom management and end of life planning support. • Liaise with hospices within the locality to discuss previously set up MND Well-Being days supporting local patients with MND (Covid-19 limitations dependent). **Issue:** Nutrition and Gastrostomy • **Action:** Explore the potential for dietetic involvement within the newly diagnosed MND MDT clinic. • Maintain good, effective communication with Gastro services in local DGH. **Issue:** Psychological support • **Action:** Discuss psychology services with the newly appointed service lead to devise a protocol of referral to access specialist psychological support **Issue:** Cognitive assessments • **Action:** OT to explore completing on every patient who attends clinic, to be completed face to face or via Attend Anywhere the following week. • Develop a referral protocol taking into consideration patient presentation and ECAS results. **Issue:** Saliva management **Action:** Set up a specialised secretion clinic for patients with MND who experience saliva difficulties. Led with a specialist SaLT, physio and Neurology Registrar.
Review of standards for reporting and interpretation of ultrasound (NRP 02)	• No actions necessary
Review of standards for reporting and interpretation of fluoroscopy guided lumbar punctures (NRP 08)	• No actions necessary
Audit of CT pulmonary angiograms (NRP 11)	**Issue:** Education/training of staff of CTPA scanning technique • **Action:** Training and refresher sessions. Feedback from Radiologists

	Issue: Endeavour to raise patients arms above their heads whenever it is safe to do so • **Action:** Reminder about technique issued into the monthly brief. Feedback from Radiologists **Issue:** Consider re-evaluating our current local DRL, the use of weight based contrast doses, and breathe hold techniques. • **Action:** Discuss options with Radiologists to trial different techniques
Audit of WHO surgical checklist (NRP 15)	• Principal radiographer will remind staff about the importance of completion of the checklists in its entirety
Audit of standards of communication of radiological reports and fail safe notifications (NRP 20)	• Patient Access Centre manager to monitor the new process carried out by the office staff
Ethnic differences in dystonia prevalence and phenotype (N 321)	• No actions necessary
An audit of the prevalence of screening and brief interventions (SBI) at The Walton Centre regarding patients consumption of alcohol (N 331)	• Dissemination of the audit results to other clinicians
Audit of compliance with mortality and morbidity review policy (N 395)	• Rewrite policy as 'learning form deaths policy' • Appoint governance lead for mortality

Neurosurgery Clinical Audits & Service Evaluations

Audit title	Actions
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
Oral ketamine to support outpatient and inpatient opioid weaning (NSRP 5)	Patient information leaflet developed and 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. Present to the headache group
GlobalSurg/Covid-19 Surg 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

Audit of Patient selection for PCA (NS 312)	Findings from the audit proved conclusively that the measures we have taken have success in mitigating the risks caused by PCA Post-operative admission to a HDU is not necessary in our hospital set up for this group of patients.
Audit of Seizure Kits at The Walton Centre (NS 313)	Provide educational session to new and existing nursing staff on emergency kits in the Trust. Re-in state audit of emergency trollies. Explore the possibility of the Aintree Pharmacy Department re-filling Seizure Kits Review the location of Seizure and Intubation Kits and produce the list of locations and contents of various kits in The Walton Centre
Management and outcome of primary CNS lymphoma (NS 112)	Any patients presenting with symptoms or radiological features suspicious for PCNSL should be admitted, have steroids withheld, and undergo stereotactic biopsy within 7 days. These patients should, subsequently, be referred for oncological therapy within 14 days of a confirmed diagnosis Findings of audit and recommendations to be presented at Neuro-oncology MDT and M&M meeting by June 21
To evaluate the effect of sedation on delirium in ITU patient (NS 362)	As part of our implementation plan, we shall send a gentle reminder email to all clinicians working on Horsley ITU to remind them to document the target the RASS score for every patients requiring sedation
Covid-19 infected patients who undergo surgery (NS 290)	No actions necessary
The historical use of suction drains after cranial neurosurgery at The Walton Centre NHS Foundation Trust (NS 341)	Suction drains aren't to be used for cranioplasty cases Feedback to the Consultants
Audit on Anaesthetic management and outcome of patients undergoing posterior circulation stroke thrombectomy (NS 294)	No recommended actions although there was increased mortality in GA group (50%) when compared to sedation group (0%) in our audit, our sample size was small we could not conclude any one technique is superior to other. There was no observed difference in the outcomes between the GA group and LA/sedation group in a large study of 1200 patients. Some of these patients (58%) were already intubated prior to transfer; therefore we cannot choose a particular technique.
Evaluation of anaesthesia delivered for thrombectomy in 2018 (NS 249)	To develop a guideline for anaesthetic management of thrombectomy and save it in trainee folder on intranet Guidelines to be included in the trainee induction pack

BIOC 155 - CSF samples for xanthochromia pre-analytical requirements audit 2019 (NS 342)	No internal requests were received from WCFT patients during the period of data collection, all requests were referred to us from external Trusts. This meant that we were unable to answer a number of the audit questions as the information was not available to us. For example, in the majority of cases we were unable to ascertain whether the last fraction of CSF collected was referred for xanthochromia analysis as this would all have been handled by the referring lab. If this audit were to be repeated at a later date, we would recommend that the questions be altered to just focus on the areas where we would definitely be able to answer the questions eg. was the sample received protected from light?
Service evaluation to review recognition and management of delayed ischaemic deficit in aneurysmal subarachnoid haemorrhage (NS 285)	Teaching for ward staff and registrars CTA should be requested for all patients who are displaying symptoms that may be reflective of DID – registrar training, all neurovascular CNS to have protocol to request CTA Ward rounds should be thorough and consistent, setting BP and Fluid balance goals each day until patient is stable. All patients with symptomatic DID should be managed in the critical care unit until safe to transfer. Patient care will benefit from management supported by TCDs to minimise the impact of unnecessary prolonged care and use of inotropes, radiological examination and support timely transfer from critical care. Complete fluid balance audit
Assessing if CAM-ICU is being used according to trust guidelines to screen for delirium patients admitted on Horsley ITU and if RASS targets are being achieved for each patients being sedated (NS 362)	Compliance with use of CAM-ICU – reminder email to all nursing staff to use the ICU CAM for all patients with a RASS target of -3 and above Compliance with recording RASS target score – reminder email to all clinicians working on ITU to remind them to document the target RASS score for every patient requiring sedation
HIST/384 Intraoperative Diagnosis versus Final Diagnosis 2020 (NSRP 10)	No actions necessary
Clinical Outcomes Following Re-operations for intracranial meningioma (NS 195)	No action required. Clinicians and patients reach a shared care decision for management of their recurrent symptomatic meningioma. Without further treatment the patient will continue to deteriorate neurologically. This is therefore balanced against the risk of complications and worse performance status, which is higher at re-operation, than at the first operation
Audit of tracheal tube length om ventilated patients on ITU (NS 205)	Discussed at ITU op group, felt the best way of implementing change would be to change the wording on the ITU chart where this daily check is documented to

	include “measured at teeth” where before it read “measured at” leaving this open to interpretation. Once the charts are in circulation. I will send an email to all on Horsley and the ACCP team will inform staff on the daily rounds
Outcomes of surgical management of glioblastomas and cerebral metastases in patients over 75 years old (NS 245)	No actions necessary
Laterality of ACDF (NS 297)	No change of practice is needed as results very much reflect findings in the literature – nil actions
Re-audit of spinal deformity practice (NS 301)	No actions necessary
Immunology vertical audit 2020 - Anti-AChR (NSRP 18)	Technidata to update collating order on worksheet. Review stock levels over periods of absence such as public holidays. Raised as a staff suggestion ES92.To be considered on the next update of the intranet and internet departmental web page.
Seizure Kits audit (NS 313)	Produce a list of emergency kits available in the Trust, their contents, location where they are stored and how they should be refilled/replaced if the seal is broken or the expiry date has passed. The list should be available on the intranet. Explore the possibility of Pharmacy Department replacing used or expired Seizure Kits – update pharmacy will take over supplying seizure kits Re-instate the SMART lead audit of emergency trollies. Information provided to new staff on induction. Cascade of information to existing staff via Ward Managers.
Local Audit of Care at the End of Life (LACEL) (NS 368)	Limited information on previous National Audit of Care at the End of Life, therefore not able to make full direct comparisons to note improvement or areas for development with all aspects of end of life care. To complete in National Audit of End of Life Care Round 3
Managing Perioperative Normothermia (NS 352)	Audit temperature of fluid warming cabinets. Discussion to be had with procurement regarding obtaining surgical access blankets therefore preventing the need for them to be cut.
IMMU/72 How often is a well characterised paraneoplastic anti-neuronal antibody identified in a regional neurological centre (NS 272)	No actions necessary
Clinical Management: Perioperative patient care, Post-anaesthetic Care 2020 (NS 351)	The Environmental temperature of Recovery is not always between 19-22 degrees for adequate ventilation – heating systems now upgraded by estates, additional heaters can also be provided

	No universal Padded cot sides available. Blankets to be used instead to pad cot sides
Development of a prognostic score to reduce avoidable referrals for mild Traumatic Brain Injury (TBI) (NS 246)	Submit ethical approval/audit approval for prospective testing of the score Notify audit department when accepted paper has been published Begin plans to develop long-term prospective study of the scoring system
HTA 63 Traceability 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 National External Quality Assurance Scheme (NEQAS) back with the original case rather than in a separate EQA file reinforced with staff. Monitor return of slides from Haematological Oncology Diagnostic Service (HODS) in next audit following the service move earlier this year. Neuropathology staff to add haematoxylin and eosin (H&E) to the Laboratory Information Management System (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.
Coroner's and Hospital Post Mortems Horizontal Audit 2020 (NSRP16**)**	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. The three senior members of staff are now on a monthly rota to ensure respectful disposals are arranged promptly. A database is currently being updated to record when wet tissue has been retained – this database is still not active currently, work is on-going to implement a database to incorporate retention/disposal and return of post mortem material.
HTA 71 Research Ethics Committee (REC) & Regional Governance Committee (RGC) Approvals Audit 2020 (NSRP 15)	No actions necessary
HTA 72 Research Request Forms R2 & R3 Horizontal Audit 2020 (NSRP 13)	No actions necessary

Management of specimens in theatre audit (NS 350)	For all Theatre Staff to be aware of importance confirming patient details are correct on specimen container The Labels should be affixed properly before placing specimen in container
Outcome of patients with lung cancer and brain mets (NS 360)	Tell people about the problem – Presentations Conventional cytotoxic chemotherapy (CCC) complete, also WCFT, and CCC Scottish Referral Guidelines (SRG), and British Neuro Oncology Society (BNOS) proposed as well as a publication Consider new pathway - New pathway agreement which can go through the CQG. Assessment of compliance - Reaudit after pathway running for > 1 yr
Specimen Acceptance Policy Horizontal Audit 2021 (NSRP 6)	Essential information not complete in 69% of Neuropathology request forms. On-going Trust wide actions to implement an electronic order communications requesting system.
Imaging timing after surgery for glioblastoma- an evaluation of practice in Great Britain (INTERVAL-GB)- Liverpool pilot study (NS 370)	Low compliance to 72hr MRI scan after surgery - Inform surgeons of the need to scan patients, and re-audit in 3-6 months, additional slot capacity in radiology made.
HIST 313 Surgical Vertical Audit 2019 (NSRP 1)	Information on request form not completed by clinicians, Tracey Rowan to email theatre staff to ensure all forms are properly completed
HIST 332 Surgical Vertical Audit 2020 (NSRP 1)	No action necessary
LNBW11 Research Consent forms Audit 2020 (NSRP 14)	Incomplete consent forms – contact specialist nurses and retrospectively complete consent forms The correct colour (white forms) of completed Walton Research Tissue Bank consent forms are not being sent to the labs – contact theatre staff and give reminder that white copy of completed consent forms is for Liverpool Neuroscience Biobank, blue for patient notes and pink for the patients as mentioned in the protocol, as a refresher
28 Day Faster Diagnosis Patient Pathway (NS 175)	2 week wait referrals are not current triaged, leading to inappropriate referrals being tracked on a cancer pathway, increasing the risk of breach to Faster Diagnosis Standards (FDS) & other relevant cancer pathways - Discuss with consultant about the need for clinical triage of 2 week wait referrals The audit highlighted that in the majority of records, it was not clearly documented that these patients were referred via a 2 week wait pathway - Meet with records and PAC to discuss a mode for easy identification of referral status

	For some tumour diagnoses (meningioma, low grade glioma), it was not clear what the patient had been informed i.e. cancer or not cancer - Discuss in cancer services with Neuro-oncology Surgeons Clarity of clinical documentation in clinic letters - To be discussed in Neurology Consultants meeting and cancer services
Initiation of anti-epileptic (AED) therapy post head injury (NS 209)	Develop guidance in conjunction with Consultants – action developed into a clinical trial, MAST, to randomise patients after head injury to certain anti-epileptic treatment Dissemination of audit to relevant team
rTMS for neuropathic pain: Patient Reported Outcomes about, Pain, Function and Quality of Life. (NS 218)	Review non-responders and responders in more detail. Brain connectome analysis in process as part of MRes project Meeting with psychiatry and alder hey neurosurgeons to finalise potential SLA to make transcranial magnetic stimulation (TMS) financially viable
Long Term Survivors of Glioblastoma (NS 224)	Under documentation of performance status, to add a field for performance status in a pre-existent electronic form for GBM patients Under documentation of radiological parameters –discuss at MDT AGM how to take forward To incorporate all outcome forms into EP2 and add in variable
Clinical Management: Perioperative patient care, Post-anaesthetic Care 2018 (NS 227)	Recovery temperature – estates and heating system upgrade completed and additional heaters provided if needed Look to purchase padded cot sides – unable to purchase as no universal cot sides available
Anaesthesia in theatre (NS 231)	There is no explicit local guidance that supports anaesthetic practitioners to prepare emergency/exceptional circumstances - Discuss with LODP team leader and LODP for Education.
Omission and delay of critical medicines in neurocritical care (NS 304)	Raise awareness of critical medicines – list of critical medicines to be incorporated into each patient's bedside folder Raise awareness of issues leading to inappropriate omission/delay of critical medicines – pharmacy bulletin to be emailed to ITU staff in Horsley internal newsletter summarising audit findings and outcomes Re-audit 6 monthly
Outcomes of patients with GBM treated at WCFT in 2019 (NS 317)	Increase use of 5 ALA – continue to support and suggest 5 ALA use in Neuro-oncology MDT Improve outcomes for tumour patients – discuss treatments in MDT and increase enrolment into clinical trials

Use of Handling of surgical instruments (NS 349)	To ensure all new staff have completed the educational packs and competencies
Comparison of Clinical Outcomes For The Online Pain Management Programme (PMP) Compared To Previous Face to Face Outcomes (NS 394)	Lack of existing published data on online pain management programmes – write up audit for publication Lack of 6 month follow up data - Examine outcomes of follow up data and compare with face to face Develop assessment guidance document to improve assessment decision making when deciding treatment planning
Traceability Audit 2020 (NSRP 19)	Slide unaccounted for. Differing uses of fail and repeat code. - Clarification of fail and repeat process as not currently defined Additional slides not recorded on LIMS. Referral stains not recorded in LIMS - Clarification of process for recording stains performed elsewhere as not currently defined. Tracers not included in file - Staff reminded to include tracers in file
Review of overall activity regarding shunt admissions and procedure at WCNN during 01.04.2019 – 31.03.2020 (re-audit) (NS 322)	N/A - shunt procedures completed from 2020 onwards will have been prospectively added onto the UKSR as outlined in the SOP; which will further increase compliance with reporting into the future
Accountable Items, Swabs Instruments and needle count (NS 355)	Discuss with Staff the importance of the Theatre Team engaging when counts are being performed. Discuss with Scrub Staff the importance of informing the Surgeon that count is correct before closure of a cavity To note, swab count compliance is documented on the local risk register and highlighted as part of WHO checklist
Antimicrobial Stewardship (NS 364)	Disseminate audit findings and recommendations to ITU/Microbiology MDT Stop / duration / review dates omitted in 50% of prescriptions. Indication documented in 89% - reminders to ITU prescribers to document a duration / review / stop date /indication on prescription kardex. Limited utilisation of Micro Tracker form to document – encourage use of micro tracker form on ward round Set re-audit review date
Audit of quality of reporting peripheral nerve biopsies at The Walton Centre. (NS 385)	Assessment of endoneurial inflammatory reaction, particularly in relation to vasculature. While describing endoneurial cellular infiltrates specific comments to be added as to their relation with the endoneurial vasculature or not.

	Information of material available for electron microscopy. Nerve report template to incorporate this information under macroscopy. Existing nerve panel - This requires changing in line with that suggested by RCPath.
Central line insertion documentation audit / Re-audit of CVC LocSIPPs' documentation adherence (NS 390)	Continue to adhere to the CVC LOCCSSIP forms when performing CVC insertion, reminders to all appropriate staff to fill in the during procedure section, presentation and discussion has been made during the audit meeting Re-audit to check compliance
The Use of Electrosurgery (NS 353)	Presently no smoke evacuators in Theatre when using monopolar diathermy - theatres have acquired filters that project the suction equipment. Conventional suction still used to clear smoke, ideally the device is attached to the diathermy – options being trialled at the moment, surgeons are finding "bulky". To note, the danger of surgical smoke is also due in parliament in due course

Trust wide Clinical Audits & Service Evaluations

Audit title	Actions
Review of documentation and compliance utilising MCA audit tool against current mental capacity act policy	• To continue to provide supplementary training, additional to the Trust mandatory on line module for MCA. The supplementary training is to be updated to include a focus on Trust MCA/Best Interests documentation, in order to promote discussion around the required standard of documentation and information to be recorded on the documents. • Hill Dickinson to provide bespoke training for Medical staff regarding MCA and best interest decision making – a focus on complex cases

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 2021/22 that were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority was 489.

Due to the impact of Covid-19 no yearly target was set for this financial year, however an approach was developed to manage our research delivery portfolio during the pandemic.

This has enabled us achieve our high level objective of determining a plan of upcoming research studies and closing smaller studies, allowing us to shape a financial plan and taken on the decision of which research projects to implement.

In total there are currently 86 clinical studies open to recruitment at The Walton Centre, with a research pipeline of new studies in the set-up phase (in total 50) that will be ready to open at different points throughout the latter part of this year into early 2023.

Having secured local collaborations, the Neuroscience Research Centre (NRC) patients now have access to participate in Phase 1 clinical trials these trials are offered to our patients with Parkinson Disease and Huntington's disease and are conducted at a specialist clinical research facility.

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.

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 2021/22 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) - SPARK
- 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
- Spinal Network
- Stroke Network
- Other NHS organisations
- Pharmaceutical companies (industry)

The collaboration with Liverpool Health Partners. Liverpool Health Partners is a thriving network of 12 world-leading organisations who are working together to develop ground-breaking research, and we are delighted to be part of such an innovative approach to offering wider access to clinical trials for our patients.

2.3.7 CQUIN Framework & Performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. Due to the Covid-19 pandemic all CQUIN activity was suspended. CQUINS have been circulated for the forthcoming year.

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 2021/22. The CQC undertook an inspection, including well led, during March and April 2019, which resulted in an Outstanding status for the second time.

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 2021/22 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 (January 2022) which included the patient's valid NHS Number was:

99.9% for admitted patient care

99.9% for outpatient care

The percentage of records in the published data (January 2022) which included the patient's valid General Practitioner Registration Code was:

99.9% for outpatient care

100% for admitted patient care

This year is the fourth year of the new Data Security and Protection Toolkit. The Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health Policy. Within the Toolkit there are 38 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 2022. This deadline was extended in line with Covid-19 and will now remain as the new submission date for future years.

The Trust has implemented action plans to aim 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 21-22 DS&P audit requirements is currently ongoing throughout March and April 2022 and the Trust will then receive the outcome of this review in May 2022.

The latest figures from the NHS Information Centre 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 2021/2022

Coding Field	2020/21	2021/22	Difference	Mandatory	Advisory
Primary diagnosis	91.00%	96.70%	+5.70%	90%	95%
Secondary diagnosis	86.00%	94.14%	+8.14%	80%	90%
Primary procedure	97.00%	99.40%	+2.40%	90%	95%
Secondary procedure	98.00%	93.87%	-4.13%	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 2021/22, 64 of The Walton Centre patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 12 in the first quarter
- 21 in the second quarter
- 14 in the third quarter
- 17 in the fourth quarter

By 31st March 2022, 58 case record reviews have been carried out in relation to 64 of the deaths included in item 2.3.10.1. Six 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:

- 12 in the first quarter
- 21 in the second quarter
- 14 in the third quarter
- 11 in the fourth quarter

2.3.10.2 0 representing 0% 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.

In relation to each quarter, this consisted of:

- 0 representing 0% for the first quarter
- 0 representing 0% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% 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.

0 case record reviews and 0 investigations completed after 31.03.21 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 (6 cases awaiting review).

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-19 pandemic, but there are plans to re-audit this during 2022.

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) 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, but since the onset of the Covid-19 pandemic there has at times been a need to intentionally relax these criteria as part of mutual aid to the acute Trusts in our region. 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 is also a FTSU Champion 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. The policy provides details of who to contact within the Trust or externally if they wish to raise a concern. Staff are encouraged to raise their concern with their line manager but they may wish to raise their concern outside of their team. If this is the preferred route they can contact HR, have a concern.

Staff may We recognise that our staff, including leaders, may experience barriers at any part of the speak up cycle that may require staff to seek support outside of their team or line management routes. If staff make use of the FTSU service for support, we might also sign-post to other services within the Trust such as Equality, Diversity & Inclusion, Unions, HR, Occupational Health, Occupational Health, Anti-Fraud Specialist, to name a few.

Regular contact is made with those who speak up and other parties to ensure progress is being made in terms of a resolution. This also safeguards the person/team who raised the concern from experiencing detriment. Once a concern has been addressed and appropriate action the FTSUG meets with the concern raiser and closes the concern with the agreemen of the person who spoke up. They are also asked to make contact with the FTSUG if they perceive to be treated unfairly following them speaking up.

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 questioned whether they had any concerns they wished to raise. This was important to ensure that staff had a voice, at a time when people were feeling vulnerable nationally due to the pandemic.

2.3.13 NHS Doctors in Training

On average the Trust has approximately 52 HEE trainees on rotation at any one time that comply with Terms and Conditions for NHS Doctors and Dentists in Training (England) 2016. Some do not partake in any out of hours duties and therefore can be supernumerary to the service delivery, therefore if we have a gap for daytime duties only it will not have a detriment effect on patient care as they are supernumerary to the workforce and there for training purposes.

Where a trainee is integral to the out of hours rota's then the Trust will make arranges to either employ a Locally Employed doctor to fill the daytime and out of hours or in the interim until it can be recruited to via NHS Jobs an agency locum or internal locum cover will be considered.

The Trust also employs Clinical Fellows to supplement the trainee workforce and support both the elective and emergency work. The Medical HR Manager together with the Clinical and Divisional Mangers monitor the rotation periods and if additional doctors are required then action will be taken to recruit.

We have not had any exception reports against any gap in recruitment.

Part 3 Trust Overview of Quality 2021/22

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2021/22.

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	2019/20	2020/21	2021/22	National Trajectory
C Difficile	5	3	8	5
MRSA Bacteraemia	0	0	0	0
Ecoli	13	7	11	11
Minor and Moderate Falls	37	19	30	n/a
Never Events	1	0	2	n/a
Data Source: Infection Prevention and Control NHSE Set following review of previous years' performance using NHSE national calculation				

Clinical Effectiveness Indicators

Mortality	2019/20	2020/21	2021/22
Neoplasms	13	7	8
Diseases of circulatory system	36	52	23
Injury, poisoning and certain other consequences of external causes	29	27	24
Diseases of the nervous system	9	15	7
Other	6	10	2
Total	93	111	64
Data Source: Patient Administration System			

The Trust reviewed how the data for the clinical effectiveness indicators was being reported. Previously the data was repored under specialities which has since been amended so that the data is reported under groupings by diagnosis chapters which is in line with external data reporting.

Patient Experience Indicators

Patient Experience Questions	2019/20	2020/21	2021/22
Were you involved as much as you wanted to be in decisions about your care and treatment?	95%	89%	89%
Overall did you feel you were you treated with respect and dignity while you were in the hospital?	99%	99%	93%
Were you given enough privacy when discussing your condition or treatment?	94%	84%	99%
Did you find someone (hospital staff) to talk to about your worries and fears?	82%	93%	93%
Data Source: CQC Adult Inpatient Survey 2021			

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 this was particularly tough during a pandemic when visiting restrictions continued. The Patient & Family Experience Team (PET) provides a confidential support and advice service to patients, their families and carers, as well as helping to resolve enquiries and concerns and complaints 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, in writing, book an appointment 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 if these have been identified and 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
- Provided support to families who struggled with visiting arrangements and escalated concerns on their behalf
- Continued to support and engage with volunteers and safely re-introduce them into roles into the trust in line with infection prevention guidance and precautions
- Ensuring all volunteers receive adequate training and support before resuming in roles
- Reviewed and enhanced the complaints management process including implementing a local resolution pro-forma and responded to all concerns and complaints within the Trusts KPIs
- Proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meeting prior to discharge
- Continued with supporting virtual visiting with large activity screens and Letters to Loved Ones which enabled families to stay in touch with their loved ones during the visiting restrictions.
- Provide bi-monthly assurance to Trust Board by presenting complaints data/trends and analysis
- Introduced new initiatives including: Birthday Gifts/cards/visits for inpatients, so no patient is forgotten on their birthday, Sleep Well packs for inpatients all initiatives supported by The Walton Charity and Connecting hearts for memory boxes
- Applied for external funding from NHSI for a 12 month project and developed 7 day role for Patient Support Assistants to provide support for patients/families and bridge the gap between ward and Patient Experience Team. The aim of this service is to support new and existing volunteers returning to clinical areas and improve communication between patients and families

- Facilitated external engagement events in partnership with Healthwatch to gain and act on feedback provided from patients and groups who represented them
- Developed the process for an improved death certification/coronial/Medical Examiner referral pathway in partnership with LUHFT. The aim of this service is to improve communication and prevent delays to bereaved families. This will also support ward staff in addition to offering assurance to the Board that the Trust adhere to national standards identified in the Learning from Deaths Guidance.
- As part of the Mortality Governance Lead role/PET developed a pathway to proactively provide family support following a death
- Developed a process in collaboration with the Communications Team for the Trust Board to receive a patient story either video formal or live via MS Teams from each of the different service lines at each Board meeting.
- Ontinued education and support provided to junior drs and consultants in relation to good practice/documentation and when required to provide input into coronial enquiries-inquests and claims
- High level learning from complaints/claims/coronial inquests and enquires share in quarterly governance bulletin

3.1.2 Complaints Management and Lessons Learnt

The Patient Experience team work proactively in collaboration with the Neurosurgical and Neurology Division and Senior Nursing Team in order to manage complaints in an aim to meet the needs of each individual patient or family member. This may involve meeting with patients or family members 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 triage and consideration. Each concern and complaint receives an appropriate investigation and complainants receive their response in their preferred format. This can be in a telephone call to give them an opportunity for further discussion, or response from the Patient Experience team via email or letter. All formal complaints are responded to by the Chief Executive and/or complainants may be offered a meeting with the senior staff from the respective division, supported by the Patient Experience Team.

In June 2021, Merseyside Internal Audit awarded the Trust High Assurance following an external audit related to the complaints process as they identified there is a strong system of internal control which has been effectively designed to meet the system objective and noted that the Trust's controls were consistently applied in all areas reviewed. This was following a previous review of the complaints management process.

The last 12 months have demonstrated that the complaints process is robustly 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 appropriate investigations are in progress and to ensure timeframes are met. Every effort is made to ensure that responses are comprehensive and that any lessons are learnt are outlines within the response. 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, themes and lessons learnt are discussed in detail in the Governance, Risk and Patient Experience Quarterly report which is presented to Quality Committee. This report is also presented externally at our Specialist Commissioners meeting. Any trends in subject, operator or area of concern identified from complaints/concerns 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 the team and feedback from those who have used the complaints process is used to help us improve and shape the service we provide. Compliments received following a concern or complaint are recorded on Datix as the team often receive feedback regarding the level of support they have received from the team during the process.

Examples of lessons learnt from complaints during 2021/22 include reviewed administration processes and letters on the Patient Administration System (PAS) and developing a letter to send when patients are added to the waiting list to improve communication and appointment arrangements. Reviewed processes to improve patient care and dignity for inpatients. Recruitment of Patient Support Assistants to a 12 month project working across wards providing a 7 day service to provide support and improve communication with patients ensuring swift escalation of any concerns to the Patient Support Team.

3.1.3 Complaints Activity

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

- 76 new complaints were received in 2021/2022, Q1(16), Q2 (16), Q3 (22), Q4 (22) which is a 13% increase from 67 in 2020/2021. This is still a significant improvement compared to previous financial years (129 in 2019/20)
- There has been a significant increase in concerns (44%) and enquiries (17%) which were effectively investigated and responded to by the Patient Experience Team to prevent escalation
- Response time for formal complaints continues to be significantly reduced in comparison to previous years (57 working days in 2019/20) with an average response time at 23 working days which is an excellent outcome below the 25-working day target demonstrating robust management processes
- The aim is to continue to reduce the number of complaints in 2022/23 by proactively resolving concerns at the earliest opportunity and by continuing to embed actions and lessons learnt
- The Trust aim to improve on response times

Complaints received 01 April 2021 – 31 March 2022

	Quarter 1 April–June 21	**Quarter 2** July–Sept 21	**Quarter 3** Oct– Dec 21	**Quarter 4** Jan–Mar 22
Number of new complaints received	16	16	22	22

The slight increase in complaints is not surprising and in keeping with the current pressures on the NHS, as trends included appointment arrangements, waiting times and communication. It is reassuring to note that 100% of complaints were responded to within the Trust's KPI timeframe and there was a noted improvement in average response times. A key element of the person and family centred care approach is focusing on the individual outcomes patients and families are seeking when they raise concerns. The Patient Experience Team acknowledges all complaints and agrees the best way of addressing their concerns, in line with managing expectations. 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 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 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 Trust's Quality Strategy (2019-2024) aims to improve on the quality of care provided for patients and their families and reduce avoidable harm however Covid-19 has changed how we work and care for our patients. It is for this reason that we have been working with our staff to launch a new strategy for 2022 onwards to identify new ways to deliver outstanding care.

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 NHSX Digital Aspirant funding will mean more integrated health care for Walton Centre patients

NHSX announced The Walton Centre NHSFT 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.
The country's only specialist neurosciences trust is one of seven organisations to receive up to six million pounds each over the next three years to help deliver digital ambitions.

3.5 MS Awareness Week - FACETS programme

Virtual FACETS programme was launched which has since received very positive feedback. The online programme was provided as patients were unable to attend in person due to Covid-19. As the UK's only specialist Trust dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services, The Walton Centre have one of the biggest Multiple Sclerosis services in the country. It integrates elements from cognitive behavioural, social-cognitive, energy effectiveness, self-management and self-efficacy theories. To mark MS Awareness Week a Senior Occupational Therapist worked in the Multiple Sclerosis team and two Occupational Therapists ran the FACETS programme supporting patients to learn how to self-manage fatigue.

3.6 New spinal clinic in North Wales brings care closer to home

The Walton Centre has extended satellite spinal clinics in North Wales for the first time. The Trust is working alongside the Robert Jones and Agnes Hunt NHS Foundation Trust to bring care for spinal patients closer to home. As part of the Trusts Care Close to Home Initiative,

bringing clinics to some of the more remote regions the hospital serves, means less travel and more meeting with clinicians, which is often a stressful occurrence, in a familiar setting.

3.7 Families continue save and improve lives through deceased organ donation

Figures revealed that The Walton Centre is one of the top 20 centres for organ donation last year. 17 patients who passed away at the hospital became organ donors, contributing to the national effort to save or improve the lives of 3,391 people desperately in need of a transplant in the UK. NHS Blood and Transplant and The Walton Centre have released the figures to mark the publication of the annual Transplant Activity Report.

3.8 Staff and supporters take a leap of faith for charity

A team of 21 staff and supporters took a leap of faith and abseiled 150 feet down the Liverpool Cathedral to raise money for The Walton Centre Charity and support excellence in neuroscience, and patient treatment and care. Donations of over £5,000 went towards the Home from Home relatives' accommodation at The Walton Centre where relatives can stay after a patient has been admitted for urgent treatment.

3.9 Making it to the Tokyo Olympic Games – with help from The Walton Centre

One of Team GB's Lead Physiotherapists made it to the 2021 Tokyo Olympics, thanks to The Walton Centre effectively treating his Cluster Headaches. Cluster headache can completely take over normal life and cause severe sleep disruption, mood disturbance, fatigue and difficulties with normal concentration. The Trust actively engages in the pursuit and research of new treatments to offer patients increased options to manage their disorder successfully.

3.10 Patient drinks innovative 'pink drink' to help surgeon remove brain tumour

A study involving a drink (the Pink Drink) which helps surgeons distinguish between healthy tissue and a tumour, which can be difficult to do with brain tissue, called 5-ALA (branded as Gliolan), is diluted in water and drunk by the patient prior to surgery. The 5-ALA is absorbed into the bloodstream and carried to the brain and the tumour. Under blue ultraviolet light, the solution makes the tumour glow pink or red, showing the surgeon where the edges of the tumour are. By using the drink more cancerous tissue can be removed therefore improving the patient's chances of survival.

3.11 International Nurses make The Walton Centre their home

Registered nurses from Asia and India arrived to work at The Walton Centre. In the weeks following their arrival they underwent intensive training and gaining additional qualifications to ensure they have the specific skills to care for our patients to a high standard. The recruitment is part of a regional incentive to encourage international nurses to work in the North West.

3.12 The Walton Centre awarded Tessa Jowell Centre of Excellence Status

The Walton Centre NHS Foundation Trust, alongside the Clatterbridge Cancer Centre NHS Foundation Trust and the North Wales Cancer Treatment Centre, has been awarded Centre of Excellence status after rigorous assessments led by experts from the Tessa Jowell Brain

Cancer Mission (TJBCM). The entire team works extremely hard to deliver the best possible wrap-around care for all the 500 brain tumour patients and their families treated at The Walton Centre each year.

3.13 New neurology assessment eases bed pressures in Cheshire and Merseyside

The Rapid Access to Neurology Assessment (RANA) service, developed by clinicians at The Walton Centre, provides patients with direct access to expert neurologists when they visit Emergency Departments with neurological signs and symptoms. The vast majority of acute inpatient referral requests from partner hospitals can be a range of common neurological disorders, from migraines and seizures to functional disorders and sensory disturbance. Before RANA, these patients would often be admitted and have to wait for a visiting neurologist, who would assess them and in most cases discharge them and agree next steps. I saw that we could improve this process and free up much needed beds in emergency departments across the region.

3.14 Enhanced Thrombectomy service

The Walton Centre enhanced the Thrombectomy service to run 24 hours a day seven days a week, enabling hospitals in the region to refer to the service at any time. Thrombectomy is an innovative procedure which involves using guide wires and specialist equipment to remove blood clots from arteries and veins in the brain.

3.15 The Walton Centre and UCLan lead pilot study into innovative digital stroke rehab tool

The Virtual Engagement Rehabilitation Assistant (VERA) is a bespoke digital tool being developed by The Walton Centre NHS Foundation Trust and Citrus Suite software company, with research, funded by The Stroke Association and MedCity, led by the University of Central Lancashire (UCLan). Through an individualised programme, VERA aims to vastly improve patient recovery and how survivors adapt to life after a stroke. It allows mobile devices to access a range of applications to support rehabilitation and provides patient information, images and videos to guide bespoke personalised exercises, treatment information, a daily schedule and support.

3.16 Overview of Performance in 2021/22 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	2021/22 Performance	2021/22 Target	2020/21 Performance
Incidence of MRSA	0	0	0
Screening all in-patients for MRSA	97.94%	95%	96.55%
Incidence of Clostridium difficile	8	5	7
All Cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery	100%	94%	100%
All Cancers: 62 days wait for 1st treatment from urgent GP referral to treatment	100%	85%	100%
All Cancers: Max 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	100%	93%	98.9%
All Cancers: 28 Day Faster Diagnosis	98.75%	75%	N/A
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	0.30%	1%	19.33%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Fully Compliant		

3.17 Overview of Performance in 2021/22 against NHS Outcomes Framework

The Department of Health and NHSE/I 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 2021/22 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
2020/21	139	4.25%
2021/22	201	4.56%
Change	N/A	0.31%

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:

- The Trust is required to participate in the CQC National Inpatient Survey annually to allow benchmarking of the patients' experience with other NHS providers. The survey is recognised as being a key indicator of overall care for the organisation and regulators, including the CQC and commissioners. Picker Institute was commissioned by The Walton Centre together with 75 other NHS organisations to collate and present the organisation's results for each Trust
- The Walton Centre has been identified as performing 'Better Than Expected' because our patients answered positively about their care across the entire survey and this was significantly above all other Trust averages. The results highlight a 56% response rate (previously 50%, with an average response rate of 45% for other organisations and the Trust scored much better, better or somewhat better for 9 out of 10 sections of the survey. This is remarkably positive and especially as this was during the Covid-19 pandemic
- The Trust was rated 8th out of 75 Trusts of those using Picker for overall positive score, which is an improvement in rank from last year (9th). 78 of respondents said they had a long term condition

National Inpatient Survey Question	2017 Result	2018 National Comparison	2019 Result	2020 Result	2021 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	89% Better	Due Sept/Oct 22
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	93% Better	Due Sept/ Oct 22
3. Were you given enough privacy when discussing your condition or treatment?	8.6	About the same	Slightly worse	84% Better	Due Sept/ Oct 22
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.1	About the same	Better	92% Much better	Due Sept/ Oct 22
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.7	Better	Better	91% Much Better	Due Sept/ Oct 22

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

Friends and Family Test (FFT) - the Trust continued to meet internal targets of 30% response rate for inpatients with an overall annual rate of 40.1% and a recommended rate of 97.96% which is excellent. For outpatients, the internal target of 90% recommended rate was exceeded at 91.22% with a response rate of 3.5%. Outpatient FFT post cards were only reintroduced at the end of January 2022 due to infection prevention precautions in line with Covid-19 restrictions and guidance.

A digital platform was introduced for patients who have attended a virtual appointment via Attend Anywhere and they are able to provide real-time feedback following this appointment.

In addition, posters with QR codes have been placed in all clinical areas for patients so they are able to scan and provide feedback at their convenience and with the introduction of the Patient Support Assistants within the Patient Experience Team they support patients complete FFT digitally with a smart phone. This service has recently been extended to our radiology and neurophysiology services to enable them to provide real-time feedback.

Patient Experience Initiatives

- The introduction of the digital platform for FFT has been extended from the ward areas to radiology and neurophysiology so they can encourage patients to provide feedback on the services.
- The complaints policy and process was reviewed in 2021. Merseyside internal audit awarded the Trust High Assurance for complaints management. this followed an external audit which identified that the Trust has a strong system of internal control which have been effectively designed to meet the system objectives and noted that controls were consistently applied.
- Engagement with Divisions to implement escalation process to support staff in resolving concerns in the first instance
- In 2021 bespoke complaints training/support provided for specific teams which has been extended to all teams upon request
- Patients, families and staff stories in various formats are presented to Trust Board, and other committees such as Quality Committee. These can be verbally read on behalf of the patient, via live video link or recorded video to share their lived experience. Patient stories are identified from each of the difference service lines to be presented. The content may be positive, negative or indifferent, as it is recognised that it is important to share exactly how it was for the patient in their words so the impact of their experience can be heard. For 2022/23 there is a plan for the Board to receive a story from a different service line each month supported by the Patient Experience and Communications Teams. The story will be presented in a format that is preferable to the patient, and they will be invited to attend virtually if they feel able to do so. This will enable a Q&A session after each story.
- Qualitative feedback from friends and family test shared in poster format with ward managers on a monthly basis, including negative comments in order for them to action
- Engagement Events with external stakeholders including Healthwatch
- Sleep-well packs developed for inpatients containing sleep masks/ear plugs
- Implemented new contact form on website
- Introduction of 7 day service of Patient Support Assistants (PFAs) in ward areas to provide emotional and practical support to patients with the aim of improving communication and escalating any concerns to prevent escalation. PFAs identifiable with uniforms and have a mobile phone to support patients communication with their families.
- Review of mortality process and engagement with bereaved relatives at earliest opportunity and introduction of Memory Boxes for relatives.
- Implementation of Birthday Cards for inpatients supported by charities

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

To continually review and embed new patient experience initiatives and embed patient & family centred care.

The Walton Centre has taken the following initative to furter improve this quality indicator and so the quality of its services, by:

- Developing a business case for the Patient Suppport Assistant to be permanenr role within the Patient Experience Team to continue to enhance and develop patient experience
- Develop Patient Experience Training to teams across the Trust including administration and the Cheshire & Mersey Rehab Network
- Continue to develop initiatives to improve FFT scores and feedback

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

Response:

The Trust had a response rate of 41% for the 2021 national staff survey; the national average for acute specialist trusts in England for 2021 was 54%.

Within the survey, the percentage of staff who would recommend the Trust as a place to work scored 68.9% against an average of 70.7%. and the percentage of staff who would recommend the Trust as a place to receive treatment scored 88.7% against an average of 89.6%.

The findings for 2021 are arranged in the form of People Promises, there are seven people promises and two themes as follows:

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

The Trust scored significantly better in 16 questions than the benchmarking sector, significantly worse in 3 and 80 questions showed no significant difference.

Ranked People Promises

NHS People Promise:
This is a national promise all staff make across the NHS to each other – to work together to improve the experience of working in the NHS for everyone. The themes and words that

make up the People Promise have come from those who work in the NHS in the form of the above seven promises.

The 2021 staff survey ranked these promises from 1 to 7 for the Trust which are shown below. People Promises can be considered as summary scores for groups of questions which, when taken together, give more information about a particular area. They are presented as scale scores (on a scale of 0 to 10).

1	People Promise 1	We are compassionate and inclusive	7.58
2	People Promise 3	We each have a voice that counts	7.18
3	People Promise 7	We are a team	6.91
4	People Promise 6	We work flexibly	6.51
5	People Promise 4	We are safe and healthy	6.36
6	People Promise 2	We are recognised and rewarded	6.13
7	People Promise 5	We are always learning	5.45

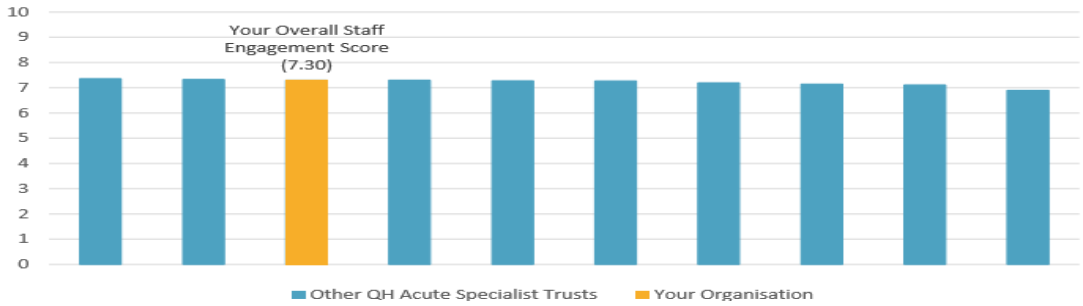
Staff Engagement

Staff Engagement is measured across three sub scores:

- Motivation,
- Involvement
- Advocacy

Overall Staff Engagement is measured as an average across these three scores. Staff Engagement scores fall between 0 and 10, where the higher the score, the more engaged the staff.

Presented in the chart below is the range of Overall Staff Engagement Scores across the Acute Specialist sector, shown in ranking order. The Trusts organisation's score is (7.30) and its position within the sector is marked orange. The blue bars represent the scores of other organisations within the sector.



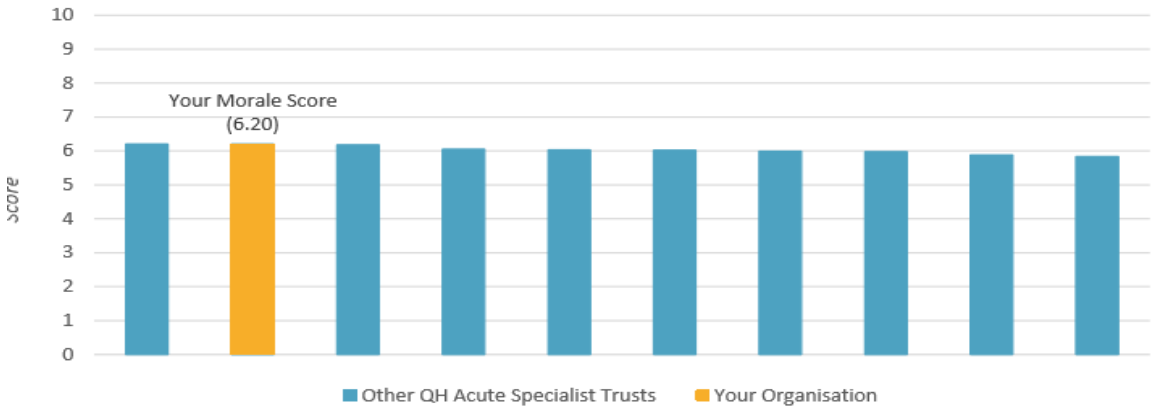
Morale

Morale is measured across three sub-scores:

- Thinking about leaving
- Work pressure
- Stressors

Morale is measured as an average across these three scores. Morale scores fall between 0 and 10, where the higher the score, the higher the morale amongst staff.

Presented in the chart below is the range of Morale scores across the Acute Specialist sector, shown in ranking order. The Trusts score is (6.20) and its position within the sector is marked orange. The blue bars represent the scores of other organisations within the sector.



Top and Bottom Question Scores

The top ten scores for the Trust in the 2021 survey are:

1	13b	In the last 12 months I have personally experienced physical violence at work from managers.	0%
2	13c	In the last 12 months I have personally experienced physical violence at work from other colleagues.	1%
3	16c03	Experienced discrimination on grounds of religion.	3%
4	16a	In the last 12 months I have personally experienced discrimination at work from patients / service users, their relatives or other members of the public.	4%
5	16c04	Experienced discrimination on grounds of sexual orientation.	6%
6	3b	I am trusted to do my job.	92%
7	14b	In the last 12 months I have personally experienced harassment, bullying or abuse at work from managers.	8%
8	16b	In the last 12 months I have personally experienced discrimination at work from a manager / team leader or other colleagues.	9%
9	16c05	Experienced discrimination on grounds of disability.	10%
10	21d	If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	89%

The bottom ten scores for the Trust in the 2021 survey are:

1	12e	I often/always feel worn out at the end of my working day/shift.	40%
2	12c	My work often/always frustrates me.	35%
3	19b	The appraisal/review helped me to improve how I do my job.	23%
4	12a	I often/always find my work emotionally exhausting.	32%
5	19d	The appraisal/review left me feeling that my work is valued by my organisation.	31%
6	5a	I have unrealistic time pressures (Never/Rarely).	32%
7	12b	I often/always feel burnt out because of my work.	33%
8	19c	The appraisal/review helped me agree clear objectives for my work.	35%
9	4c	I am satisfied with my level of pay.	37%
10	12g	I do not have enough energy for family and friends during leisure time (often/always).	28%

In addition to the annual staff survey, a pulse survey took place in April and July 2021 and January 2022. The purpose of these is to take a temperature check of how staff are feeling and in particular to assess how likely employees are to recommend The Walton Centre as a place to work and also as a place to receive treatment.

In April 2021 the results showed that 88.2% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 62.7% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

In July 2021 the results showed that 88.7% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 68% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

In January 2022 the results showed that 86.8% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 63.2% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

WRES/WDES

- Abuse by patients: above average experiences of abuse by service users. 25.1%white vs 21.6% BME
- Abuse from staff: below average for white, above for BME. 19.7% white vs 33.3% BME
- Equal career opps: on average for both white and BME (falling for white – getting worse) Only 45% of BME feel that they have equal career opportunities
- Discrimination from managers: increased for white, and BME/ - up 5% for BME

WDES Headlines The Walton Centre

- Abuse by patients: above average experiences of abuse by service users – above average for both staff groups, worse than last year
- Abuse from managers: fallen for both groups, below average - 3% worse for those with disabilities
- Abuse from colleagues: worse than last year, below average – 23% of staff with a long term condition (LTC) have experienced this
- Reporting: 54% of people with LTC report it (same as average). 58.9 without report it (above average)
- Equal career opps: Less than last year, 47.9% LTC (below average) vs 63.3 no LTC
- Pressure to come to work when not well: both are average 29% with LTC vs 20% without
- Values their work: above average 43% LTC vs 48.9% no LTC
- Adequate adjustments: below average adequate adjustments made

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 2022 survey. A Trust action plan and Divisional action plans will be formulated and approved by Board

Volunteers

Volunteers were safely re-introduced into The Trust during the 2nd part of 2021 in specific roles including prior to this support continued as follows:

- Regular welfare calls and virtual meetings
- Virtual Coffee Mornings and quizzes
- Newsletters
- Socially distanced safe park walks
- Engagement and staff/volunteer support with local foodbanks
- Picnic in the park to celebrate National Volunteer Week

When able volunteers have been safely introduced in line with our Volunteer Roadmap in a very balanced way they support in the following roles:

- Meet & Greet
- Infection Prevention Volunteers
- Tonic Research Support
- Supporting with LAMP testing kits

In summary, although it continued to be a very 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 2022/23.

The Walton Centre considers that this data is as described for the following reasons:
The Trust recognises that the main causes for the less positive scores and the response rate is due to the inability to engage with staff face to face due to covid restrictions.

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

- To hold various staff engagement sessions to understand the reasons behind the responses and to increase the response rates and percentage scores for the 2022 survey.

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:

YEAR		Q1	Q2	Q3	Q4
2017/18	The Walton Centre	99.09%	99.69%	98.34%	97.17%
	National Average	95.20%	95.25%	95.36%	95.21%
2018/19	The Walton Centre	98.52%	99.00%	98.86%	96.78%
	National Average	95.63%	95.49%	95.65%	95.74%
2019/20	The Walton Centre	98.79%	98.97%	98.85%	98.58%
	National Average	95.63%	95.47%	95.33%	Suspended due to Covid
2020/21	The 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
2021/22	The Walton Centre	99.03%	98.7%	98.44%	98.6%
	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:

	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
The Walton Centre	21.6	15.7	14.5	13.3	13.7	9.5	7.81	17.48

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

In 2021/22 The Walton Centre had a total of 8 Clostridium difficile infections against the trajectory set by NHSE/I of 5. Although disappointing this appears to reflect the rise observed across the region. The Walton Centre has taken the following actions to improve this rate, and so the quality of its services, by:

- The development of an Infection Prevention and Control Strategy
- Setting clear objectives, implementation and monitoring of the Healthcare Associated Infection (HCAI) reduction plan
- Investing in "Tendable" an audit and quality package to enable intelligent, real-time data for infection prevention control audit
- Monitoring and reporting infection prevention outcomes to the Quality Committee
- Use of technology e.g. Hydrogen Peroxide Vapour (HPV) and UV machine to support environmental cleanliness
- The development of a Trust Antimicrobial Strategy in addition to ongoing training, support and audit of antimicrobial prescribing

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 1000 bed days

Response:

In 2021/22 1429 incidents occurred against 45,769 bed days (as per NLRS figures) this equals 31.22 incidents per 1000 bed days.

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

The 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 electronic root cause analysis system (ERCA) to support the Trusts reporting requirements

Annex 1

healthwatch Liverpool

The Walton Centre Foundation Trust 2021-22 Quality Account commentary

Healthwatch Liverpool welcomes the opportunity to comment on this 2021-22 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 this year. We carried out a joint online event with Healthwatch Sefton and the Trust instead, which although small did provide both positive feedback and some suggestions for improvement.

The quality account provides an overview of the extent to which the 2021-22 priorities have been achieved. The backlog in patient appointments has continued to increase across the NHS during the pandemic, and we were therefore reassured to see that one of the priorities the Trust achieved was to increase outpatient slots utilisation.

We were also pleased to see some of the achievements in improving patient flow. Providing inpatients with their take-home medication the day before they are discharged is likely to also improve patient experience upon leaving hospital.

As the report mentions, pressure ulcers are preventable. The target of reducing hospital acquired pressure ulcers was not achieved, but we look forward to seeing a reduction now that the Trust has appointed a specialist tissue viability nurse.

The pandemic highlighted and exposed many health inequalities that have existed for years, including for people from ethnic minority communities. It is positive to see that the Trust took part in joint work identifying and hopefully mitigating some of these issues, by looking at the Covid -19 impacts on diverse communities. We will be interested to learn more about any resulting actions from this.

We welcome the priorities the Trust has chosen for the coming year, in particular the introduction of same day admission and discharge, which if done safely and successfully should improve patient experience, and not lead to an increase in readmissions.

We also welcome a focus on staff supporting patients who have issues communicating, as we believe this can have a substantial impact for patients and support staff in providing appropriate care.

We would like to congratulate the Trust for once again doing well in the National Inpatient Experience Survey. We were pleased to see that new initiatives were taken to support inpatients, by for example ensuring that patient birthdays were celebrated when they could not receive visitors.

Due to the pandemic we could not visit Trust sites and meet patients and visitors face to face to capture their feedback. We are hoping to carry out a face to face listening event during 2022-23, and look forward to working with the Walton Centre, 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.

The Walton Centre NHS Foundation Trust

Healthwatch Sefton would like to thank the Trust for presenting the Quality Accounts during a presentation on 10th June 2022 and producing the Quality Account report that is written in a clear and understandable format.

The Trust engaged with Healthwatch Sefton and other stakeholders via the Patient Experience Group meeting to provide the opportunity for Healthwatch to be involved in selecting potential Quality objectives for the Trust.

The Trust continues to work in partnership with Healthwatch Sefton and hold regular Patient Experience Group meetings that we are invited to attend and feed in any emerging issues. Currently the meetings are held remotely due to Covid-19.

Due to Covid-19, as a Healthwatch we have been unable to carry out our engagement with patients and visitors on site but we have worked in partnership with the Trust and Healthwatch Liverpool to hold a virtual engagement event during February 2022 which was well attended by both Voluntary & Community groups representing patients and individual patients. We will continue to work in partnership to gather the patient voice.

The report provides an update on improvement priorities for 2021 – 2022 and identified the priority to reduce pressure ulcers was 'not achieved'. Healthwatch would welcome updates on pressure ulcers and how the new tissue viability specialist nurse is working to support the reduction through enhanced education and support regarding pressure relieving equipment.

An achievement noted during 2020/21 was that the Trust introduced Patient Initiated Follow Up (PIFU). We look forward to hearing how this initiative is rolled out across Neurosurgery and the positive impact this has on patient care.

It is good to see that the Trust is working to launch a new Quality Strategy for 2022, taking into account Covid-19 and identifying new ways to deliver outstanding care.

Despite Covid-19 the Trust were rated 8th out of 75 Trusts using Picker for overall positive score which is impressive.

The staff engagement section included detailed scores given to specific questions. We feel this is good practice to include staff engagement and processes in place to take a temperature check of how staff are feeling. We would like to hear from the Trust on how they are working to improve staff working conditions.

Healthwatch Sefton continues to have a good working relationship with the Patient Experience Team and it is good to see all the work and initiatives that have been implemented by the team to improve patient care. It is an achievement to note that the response time for formal complaints continues to be significantly reduced in comparison to previous years and this is testament to the team who have worked hard to achieve this.

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.

Council of Governors
Quality Account Statement 2021-22
Walton Centre NHS Foundation Trust

Quality Account commentary

The Walton Centre Governors welcome the opportunity to comment on the Quality Account Statement for 2021-22.

We recognise that the Trust has sustained an outstanding level of quality care in the context of a continuing pandemic and, indeed, built on lessons learned from the pandemic to promote innovation and provide even better care and services for patients and their families. One example of this that the governors commend is the design and development of the on-line Pain Management Programme, which has proved invaluable support for patients living with chronic pain. Another is the development of the Rapid Access Neurology Assessment (RANA) Service, which demonstrates the trust's collaborative approach to supporting other hospital trusts in the region.

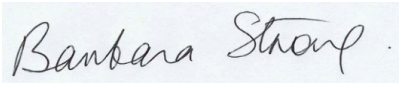
We were pleased to note the further development of the thrombectomy service and the work in progress to develop the digital stroke rehabilitation tool.

The governors are particularly impressed with the progress made on improving wellbeing and equality for Black and Asian minority ethnicity (BAME) patients and staff, and the success of the Trust's participation in the International Nurses initiative.

We congratulate the trust alongside the Clatterbridge Cancer Centre NHS Foundation Trust and the North Wales Cancer Treatment Centre, on being awarded Centre of Excellence status from the Tessa Jowell Brain Cancer Mission (TJBCM) for their work with brain tumour patients and their families.

We applaud the open and transparent assessments contained in the report, on the achievement against objectives for 2021/-2022 Quality Priorities. The governors appreciate and support the efforts of trust staff towards continuous improvement and commend them for their hard work in these important areas.

The Governors were grateful for the opportunity to be involved in the identification of the Quality Priorities outlined for the year 2022-2023 and look forward to receiving updates on progress and reviewing the outcomes at the end of the year.



Barbara Strong
Lead Governor
On Behalf of the Council of Governors

NHS Liverpool Clinical Commissioning Group
NHS Knowsley Clinical Commissioning Group
NHS Sefton Clinical Commissioning Group
NHS Southport and Formby Clinical Commissioning Group
NHS Halton and Warrington Clinical Commissioning Group
NHS St Helens Clinical Commissioning Group
NHS England and Improvement Specialised Commissioning

Quality Account Statement 2021-22
Walton Centre NHS Foundation Trust

NHS Liverpool, Sefton, Southport & Formby, Knowsley, Halton and Warrington and St Helens CCG's along with NHSE/I Specialist Commissioning welcome the opportunity to jointly comment on the Walton Centre NHS Foundation Trust Draft Quality Account for 2021-22. It is acknowledged that the submission to Commissioners was draft and that some parts of the document may require updating. Commissioners look forward to receiving the Trust's final version of the Quality Account.

The Trust has continued in 2021/22 to manage the challenges posed due to the ongoing COVID-19 pandemic. We would like to take this opportunity to thank the Trust and its staff for the work it has undertaken through the different waves of the pandemic to adapt and deliver care and for their support in providing mutual aid to support the wider system and by supporting the COVID vaccination program.

Commissioners have worked closely with the Trust throughout 2021/22 to gain assurances that the services delivered were safe, effective, and personalised to service users. The Commissioners share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care.

The Trust's presentation of its Quality Account was an honest, open, and positive demonstration of the improvements made to date and an acknowledgement of areas that need to be developed further. The account reflects good progress on most indicators.

This Account details the Trust's commitment to improving the quality of the services it provides, with commissioners supporting the key priorities for the improvement of quality during 2021/22 which were:

- Reduction of 10% in pressure ulcers
- Redevelop Pain Management Programme
- Improve patient flow across the Trust
- Introduce patient initiated follow up
- Increase outpatient appointments
- Implement inventory management system
- Improve wellbeing and equality of BAME
- Provide mental health first aid training
- Improve Start Time of Theatre Lists and Same Day Discharges

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvements are required and what actions are needed to achieve these goals, in line with the Trust Quality Strategy.

This account shows a consistent drive for quality improvement and despite the ongoing impact of the pandemic 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 2022/23 in three key areas:

Patient Safety:

- Completion of Malnutrition Universal Screening Tool (MUST) 98% completed MUST within 12hrs of ward admission and compliance with weekly: MUST re-assessment
- Pilot the Whiston Project (initially Whiston Hospital patients): To provide enhanced responses and information for patients and reduce AED attendances
- Introduce Same Day Admission/ Discharge (surgery): Ensure patients are not spending longer than is absolutely necessary in hospital

Clinical Effectiveness:

- Introduce Nutrition Champion Training: Increase staff training to support nursing teams to focus on nutrition and mealtimes
- Implement Virtual Reality (VR) Simulator: Purchase neuro VR simulator for teaching junior neurosurgeons. Offer training as an educational tool to the region and beyond
- Introduce Patient Initiated Follow Up (PIFU) – Surgery :2% (trust wide) of patient follow up cohort to be initiating their own follow up appointments

Patient Experience:

- Develop Training Programme Cheshire and Mersey Rehab Network: Staff to develop knowledge and skills in undertaking and evaluating quality improvement projects
- Introduce Staff Training to Support People with Communication: Ensure Trust is accredited to use Communications Access Symbol
- Reduce the number of complaints: Year on year reduction of complaints received by the divisional teams

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 also recognise however Covid-19 has changed how they work and care for patients and for this reason have been working with their staff to launch a new Quality Strategy for 2022 onwards to identify new ways to deliver outstanding care.

The Trust places significant emphasis on safety, patient/staff engagement and demonstrating commitment to continuous evidence-based quality improvement, and the work that the Trust has undertaken to improve outcomes on the following work streams throughout 2020/21 are of particular note:

- New spinal clinic in North Wales bringing care closer to home
- Enhanced Thrombectomy service
- NHSX Digital Aspirant funding will mean more integrated health care for patients
- MS Awareness Week – FACETS Programme
- Families continuing to save and improve lives through deceased organ donation
- Patient drinks innovative 'pink drink' helping surgeon remove brain tumour
- International Nurses made The Walton Centre their home
- The Walton Centre awarded Tessa Jowell Centre of Excellence Status
- New neurology assessment eases bed pressures in Cheshire and Merseyside
- The Trust & UCLan leading pilot study into innovative digital stroke rehab tool

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, in particular the priority in improving Malnutrition Universal Screening Tool usage and increasing Nutrition Champions across the Trust while also acknowledging the further work required in the reduction of hospital acquired pressure ulcers and the recruitment of a dedicated tissue viability nurse.

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

Signed on behalf of the Chief Nurses for NHS Liverpool, South Sefton, Southport & Formby and Knowsley Halton and Warrington and St Helens CCG's

Annex 2 Statement of Directors' responsibilities for the Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS Foundation Trust Boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021/22
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period 1st April 2021 to 9th June 2022
  - Papers relating to quality reported to the Board over the period 1st April 2021 to 9th June 2022
  - Feedback from the commissioners including Liverpool, South Sefton and Southport and Formby and Knowsley Clinical Commissioning Groups 27th June 2022
  - Feedback from governors dated 31st May 2022
  - Feedback from local Healthwatch organisations – Liverpool dated 14th June 2022, Sefton dated 22nd June 2022
  - Feeback from the Council of Governors dated 31st May 2022
  - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 9th June 2022
  - The National Patient Survey dated November 2021
  - The National Staff Survey for 2021 presented to Trust Board on 3rd March 2022
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated April 2022
  - The Care Quality Commission's inspection report dated 19th August 2019
- the Quality Report presents a balanced picture of the NHS Foundation Trusts performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

Jan Ross

Chief Executive

Glossary of Terms

ACCP	Advanced Critical Care Practitioner
BAME	Black and Asian Minority Ethnic
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
EDC	Electronic Demand Capture
EP2	Electronic Patient Record System
FACETS	Fatigue Applying Cognitive Behavioural & Energy Effectiveness Techniques
FFFAP	Falls and Fragility Fractures Audit Programme
FTSUG	Freedom to Speak Up Guardian
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit & Research Centre
KPI	Key Performance Indicator
MDT	Multidisciplinary Team
MHFA	Mental Health First Aid
MIAA	Mersey Internal Audit Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool
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
PET	Patient Experience Team
PIFU	Patient Initiated Follow Up
RCA	Root Cause Analysis
SJR	Structured Judgement Review
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