The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

# Quality Account

## 2022 – 2023

## Part 1 Statement on quality from the Chief Executive

## Part 2 Priorities for improvement and Statements of Assurance from the Board

## Improvement priorities

### 2.1 Update on improvement priorities for 2022/23

2.1.1 Patient safety
2.1.2 Clinical effectiveness
2.1.3 Patient experience

### 2.2 What are our priorities for 2023/24?

2.2.1 Patient safety
2.2.2 Clinical effectiveness
2.2.3 Patient experience

### 2.3 Statements of Assurance from the Board

2.3.1 Data quality
2.3.2 Participation in Clinical Audit and National Confidential Enquiries
2.3.3 National audits
2.3.4 National Confidential Enquiries
2.3.5 Participation in local clinical audits
2.3.6 Participation in clinical research and development
2.3.7 CQUIN framework and performance
2.3.8 Care Quality Commission (CQC) registration
2.3.9 Trust data quality
2.3.10 Learning from Deaths
2.3.11 Progress in implementing clinical standards for seven day hospital services
2.3.12 Speaking up
2.3.13 NHS Doctors in Training

## Part 3 Trust overview of quality 2022/23

## Part 1 Statement on quality from the Chief Executive

It gives me great pleasure to share the Quality Account for 2022/23 which demonstrates our continual drive and commitment to delivering excellent standards of quality care to our patients and their families.

As Chief Executive, I see examples of fantastic work on a daily basis, from the big to the small, impacting the lives of our patients and our staff across every area of the hospital.

The past year has seen some great developments, demonstrating our innovation and leadership both within The Walton Centre, and with our partners.

Our new Trust Strategy was launched in September 2022, setting out how we will continue to develop excellent clinical outcomes and patient experience with our teams of dedicated, specialist staff. The strategy reflects the pace of change in the NHS to move to a more collaborative approach and the ambition of the Trust to deliver services that meet the needs of our patients and communities.

The Quality Account details our performance over the last year whilst also highlighting our key priorities for 2023/24.

Our mission is to provide high quality treatment, care and patient experience in the most appropriate place for the needs of our patients. Some of our achievements within year include:

- Our spinal service became the regional centre and received a Centre of Excellence award for its fully endoscopic spinal surgery
- The Trust became a member of the University Hospitals Association recognising its specialist research and education status
- Our new brain tumour pathway was implemented, in collaboration with neighbouring Trusts
- The establishment of our purpose-built Rapid Access to Neurology Assessment (RANA) service for fast referral from regional A&E departments

I feel incredibly privileged and proud of our Walton Centre family and everything we have achieved this year for the benefit of our patients, their families and friends. By working together and supporting each other, we are stronger and I would like to thank every single member of staff for their tireless efforts over the past year, which mean so much to our patients, and each other.

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 stakeholders to identify areas of improvement for the forthcoming year. This also allowed the Trust to reflect on the year's previous performance against the identified quality improvement priorities.

The delivery of the quality improvement priorities is monitored through meetings of the Quality Committee, chaired by a Non-Executive Director, with subgroups focusing on the three 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 the priorities were identified following a review by Trust Board on the domains of quality reported in 2021/22. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing our priorities for 2022/23.

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 priority improvement areas for 2022/23.

## 2.1 Update on improvement priorities for 2022/23

In December 2022 the Council of Governors and 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. Quality priorities were also identified and agreed for 2023/24. The improvement priorities 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) undertook an audit of the Quality Account and provided an overall outcome of significant assurance. There is no national requirement for NHS trusts or NHS Foundation Trusts to obtain external auditor assurance on the Quality Account or Quality Report, with the latter no longer prepared.

### 2.1.1 Patient safety

**Priority: 98% completion of MUST within 12 hours 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: Partially achieved**
We achieved compliance against the 98% target of patients have a weekly MUST re-assessment undertaken. The compliance for patients having a MUST risk assessment within 12 hours of admission did not meet the target of 98%. The overall compliance as at the end of March 2023 was 96%. The Trust will continue to monitor compliance against MUST risk assessments throughout the year.

**Priority: Pilot the brain tumour optimisation pathway (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: Achieved**
Pilot complete at Whiston Hospital and results currently being audited. Roll out of pathway underway across the rest of the region, starting with Arrowe Park and Warrington Hospital.

**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 experience overall but will also reduce length of stay and mitigate against hospital acquired infections.

**Outcome: Achieved**
Same day discharge (SDD) pathway pilot underway with criteria led spinal patients. Dedicated area for SDD in-situ and failed SDD processes in place. Discussions underway to continue SDD pathway into other sub-specialty areas such as Functional and Oncology in quarter 1 of 2023/24.

### 2.1.2 Clinical effectiveness

**Priority: Introduce Nutrition Champion Training Programme**

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

**Outcome: Achieved**
Nutrition, dysphagia and mouthcare e-learning has been uploaded onto ESR for all clinical staff. Dietitians have developed nutrition link champion training pack and resources. Train the Trainer presentation has been developed by Dietitians for the nutrition champions. A Nutrition Champion role has been allocated to at least one staff nurse and HCA in all ward areas.

**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: Achieved**
VR simulator purchased and is currently being used to train neurosurgical trainees at The Walton Centre. The VR simulator needs to be moved to a more suitable location for hosting external training programmes.

**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: Achieved**
PIFU commenced in most neurosurgical areas (where it is clinically appropriate to do so). Uptake will be encouraged and monitored in each subspecialty service meeting to monitor the growth of PIFU uptake.

### 2.1.3 Patient experience

**Priority: Develop a training programme for the Cheshire and Mersey Rehabilitation Network**

**Reason for prioritising:**
Increase staff training for specialist rehabilitation practice and to identify and undertake quality improvement initiatives and evaluate the impact on patients, staff and the service. This will improve patient outcomes and experience and overall service delivery.

**Outcome: Achieved**
A network wide Education and Training Programme has been developed to meet the needs of the network in the delivery of safe and high-quality care for patients, and in the functioning of the network. The programme will be rolled out across all network teams and services in 2023/24 and evaluated to measure impact of the education and training, and results will be used to inform future programmes.

**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: Achieved**
The Trust has been successfully accredited to use and display the Communication Access symbol. This will assure patients, their carers, and their families that staff will receive training to support people with communication difficulties, and that their communication needs will be established at first contact and recognised throughout their appointments and inpatient stays. Subgroups of staff have already completed their training and we aim to roll this out to further groups across the Trust.

**Priority: Reduce the number of complaints**

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

**Outcome: Not achieved**
This has not been achieved and complaint numbers have increased in line with pre-covid figures. In quarter three, as communication and appointment arrangements has been a long-standing trend, the Patient Experience Team (PET) undertook a piece of work with divisions to review categories,

subjects and sub-subjects on the complaints model of Datix. This was to ensure that concerns received were categorised correctly to provide meaningful data to drive improvements.
The aim is to deep dive into the complaints and provide richer data in quarter one 2023/24 to facilitate learning and reduce complaints.

## 2.2 What are our priorities for 2023/24?

In December 2022, 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 2023/24. The Quality Committee, Health Watch and Specialist Commissioners then identified 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:**

Updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Quarterly quality meetings are held with commissioners to review quality assurance and provide external scrutiny and performance management.

### 2.2.1 Patient safety

**Priority: 20% reduction in hospital acquired 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 2022/23 there were a total of 34 hospital acquired pressure ulcers, inclusive of category 2, deep tissue injury, mucosal and device-related pressure ulcers. We also had one unverified reported pressure ulcer.

**Outcome required:**
To have an overall 20% reduction in the number of hospital acquired pressure ulcers compared with the 2022/23 year end position. This will improve safe care and overall patient experience.

**Priority: At least a 20% reduction in catheter acquired urinary tract infections (CAUTIs)**

**Reason for prioritising:**
There has been an increase in catheter acquired urinary tract infections.

**Outcome required:**
A reduction in CAUTIs within year which will improve patient safety and experience.

**Priority: 100% of patient facing staff trained in aseptic non-touch technique (ANTT)**

**Reason for prioritising:**
There has been an increase in MSSA during 2022/23. This is a key intervention within our Healthcare Associated Infection Reduction Plan.

**Outcome Required:**
A reduction in healthcare associated infections (HAIs) which will improve patient safety by supporting effective education, competency assessment and safe clinical practice.

**Priority: Introduce low stimulation room on Chavasse Ward**

**Reason for prioritising:**
We need to provide patients who present with agitated behaviours a more suitable low stimulation, calming environment.

**Outcome required:**
To have a low stimulation space available on Chavasse Ward to help support the management of agitated and aggressive patients.

### 2.2.2 Clinical effectiveness

**Priority: Introduce the use of lung ultrasound as a diagnostic tool into the Physiotherapy Critical Care Service**

**Reason for prioritising:**
To support early recognition of abnormal lung pathology and ensure targeted care and treatment to patients. To provide real-time feedback on efficacy of physiotherapeutic interventions and allow staff to adapt/alter treatment approaches based on findings.

**Outcome required:**
Ensure all local processes and policies, associated with the introduction of the lung ultrasound, are available and supporting safe care.

**Priority: Introduce electronic quality boards on each ward**

**Reason for prioritising:**
To centralise information and provide the ward leadership teams with accurate, up-to-date data in the form of an electronic dashboard reporting monthly ward performance, patient safety data and unit feedback.

**Outcome required:**
Implement electronic ward dashboards which reflect accurate and up-to-date information.

**Priority: Increase the number of MR scans performed daily by 10%**

**Reason for prioritising:**
The MR scanners will be upgraded with new software which will reduce the time taken for each scan, thereby reducing total scanning time per patient.

**Outcome required:**
Improving patient experience by reducing time on the scan table, as well as increasing the number of patients that can be scanned per day.

### 2.2.3 Patient experience

**Priority: Increase patient discharges before 12 midday by 10%**

**Reason for prioritising:**
Discharging patients before 12 midday allows patients to go home when they are ready to, improving overall patient and family/carer experience as well as freeing up space earlier in the day for new patients who need to be admitted. The introduction of TTOs (To Take Out – prescribed medication) completed the day before planned discharge, more effective ward rounds, and the use of Caton Short Stay Ward (excluding complex discharges) will help avoid bottlenecks in hospital flow and reduce length of stay.

**Outcome required:**
Reduction in the length of stay for patients which will improve their experience, as well as patient flow.

**Priority: Introduce an end-of-life and bereavement model to the Trust**

**Reason for prioritising:**
The model is instigated at the point of recognition of dying and is used to support care throughout end-of-life, bereavement and beyond. Introducing the model will provide individualised, compassionate care to every patient and their family. Having the patient and family as the focus will enable us to meet the unique needs of each individual and their loved ones.

**Outcome required:**
Model introduced which will support and guide patients and their families during end-of-life care, and afterwards to improve patient care and family experience.

**Priority: Trial Magnetic Resonance (MR) Guided Laser Treatment for epilepsy patients (Laser Interstitial Thermal Therapy – LITT)**

**Reason for prioritising:**
Trialling the treatment for those who are not suitable for other forms of surgical intervention will provide a less invasive surgical solution to patients with drug-resistant epilepsy.

**Outcome required:**
Pilot LITT treatment for drug-resistant epilepsy patients. National Commissioning bid expected in 2023/24.

### 2.3 Statements of Assurance from the Board

During 2022/23, The Walton Centre provided and/or sub-contracted six relevant health services:

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation
- Spinal Surgery
- Clinical Neurophysiology

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

The income generated by the relevant health services reviewed in 2022/23 represents 94.9% of the total income generated from the provision of the relevant health services by The Walton Centre for 2022/23.

#### 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 collated over the last ten years includes data collection of information to support progress against the Quality Accounts and additional nursing metrics to provide internal assurance. This allows 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.

We now use the Tendable App to undertake reviews which is an electronic tool allowing the monitoring of trends and themes across the Trust and highlights new concerns that are recurrent issues.

### 2.3.2 Participation in clinical audit and national confidential

During 2022/23, nine national clinical audits and one national confidential enquiry covered relevant health services that The Walton Centre provides.

During that period The Walton Centre participated in 89% 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 2022/23 are as follows:

### 2.3.3 National audits

- Adult Critical Care (ICNARC / case mix programme)
- Severe Trauma – Trauma Audit and 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)
- Neurosurgical National Audit Programme (NNAP)
- UK Parkinson’s Audit

### 2.3.4 National confidential enquiries

- Transition from child to adult health services

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2022/23, 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 | Awaiting final figure |
| Severe Trauma (Trauma Audit and Research Network) | Yes | 100% |
| National Emergency Laparotomy audit (NELA) | N/A | No eligible cases |
| The Sentinel Stroke National Audit Programme | Yes | 92% |
| National Audit of Care at the End of Life (NACEL) | Yes | 100% |
| UK Parkinson's Audit | Yes | 100% |
| **Neurosurgery** | | |
| National Neurosurgery Audit Programme (NNAP) | Yes | 100% (HES Data) |
| National Comparative of Blood Transfusion (NCABT) | Yes | 100% |
| ***Older people*** | | |
| Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls | No | 0% = 1 unsubmitted eligible case |
| ***National Confidential Enquiry into Patient Outcome and Death*** | | |
| Transition from child to adult health Services | Yes | 100% |

The reports of four national clinical audits were reviewed by the provider in 2022/23 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) | Achievements 2022/23<br>• Move to v4.0 of ICNARC Casemix Programme (CMP) dataset<br>• Transfer of database from WardWatcher to MedICUs system<br>• As a result the audit input clerk has established links with local ICU audit teams to learn from and support each other<br>• Teaching session from MedICUs to local units took place at The Walton Centre in April 2023<br>• The data demonstrates our outcomes are within expected ranges and have provided assurance that despite an increase in the number of deaths in ICU, the risk- adjusted mortality rates are at the same level as similar units for Q1 and Q2 2022 – 23. |

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| | Concerns<br>• System has been reliant on single individual to collect and input data.<br>• Staffing for data collection and input is less than GPICS recommendation.<br>• Therefore, there is a lack of resilience.<br>• V4.0 does contain more data that needs some support from clinical staff to ensure accuracy.<br><br>Opportunities<br>• ICNARC future plans for CMP include disease specific modules so there is the possibility of developing or using the system for neuro conditions eg subarachnoid haemorrhage. Data from these modules could help improve patient care by identifying problems in patient pathways.<br>• In the next year ICNARC is planning audits of patient experience in Critical Care, the diagnosis, prevention and management of delirium, and of nurse-staffing models in Critical Care. All are highly relevant to The Walton Centre but involvement will depend on timely data collection.<br>• If configured correctly, ICU EPR could potentially automatically download data to Medicus and reduce requirement for manual input.<br><br>Actions<br>• Support from the Outcome Team has been sought and provided to help with backlog of data entry.<br>• Job plan of data collector has been modified to increase time available.<br><br>Medical lead is preparing options appraisal paper to submit to ICU Operational Group and Divisional Team for increased clinical and electronic involvement in data collection and input. |
| Severe Trauma - Trauma Audit and Research Network (TARN) | • Case ascertainment is 100%+, which is above the national target of 80%<br>• Data accreditation is 96.3%, which is above the national target of 95%<br>• Median length of stay for patients (with an Injury Severity Score greater than 15) is 16 days, which is above the national Major Trauma Centre average of 11 days. This is due to the complex nature of trauma patients who are admitted with severe traumatic brain injury or spinal cord injury, there can also be delays for patients awaiting specialist rehab.<br>• The Walton Centre has a significant rate of survival, out of 470 patients only 408 were expected to survive based on probability, however 436 were observed survivors, which gave the Trust a Ws score (comparison statistic) of 3.36 with 95% confidence intervals of 1.49 to 5.23.<br>• The Walton Centre have continued to improve the time from incident to craniotomy, median time 293 minutes, which is |

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| | below the national Major Trauma Centre average of 370 minutes, this also a decrease of 67 minutes compared to the previous year.<br>• In comparison with other Major Trauma Centres nationally, The Walton Centre is showing as the third best centre for increased survivors. It is worth noting that the Trusts either side of The Walton Centre have substantially large confidence levels which indicates an unreliable data set.<br><br>The Trust will continue to submit data to TARN and will review individual cases as appropriate. |
| The Sentinel Stroke National Audit programme (SSNAP) | • The Walton Centre's thrombectomy cases and declined referrals are reviewed at the Regional Thrombectomy MDT group.<br>• Issues identified relating to data submission have been discussed with Walton Centre senior management.<br>• The regional MDT group identify and discuss potential areas for improvement across the patient pathway. |
| UK Parkinson's Audit | • The results, from the only national Parkinson's audit in the UK, demonstrate ongoing delivery of excellent Parkinson's care. There continues to be almost ubiquitous access to specialist nurses or equivalent, and also to therapists. There have been significant improvements in many areas such as options for remote consultations, awareness of the importance of activity and exercise, bone health, and inductions for new therapists.<br>• The areas for improvement vary across the different service types but some key themes have emerged, including early referral to therapy services, waiting times, standardized assessments, anticipatory care planning and advice about driving.<br>The Walton Centre has signed up to participate in the Bone Health Improvement project. |

### 2.3.5 Participation in local clinical audits

The reports of 61 local clinical audits were reviewed by the Trust in 2022/23 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:

#### Neurology clinical audits and service evaluations

| Audit title | Actions |
|---|---|
| A single centre, retrospective cohort study of patients under the care of Neurology admitted to ICU (N 358) | • Findings disseminated January and March 2022 / Neurology Grand Round and Neuro ICU audit day.<br>• **Issue:** Ongoing service evaluation<br>• **Action:** To continue data collection to include 2022 patients. Further information to be captured |
| Assessment and management of swallowing in Parkinson's Disease patients (N 368) | • **Issue:** Missed information by clerking doctor.<br>• **Action**: Highlighting issue about required line of questioning when clerking patients with Parkinson's Disease<br>• **Issue:** Missed Malnutrition Universal Screening Tool (MUST) forms for some patients.<br>• **Action:** Ensure patients who are admitted straight to theatres have their assessment done after theatre |
| Botox service audit during covid-19 pandemic and following service recovery (N 381) | • **Issue:** Botox for chronic migraine administered outside of 12 weeks<br>• **Action:** Increase in capacity and additional clinics to be discussed with neurology division management |
| gammaCore™ service evaluation (N 390) | • **Issue:** Poor compliance with headache diaries for this group of patients on this treatment<br>• **Action:** Discussion for potential standalone gammaCore™ clinic enabling clinical outcomes to be documented |
| Evaluation of the new Motor Neurone Disease (MND) key worker project at Wirral Hospice St John's (N 375) | • Results and recommendations fed back to Wirral Hospice St John's and the MND association for consideration and implementation |
| A retrospective real-world evaluation of fremanezumab (Ajovy) in the management of refractory chronic migraine (N 388) | • No actions necessary<br>• Results disseminated to the headache multidisciplinary team. |
| Audit of genetic testing for patients with the SPG7 mutation (N 383) | • No actions necessary<br>• Dissemination of results |
| Assessment of bone health in the neurology clinic - Fragility fracture or use of glucocorticoids (N 380) | • Dissemination of results<br>• Raise awareness<br>• Include in risk bulletin |
| Monitoring and safety in prescription of corticosteroids – second audit cycle (N 383) | • Need for more awareness and discussion of steroid monitoring in outpatients – discussed in neurology audit meeting<br>• Include in risk bulletin |

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| | • Review and update steroid monitoring guideline<br>• Long term steroid guideline planned |
| Ensuring cognitive screening instruments used in routine clinical practice adhere to the Wilson-Jungner criteria for high test sensitivity and specificity, using binary receiver operator characteristic (ROC) plot and area under the curve (AUC) as a measure for adherence (N 310) | • Raise awareness<br>• Disseminate results |
| Venous thromboembolism (VTE) prophylaxis prescribing and review post neurosurgery (N 377) | • Align the VTE Policy with the NICE guideline NG89-1.12<br>• Current review of VTE guidance underway<br>• Ensure the spinal teams are more compliant with the VTE prophylaxis policy<br>• Ensure that VTE prophylaxis prescribing is clearly highlighted to the doctor or prescriber during the weekend handover on a Friday |
| Antibiotic point prevalence audit (NRP 04) | • Improve review at 48-72 hours – Targeted antimicrobial stewardship (AMS) at 48-72 hr reviews of urine, chest and sepsis infections (involve SMART, pharmacists and junior doctors)<br>• Dissemination of key points to prescribers via Walton Weekly every quarter |
| Audit of Allegro Volumetric for pre-operative brain tumours (N 378) | • **Issue:** Volumetric post contrast imaging with too small a field of view for use in surgical planning<br>• **Action:** Educate external Trusts about the purpose of post contrast volumetric imaging |
| Audit of non-medical referrers for radiology under Ionising Radiation (medical exposure) Regulations (IR(ME)R) guidelines 2022 data (NRP 03) | • **Issue**: Non-medical referrer did not log out and another user requested an examination outside of an agreed protocol.<br>• **Action**: Non-medical referrers advised to always log out.<br>• Results disseminated – Director of Nursing, Radiology Directorate management meeting and staff management meeting |
| Audit of standards of communication of radiological reports and fail-safe notifications (NRP 20) | • No actions necessary<br>• Results disseminated Radiology staff meeting and Directorate management meeting |
| Audit of CT contrast opacific of the abdomen (N 365) | • Discuss the following with consultant body:<br>  ○ Consider bolus tracking abdomen and pelvis scans<br>  ○ Determine contrast dose using a weight based look up table.<br>• Further discussion and information gathering required to agree a safe protocol using weight-based contrast dosing |
| Standards for reporting and interpretation of fluoroscopy guided lumbar punctures in line with Royal College of Radiologists guidelines (NRP 08) | • No actions necessary<br>• Following discussion with clinical governance lead, it was agreed to repeat audit every six months rather than |

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| | quarterly due to the number of procedures completed in the timeframe<br>• Findings presented at directorate management meeting |
| Recording of CT radiation doses and unsaved CT images (NRP 14) | • Staff reminder to highlight problematic themes and highlight the need for time-to-digital converter (TDC) images to be sent |
| Audit of delayed MRI for patients with reduced capacity (N 360) | • **Issue:** Ward staff delays in the completion of MR safety forms for patients with reduced capacity requiring next-of-kin contact<br>• **Action:** Completed. Transfer responsibility for next-of-kin to be contacted by MR staff rather than ward staff |
| Audit to assess the suitability of line algorithm for visualisation of nasogastric tubes (NRP 16) | • Staff reminded to ensure standard chest X-ray and line algorithm image are both sent to patient access centre (PACS) |
| Audit of patient satisfaction for MR (NRP 01) | • Staff reminded to tell patients how they receive results via monthly briefs from principal radiographers |
| Audit of Patient Satisfaction Survey Results for patients attending for X-ray guided LP (NRP 01) | • No actions necessary – re-audit 12 months |
| Audit of prediction of level 2 bed utilisation post endovascular intervention (N 355) | • **Issue:** 51 elective cases cancelled due to lack of level 2 beds, and 7.81% of underprediction of level 2 bed utilisation<br>• **Action:** Results fed back to bed management and multidisciplinary interventional radiology team<br>• Discussed at directorate management meeting |
| Audit of exam time to report availability (NRP 12) | • Communication of results to all members of the directorate management team. |
| Protocol adherence for MRI lumbar spines in and out of hours (N 389) | • Reminder will be emailed to radiographic staff to vet the out-of-hours patients when they attend for lumbar MRI |
| Midterm outcomes of low profile visible intraluminal (LVIS) EVO stent-assisted coiling procedure for treatment of wide necked and complex intracranial aneurysms (N 379) | • No actions necessary |
| Adherence to weight based iodinated contrast administration for abdominal CT (NRP 27) | • **Issue:** Non-universal use of weight-based CT protocol **Action:** Discussed with CT lead potential for including visual prompt and/or guidance in CT room for reminder of weight-based contrast dosing for abdominal CT and how to calculate dose (inc. where to find calculator etc). Dissemination of audit results in Team brief / case review meeting. Presented – Neuroradiology Consultant meeting |
| Audit of standards for reporting and interpretation of ultrasound images in line with Royal College of Radiologists (RCR) and British Medical Ultrasound Society | • No actions necessary |

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| (BMUS) guidelines 2022 (NRP 02) | |
| Audit of double reporting in line with Royal College of Radiologists guidelines (NRP 05) | • Communicated and distributed to all members of the directorate management team |
| CT Contrast Opacification of the Abdomen audit (Portal Venous Phase Enhancement at The Walton Centre – A Quality Improvement Project) – re-audit (N 410) | • No actions necessary<br>• Disseminated in CT team brief and Directorate Management meeting (Radiologists) |
| Audit of epilepsy protocols in MRI (N 341) | • No actions necessary |
| Clinical Audit Action Plan to evaluate dose for whole spine imaging using the Multitom Rax (N 85) | • Discussion required to determine if any further changes to kilovoltage peak (kVp) should be made<br>• Consider use of scoliosis follow-up parameter to reduce dose further |
| Audit to monitor the reject analysis rate for rejected plain film radiography in accordance with IR(ME)R Regulations (N 85) | • Problematic themes and how to rectify them highlighted to staff |
| Retrospective audit of clinical physiologist nerve conduction study tests to check quality assurance of waveforms and compliance with standard operating procedure (N 373) | • **Issue:** Compliance with the SOP is low with tests not performed appropriately based on the results obtained **Action:** Ask all staff to familiarise themselves with the SOP again<br><br>• **Issue:** Missing demographics on both the nerve conduction velocity (NCV) machine and the printout report as well as the physiologist performing the test<br>• **Action:** Ask all staff to ensure they input all demographics and ensure this is present on the printout. Speak to Optima to update the system on pulling the correct demographics through to the report.<br><br>• **Issue:** In consistency with the display of the sensory amplitude data with different values being used to interpret<br>• **Action:** Discuss with consultants for consensus how the data should be displayed and disseminate to all staff<br><br>• **Issue:** No option to add if there is deformity or difficulty obtaining results which would account for artefact seen. Consultants would like a comment column added to the report for Physiologist to utilise and annotate<br>• **Action:** Liaise with Optima to alter the physiologist report to include this comment column. To update physiologist when this is complete |
| Retrospective study of clinical physiologist carpal tunnel clinics/ulnar neuropathy at the elbow and investigating the need/referral for additional review | • Operator error is low, however this has led to a small minority of patients requiring re-examination in a consultant led EMG clinic. Therefore, clinical physiologists were reminded to familiarises themselves with carpal tunnel syndrome (CTS) SOP and provide an additional teaching |

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| in Consultant electromyography (EMG) clinics (N 386) | session to refresh operator errors and ways to eliminate these |
| Compliance of EEG protocol standards in a routine EEG (N 370) | • **Issue:** Low compliance to certain standards of the protocol (initially)<br>• **Action:** The protocol and compliance was addressed during a clinical physiologist session in detail, discussing the implications. The change was reflected in the next monthly results. Any further drop in compliance will be similarly addressed. |
| Monitoring “green” dietetic referral form completion that may have led to missed or delayed dietetic input (N 366) | • **Issue:** Patients potentially being missed to follow<br>• **Action:** Discussed with clinical systems and agreed plan to access a list of these patients daily |
| Compliance with report writing standards for objectives swallowing assessments – FEES (N 394) | • **Issue:** Results fed back at SLT team meeting with actions around maintaining standards where 100% is achieved and reminders/discussion where this is not the case<br>• **Action:** To ensure arears of improvement and infection standards which were under 100% are explicitly added to the template on Ep2 – i.e., add feeding recommendations heading to template |
| Naso-gastric (NG) Transition Feeding Audit (N 369) | • **Issue:** Premature nasogastric (NG) removal following commencement of oral nutritional intake on the neurosurgical and neurology wards risks compromising nutritional status of patients unnecessarily<br>• **Action:** Rollout of protocol on neurosurgical and neurology wards |
| Evaluating the benefit of respiratory physiotherapist attendance at ITU follow-up clinic (N 295) | • The respiratory physiotherapy team will no longer routinely attend ITU follow-up clinic. Instead, a ‘drop-in’ agreement is in place by which clinicians present at follow-up clinic can bleep the respiratory physiotherapy team to attend if direct input or advice is required. Since discontinuation of routine attendance in August 2022, this drop-in agreement has not been used |
| Evaluation of service gap for tracheostomy service – is there a need for outreach community service to facilitate and re-assess tracheostomy discharge (N 391) | • **Issue**: Areas of particular delay in the process identified<br>• **Action:** Discuss planning and processes with discharge co-ordinator<br>• **Issue:** Service gap identified<br>• **Action:** Presentation of data to team and department lead<br>• **Issue:** Learning points to be identified to be disseminated to wider team<br>• **Action:** Presentation of findings to associated MDT, Tracheostomy steering group - reach agreement as to how to escalate issues that fall outside the remit of the Lipton Ward MDT |
| A service evaluation of staff experience of Psychology within two community neurorehabilitation teams (N 362) | • The team had an away day and discussed the findings from the survey. There have been a number of significant changes in the Community Team in the last six months. The structure of the team (staffing levels etc.) and the model of working have been improved and this has brought |

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| | with it a lot of changes in how the team operates (waiting times, organisation, staff pressure, etc.)<br>• The team now operates with all clinicians picking up patients at the same timepoint, this way roles and goals are defined clearly from the start of the patient's input with the Community Specialist Rehabilitation Team (CSRT) |
| Evaluating the need for psychoeducation for patients with an acquired brain injury and their families/carers (N 374) | • Psychology team within the network to develop further psychoeducation videos for website. Assistants currently looking at developing videos an executive functioning.<br>• To be discussed as a quality project within the network team<br>• Discuss projects/new materials with families/carers<br>• Share resources with patients |
| Functional neurological disorder (FND) management and its outcome (N 291) | • **Issue**: Patients that are admitted are not aware and might not agree with the diagnosis<br>• **Action**: To ensure that patients are aware and had accepted the FND diagnosis<br><br>• **Issue**: Patients not being appropriately screened or selected<br>• **Action**: To screen patients by setting pre-admission guidelines<br><br>• **Issue**: In most cases, there is no continuity of care in community for FND patients<br>• **Action**: To refer or signpost the patients to the appropriate community teams or FND services<br><br>• **Issue**: Staff concerns and limited skills to look after FND patients<br>• **Action**: To provide support and provide education to the nursing staff to look after FND patients especially NEAD (non-epileptic attack disorder) |

## Neurosurgery clinical audits and service evaluations

| Audit title | Actions |
|---|---|
| Traceability Audit 2021 | **Key successes:**<br>• 91% cases accounted for<br>• All post-mortem instructions carried out<br>• Removal of the failure code following last year's audit has removed various confusing issues<br><br>**Key concerns:**<br>• Two slides couldn't be located (HNC354)<br>• Two slides found in the file but not recorded on the LIMS (HNC353)<br>• Three tracers missing from the file (HNC355) |

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| | **Other observations:**<br>• Tracer found in file that was no longer needed<br>• MAD requires a MAD positive and MAD negative slide but code on LIMS only generates one entry (PA60)<br><br>**Key actions:**<br>Code for MAD in LIMS only generates one slide where it also includes a negative-code has been updated to include two slides |
| Subarachnoid haemorrhage data collection audit | **Key successes**:<br>• Vast majority of SAH data collected is in line with SBNS/RCSEng guidance<br>• Data collection is accurate and has consistently improved over the last eight years<br>• Neurovascular Team maintains a well-organised and accurate database meeting all of guidance mandatory criteria<br><br>**Key concerns:**<br>• The addition of long-term follow up data is not mandated by the guidance but is recommended and would therefore be a useful addition to future research from this database<br><br>The addition of long-term follow up data is not mandated by the guidance but is recommended and would therefore be a useful addition to future research from this database |
| Oral ketamine to support outpatient and inpatient opioid weaning. Low dose intravenous ketamine for the treatment of Complex Regional Pain Syndrome (CRPS), refractory neuropathic pain, refractory headaches disorders, refractory visceral pain and opioid weaning | **Key successes:**<br>• Outcomes for oral ketamine is collected prospectively to audit, if implemented<br>• Low dose intravenous ketamine is a valid treatment option for patients with refractory headaches<br>• Patients for opioid detoxification are now treated with a sublingual buprenorphine protocol and oral ketamine which should reduce the need for iv ketamine considerably<br>• Except for the one CRPS patient there does not seem to be any demand for this indication at the moment<br><br>**Key concerns:**<br>• Formal consent required after clearly identifying and documenting purpose and initial goal for oral ketamine therapy on eP2<br>• Patient information leaflet needs to be written and approved outlining the rationale and purpose for oral ketamine in pain medicine<br>• Review by consultant after six months if still on oral ketamine |

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| | • Baseline liver function tests repeated after three months if still on ketamine including toxicology screen to check compliance and estimate plasma level<br><br>**Key actions:**<br>• Patient information leaflet now in use<br>Key points for data collection now updated on Trust patient information system (eP2) |
| Visual Impairment Service Review | **Key successes:**<br>• A significant number of patients had a preservation or recovery of central vision despite peripheral visual field loss<br>• The ranges of Visual Field Defect were predominately graded minimal to subtle level of field loss<br><br>**Key concerns:**<br>• 23.40% patients had a VISN alert on their medical records while 77% were not identified or not supported for their visual impairment<br>• Three patients certified sight impaired and severely sight impaired (75%) did not have an VISN alert<br><br>**Key actions:**<br>• Working group has been established to identify and improve healthcare access for patients with a disability visiting or staying at the Trust<br>• Best practice guidelines for the visually impaired now in use<br>• Sight loss patient information leaflet has been introduced<br>Care Plan has been developed for eP2 |
| An evaluation of the frequency and cause of isolated raised cerebrospinal fluid (CSF) total protein in WCFT patients | **Key successes:**<br>• The audit results suggests that, in The Walton Centre population, an isolated, raised CSF total protein is a significant but non-specific finding. However, these findings could not be applied to a general population<br>• This supports the well-established role of the CSF total protein test as a useful screening tool for neurological conditions that give rise to inflammation of the meninges or alterations in CSF flow.<br><br>**No key concerns or actions** |
| Neuropathology report-content audit following the introduction of new changes in central nervous system (CNS) WHO book 2021 | **Key successes:**<br>• The essential changes that have been brought in following the publication of the 2021 WHO blue book were correctly applied in the neuropathology reports audited on CNS tumours<br><br>**No key concerns or actions** |
| Research Request Forms R2 and R3 Horizontal Audit 2021 | **Key successes**:<br>• All the samples of the Liverpool Neuroscience Biobank at The Walton Centre (LNBW) that includes: Walton Centre Research Tissue Bank (WRTB) and Walton CSF Research Biobank (WCRB) documentation and paperwork have been |

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| | released with correct respective forms and signed by either the Designated Individual or Person Designated and comply with Human Tissue Authority (HTA) regulations<br><br>**No key concerns or actions** |
| Research Ethics Committee (REC) and Regional Governance Committee (RGC) Approvals Audit 2021 | **Key successes:**<br>• 26/26 (100%) had either an REC or an RGC number present or both which could be found on documentation/file within the Neuroscience Laboratories. This demonstrates full compliance with the HTA regulations<br><br>**No key concerns or actions** |
| Low grade glioma audit | **Key successes:**<br>• In accordance with current literature our figures show that the extent of resection is associated with increased progression free and overall survival<br>• There has been a transition to using PCV chemotherapy since the 2018 NICE guidelines were introduced<br>• The data has been shared with clinical oncologists at Clatterbridge Cancer Centre and North Wales<br><br>**No key concerns or actions** |
| GIRFT Surgical Site Infection (SSI) Survey 2019 | **Key findings:**<br>• No conclusions can be drawn from the single infected posterior cervical instrumentation incident. (One of three cases): continue to monitor via surgical site infection reports<br>• In depth review of EVD/CSF infections to be undertaken to provide an understanding of potential causes for these infections<br>• In depth review of single level spine surgery infections to be undertaken to provide an understanding of potential causes for these infections<br>• SSI recording and reporting is a labour-intensive paper based manual process and could be improved via digitalisation and automation<br>• The data collection is incorrect to state that there is no SSI bundle: this is checked via the WHO checklist at the start of every case: hair removal, glycaemic control, temperature control and prophylactic antibiotics are confirmed prior to incision<br>• Laminar flow has widely been discredited in surgical site infection prevention and is known to be harmful in cranial surgery due to excessive tissue desiccation<br><br>**Key actions**<br>• Implementation of a live digital dashboard<br>• Education for the CNS teams from IPC regarding SSI underway<br>• Digital version of SSI reporting form implemented<br>• Rapid Reviews and or RCAs are now performed on CSF infections where necessary |

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| | The One Together programme is in progress at the Trust to standardise theatre procedures and review contributory factors to SSI |
| Vertical audit – Neuropathology specimens | **Key successes:**<br>• The specimen was handled in accordance with Trust and Neuroscience Laboratory policies, procedures and SOPs<br>• All documentation was in date apart from the document HSB36 on the intranet which was replaced with HSB73.This was rectified immediately<br>• SOP HSS34 updated to the new SOP template which includes all required information and the turnaround time stated on the intranet<br>• The request card was completed correctly by both clinical staff and laboratory staff<br>• PAT testing and PDRs already organised<br>• Although the reporting of the sample breached the turnaround time of seven calendar days, TAT times are monitored monthly and as more than 80% passed in April when this specimen was received no further action is required<br><br>**No key concerns or actions** |
| Intraoperative diagnosis versus final diagnosis 2021 | **Key successes:**<br>• Diagnostic accuracy for intraoperative specimens reported in 2021 was 95.3% against a target of 93.6%<br>• The results are consistent from last year with 95.3% accuracy<br><br>**No key concerns or actions** |
| Neurobiochemistry vertical audit 2022 - Serum Albumin | **Key successes:**<br>• Process for quantifying serum albumin is working well.<br>• The specimen was handled in accordance with Trust and Neuroscience Laboratory policies, procedures and SOPs. All documentation was in date<br><br>**No key concerns or actions** |
| 5-Aminolevulinic acid (5-ALA) use at The Walton Centre | **Key successes:**<br>• The audit has highlighted that the use of 5-ALA has aided surgical resection, enabling greater resection in the majority of patients prescribed for at The Walton Centre. It has been used in accordance with NICE for HGG resections in 87% of cases<br><br>**Key concerns:**<br>• Some improvement could be made in ensuring the correct dose is prescribed and the appropriate monitoring (LFT) is carried out post procedure |

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| | • Theatre documentation could be improved so future audit can more easily identify extent of resection and extent of fluorescence<br><br>**Key actions:**<br>Reiteration for consultants prescribing 5-ALA to ensure policy and process is adhered to in terms of dosing to ensure care provided is standardised |
| LNBW 20 Research Consent forms Audit 2021 | **Key successes:**<br>• 366/367 (99%) consent forms were complete and valid<br><br>**Key concerns:**<br>• 9/273 LNBW-WRTB consent forms (3.2%) were not signed by person taking consent. (3.2% in 2020)<br>• 14/273 LNBW-WRTB consent forms (5.0%) of the wrong colour copy of consent forms received instead of white copy (2.4% in 2020). The consent forms are still valid<br>• 16/94 LNBW-WCRB consent forms (16.9%) had been ticked instead of initiated. (12.3% in 2020)<br><br>**Key actions:**<br>• Retrospective completion of missing data<br>• Refresher training to theatre staff |
| Management of subarachnoid haemorrhage | **Key successes:** N/A<br><br>**Key concerns:**<br>• Documentation on admission requires improvement<br>• Clear targets were not documented<br>• Design of proforma for admission to ICU required<br>• New admission proforma for wards required (Vascular nurse specialist has completed)<br>• Consideration for pre-Walton admission administration of Nimodipine required<br><br>**Key actions:**<br>• A programme of work is currently underway to digitise the documentation in ITU<br>• New admission proformas for wards implemented |

## Trustwide clinical audits and service evaluations

| Audit title | Actions |
|---|---|
| CSF Index and Oligoclonal band (OCB) results 2021 (NS 396) | • No actions necessary<br>• Discussed / presented Neurobiochemistry – The Neuroscience Laboratories<br>• Discussed at Neurology Governance and Risk as project also relevant to Neurology |

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 and Risk Group monthly meetings.

### 2.3.6 Participation in clinical research and development

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

1049 patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2022/23 were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority.

No yearly target was set for this financial year, however an approach is being developed to improve our systems to encourage a research-positive culture and diversify the research portfolio so that research is meaningfully embedded in the experience of all patients and service users.

There are currently 78 clinical studies open to recruitment at The Walton Centre, with a research pipeline of new studies in the feasibility and/or set-up phase (currently 39 but this number will increase as new investigators are supported via the expressions of interest process) which will be ready to open at different points throughout 2023/24.

Having secured a collaboration with an external industry partner, Neuroscience Research Centre (NRC) patients now have access to participate in a Phase 2 clinical trial for fibromyalgia.

During 2022/23 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)

### 2.3.7 CQUIN framework and performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between The Walton Centre and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2022/23 and for the following 12-month period are available electronically at wcft.enquiries@nhs.net.

A proportion of the Trust's income in 2022/23 was conditional upon achieving quality improvement and innovation goals. The total payment received against the CQUINs in 2022/23 was £1,098,000.

### 2.3.8 Care Quality Commission (CQC) registration

The Walton Centre is required to register with the Care Quality Commission. Its current registration status is registered without conditions.

The CQC has not taken enforcement action against The Walton Centre during 2022/23. The CQC undertook an inspection, including well-led, during March and April 2019, which resulted in an Outstanding status for the second time.

No further formal assessments have been undertaken during 2022/23. CQC engagement meetings restarted in April 2023.

**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 2022/23 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 (December 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
- 99.9% for admitted patient care

This year is the fifth 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 36 assertions and 113 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 30 June 2023. 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 2022/23 Data Security and Protection audit requirements is currently ongoing throughout February and April 2023 and the Trust will then receive the outcome of this review in May 2023. 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 was not subject to the Payment by Results clinical coding audit during 2022/23 by the Audit Commission.

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 2022/23**

| Coding Field | 2020/21 | 2021/22 | 2022/23 | Difference 21/22-22/23 | Mandatory | Advisory |
|---|---|---|---|---|---|---|
| Primary diagnosis | 91.00% | 96.70% | 97% | +0.30% | 90% | 95% |
| Secondary diagnosis | 86.00% | 94.14% | 95% | +0.86% | 80% | 90% |

| | | | | | | |
|---|---|---|---|---|---|---|
| Primary procedure | 97.00% | 99.40% | 98.5% | -0.90% | 90% | 95% |
| Secondary procedure | 98.00% | 93.87% | 96% | +2.13% | 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 2022/23, 112 of The Walton Centre's patients died. This can be broken down by the following number of deaths which occurred in each quarter of that reporting period:

- 20 in the first quarter
- 40 in the second quarter
- 30 in the third quarter
- 22 in the fourth quarter

By 31 March 2023,106 case record reviews had been carried out in relation to 112 of the deaths included in item 2.3.10.1. Six case records are awaiting review.

In two 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:

- 19 in the first quarter
- 39 in the second quarter
- 30 in the third quarter
- 18 in the fourth quarter

2.3.10.2 Zero 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.

Zero case record reviews and zero investigations completed after 31 March 2022 which related to deaths which took place before the start of the reporting period.

Zero 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.

Zero representing 0% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient.

### 2.3.11 Progress in implementing clinical standards for seven day hospital services

In the seven-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 seven-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 seven days. As a specialist Trust there has been discussion with the seven-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, will usually 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 2023.

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 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 Covid-19 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 and reported 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 during their induction. Each individual staff member receives a business card with specific contact details should they wish to raise a concern and can arrange a meeting on/off site.

There are sixteen FTSU Champions in post to support speaking up across the Trust.

There is a dedicated section on the Trust intranet site which provides information in relation to speaking up. It includes how to speak up, who to speak up to, what happens when staff speak up and information on who the FTSU Guardian and Champions are, their pledges, and contact details.

We recognise that our staff 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 and Inclusion, Unions, HR, Occupational Health, Anti-Fraud Specialist (not exhaustive list). Staff can also raise their concerns externally if they wish to do so.

Following the publication of the latest version of the Freedom to Speak up Policy for the NHS we have revised our policy which was approved and is held on the Trust Intranet site.

Drop-in sessions are scheduled throughout the year across each of the areas within the Trust.

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 taken the FTSUG meets with the individual raising the concern to provide an update and agree no further steps are to be taken. They are also asked to make contact with the FTSUG if they perceive to be treated unfairly following them speaking up.

### 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 detrimental 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 rotas the Trust will make arrangements to either employ a Locally Employed doctor to fill the daytime and out-of-hours or an agency locum or internal locum cover will be considered in the interim and until it can be recruited to via NHS Jobs.

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. The Guardian of Safe Working reports directly to Trust Board on a quarterly basis. Any exception reports have related to breaches in minimum rest requirements and have been satisfactorily dealt with by time off in lieu, plus payment.

## Part 3 Trust overview of quality 2022/23

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2022/23.

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 | 2022/23 | National trajectory |
|---|---|---|---|---|---|
| C Difficile | 5 | 3 | 8 | 7 | 8 |
| MRSA Bacteraemia | 0 | 0 | 0 | 0 | 0 |
| E. coli | 13 | 7 | 11 | 12 | 10 |
| MSSA | 5 | 13 | 10 | 11 | n/a |
| Klebsiella | 3 | 6 | 5 | 5 | 3 |
| Pseudomonas | 1 | 3 | 2 | 2 | 1 |
| Minor and moderate falls | 37 | 19 | 30 | 31 | n/a |
| Never Events | 1 | 0 | 2 | 0 | n/a |
| Data Source: Infection Prevention and Control NHSE<br>Set following review of previous years' performance using NHSE national calculation | | | | | |

**Clinical effectiveness indicators**

| Mortality | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|
| Neoplasms | 13 | 7 | 8 | 15 |
| Diseases of circulatory system | 36 | 52 | 23 | 43 |
| Injury, poisoning and certain other consequences of external causes | 29 | 27 | 24 | 37 |
| Diseases of the nervous system | 9 | 15 | 7 | 13 |
| Other | 6 | 10 | 2 | 4 |
| Total | 93 | 111 | 64 | 112 |
| Data Source: Patient Administration System | | | | |

**Patient experience indicators**

| Patient experience questions | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|
| Were you involved as much as you wanted to be in decisions about your care and treatment? | 95% | 89% | 89% | Results available Oct 2023 |

| | | | | |
|---|---|---|---|---|
| Overall did you feel you were you treated with respect and dignity while you were in the hospital? | 99% | 99% | 93% | Results available Oct 2023 |
| Were you given enough privacy when discussing your condition or treatment? | 94% | 84% | 99% | Results available Oct 2023 |
| Did you find someone (hospital staff) to talk to about your worries and fears? | 82% | 93% | 93% | Results available Oct 2023 |
| Data Source: CQC Adult Inpatient Survey | | | | |

## 3.1 Complaints

### 3.1.1 Patient experience, complaints handling and Patient and Family Centred Care

The Walton Centre acknowledges that attending hospital can be a difficult and frightening experience. This was particularly tough during a pandemic when visiting restrictions were in place. The Patient and Family Experience Team (PFET) 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. They can be contacted by telephone, email, in writing, booking an appointment or in person whilst in the Trust.

Where concerns cannot be easily resolved informally or are of a more serious or sensitive nature, the Patient and Family Experience Team is responsible for supporting the patients and their families in managing and resolving the complaint via the formal complaints procedure. We pride ourselves on working with patients and their families and carers to resolve complaints in a timely way. When responding to complaints if they are upheld and require action and learning this is explained within and how the learning will be applied 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. We respect this at all times and will always seek consent from the patient in order to investigate concerns or complaints on their behalf.

Throughout the past year, the Patient and Family Experience Team have:

- Continued to actively listen and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- Provided support to families of the bereaved advising and signposting them to through the correct process, i.e., the Medical Examiner or the Coroner
- Reviewed the Complaint Policy and Procedure to include more detail regarding Welsh complaints in line with Putting Things Right and additional information with regards to guidance on the Trust website.
- Continue to proactively engage with families/clinical staff by being involved at the earliest opportunity at best interest and multidisciplinary meetings during long admissions for rehab or prior to discharge
- Provide bi-monthly assurance to Trust Board by presenting complaints data/trends and analysis and updates on patient experience activity to the Executive Team

- Continued to support and engage with all volunteers and provide them with adequate, timely training and support.
- Continue to provide birthday gifts/cards/visits for inpatients, Sleep Well packs for inpatients all initiatives supported by The Walton Charity and connecting hearts for memory boxes
- Facilitated internal engagement listening events in partnership with Healthwatch to gain and act on feedback provided from patients and groups who represented them
- As part of the Mortality Governance Lead role/PFET developed a pathway to proactively provide family support following a death
- Continue to work in partnership with the Communications and Marketing Team to arrange a patient story for the monthly Trust Board meeting either in person or via MS Teams from each of the different service lines
- Introduced training for Band 6 prospective Ward Managers as part of the Building Rapport course
- Continue to provide junior doctors and Consultants in relation to good practice/documentation and when required to provide input into coronial enquiries, inquests and claims
- Provided on-site 1:1 support for staff prior to and during a high profile coroner's inquest
- Planned an on site Mock Coroner's Inquest provided by Trust solicitors
- High level learning from complaints/claims/coronial inquests and enquires share in quarterly governance bulletin
- Engagement and attendance at off site patient support groups
- Facilitated focus groups with view to gaining feedback to drive improvements
- Developed Patient and Family Centred Care workplan

### 3.1.2 Complaints management and lessons learnt

The Patient and Family Experience Team work proactively in collaboration with the Neurosurgical and Neurology divisions and Senior Nursing Team in order to investigate and manage complaints in an aim to meet the needs of each individual patient or family member and reach a resolution. 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 by the appropriate division and complainants receive their response in their preferred format. Those who raise concerns can received their response via a telephone call to give them an opportunity for further discussion, or response from the Patient and Family Experience Team (PFET) via email or letter. All formal complaints are responded to in writing by the Chief Executive and/or complainants may be offered a meeting with the senior staff from the respective division, supported by PFET.

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 and Family Experience Team and the Divisional Management Teams at a weekly joint divisional meeting held on MS Teams. Progress is recorded each week and escalations made if required. 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. 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. Draft responses are quality reviewed by the Deputy Chief Nurse and/or Medical Director before being reviewed by the Chief Executive.

Outcomes from complaints are reported monthly to the respective Divisional and/or Ward Manager, Risk and Governance committees and meetings within the Trust. Trends, themes and lessons learnt documented within the quarterly Patient Experience 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 as part of the bi-monthly Patient Experience Update Report to offer assurance that the management process is robust and actions managed in a timely way and highlight any concerns or escalations.

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. Patient feedback is also shared at the daily Safety Huddle.

Examples of lessons learnt from complaints during 2022/23 include:

- A review of the Transition Service from child to adult services. This includes a review of processes under specific services, including epilepsy, including exploring options for education, alerts within clinical systems highlighting patients who have recently transitioned. The divisional team are working in partnership with other Trusts to drive this improvement work forward
- Improvements have been made to the headache service following a patient experiencing a delay in being issued with prescription. These plans include building requests into electronic patient records for headache service to prevent the risk of recurrence and avoid internal emails to prevent errors.
- Nursing – monthly audits to include wrist band compliance to be undertaken

### 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 and Family Experience Team.

- 138 new complaints were received in 2022/23, Q1(33), Q2 (26), Q3 (43), Q4 (36) which is an increase of 84% from 75 in 2020/21. This is in line with pre-covid numbers.
- There were 835 concerns received in 2022/23 compared to 745 in 2021/22 which is am 11.4 % increase and 400 enquiries, which is a 27% increase (compared to 306 the previous year). All

enquiries and concerns were efficiently and effectively investigated and responded to by the Patient and Family Experience Team to prevent escalation.

- Despite the increase in the number of complaints received Trust have met their KPIs for responding to complaints as they aim to respond to Level 1 complaints within 25 working days and Level 2 within 45 working days.

**Complaints received 1 April 2022 – 31 March 2023**

| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 |
|---|---|---|---|---|
| Number of new complaints received | 33 | 26 | 43 | 36 |

This increase in complaints is not surprising and in keeping with the current pressures on the NHS. Trends included appointment arrangements, waiting times and communication.

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 and Family Experience Team acknowledges all complaints and agrees the best way of addressing their concerns, in line with managing expectations. The Trust works 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 Chief Nurse. 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, the Neuro Therapy Centre and Headway.

The Trust actively engaged with Governors through a forward planning event on all aspects of quality including choice of indicators for 2022/23.

### 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 introduced a strategy which covers the three years from 2022 to 2025 and reflects the pace of change in the NHS due to the COVID-19 pandemic and the infrastructure changes brought about by the Health and Social Care Bill 2021. The new strategy sets out how we will expand our services further and will continue to innovate, research and develop. It also highlights what the key initiatives will be over the next three years, and how we will further develop our services across our regions, as well as developing national neuroscience services.

Our strategy aligns with national, regional and local system plans, including acute and primary care services, along with the voluntary and third sector, linking in with the Cheshire and Merseyside ICS place-based plans and those of One Liverpool, North Wales, and across Merseyside.

In developing the strategy, we involved staff from across the Trust, patients and carers, the voluntary sector, support groups, our Governors and members, and representatives from partner trusts, primary care and the ICS. There was positive engagement from staff and stakeholders, who clearly hold The Walton Centre dear to their hearts. We will continue to listen and engage and use that feedback to further influence our plans as we implement the strategy.

The strategy comprises five strategic ambitions which will enable us to continue to deliver world-class care to our patients and their families. The strategic ambitions are:

- Education, training and learning
- Research and innovation
- Leadership
- Collaboration
- Social responsibility

Underpinning these ambitions are seven enabling strategies:

- Quality - Ensuring the delivery of the highest quality of care to our patients and their families
- People - Committed to a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background
- Digital - Developing and implementing industry-leading digital solutions for our patients and our people
- Estates, facilities and sustainability - Taking a multidisciplinary approach to ensuring that sustainability in estates and facilities is at the heart of our work
- Finance and commercial development - Maximising use of resources, improving productivity and developing market opportunities to deliver best value for the Trust and the wider system
- Communications and marketing - Promoting our work as the only specialist neurosciences NHS trust and ensuring patients and staff receive the best quality information
- Charity - Supporting the work of the Trust through new opportunities and initiatives, in particular digital fundraising

### 3.4 First Walton Centre patient receives groundbreaking treatment for essential tremor

We have rolled out a new service using cutting-edge treatment for people living with essential tremor which is a neurological disorder that causes an uncontrollable shake or trembling in a part of the body. We are the first Trust outside London to deliver this new service. The procedure, trans-cranial MR-guided focused ultrasound, involves thermal tissue ablation targeted at the key areas of the brain causing the tremors. Eligible patients get one treatment to reduce the tremors on one side of their body. Current regulatory approvals demonstrate good clinical durability, with tremor relief maintained at three years.

### 3.5 New guidelines launched for fibromyalgia syndrome

One of our Consultants in Pain Medicine was one of the lead authors of new guidelines for the diagnosis of fibromyalgia syndrome (FMS). The new guidelines were launched at the Royal College of Physicians in Liverpool. These are the first UK guidelines for the condition and will have a significant impact on patients. The new guidelines aim to support clinicians in the diagnosis of FMS, without the need for rheumatology referral, preventing unnecessary surgery, enable patients to be placed on the appropriate treatment pathway earlier and empower patients to be more knowledgeable about their condition.

### 3.6 Specialist spinal service receives Centre of Excellence award

The Trust received Centre of Excellence status after delivering outstanding fully endoscopic spinal surgery to patients in Cheshire, Merseyside and North Wales. The award, given by RIWOspine, the manufacturers of the innovative fully endoscopic equipment, comes after The Walton Centre Charity funded the project in 2020. Gaining Centre of Excellence is a gold standard, making the hospital one of only a handful to achieve the status. One of our Consultant Spinal Surgeons is one of few surgeons in the country who can perform this type of surgery.

The procedure is used to treat spinal conditions such as sciatica due to disc bulges and spinal stenosis, along with other ever evolving newer surgical indications. As part of the recovery process for some of the procedures, patients can be up and walking around merely hours after the surgery. In many cases, patients can go home the same day if they have recovered enough.

### 3.7 The Walton Centre launches its new Trust Strategy

In September 2022 we launched our new three-year Trust strategy, which sets out how we will continue to deliver excellent clinical outcomes and patient experience with our team of dedicated, specialist staff. The strategy reflects the pace of change in the NHS due to the COVID-19 pandemic and the infrastructure changes brought about by the Health and Social Care Bill 2021. Patients, their families and our staff are at the heart of the new strategy as is collaboration with our partners across the region – throughout the health, government, voluntary, education and third sectors.

### 3.8 Specialist neurosciences trust achieves University status

In September 2022 we became the newest member of the University Hospital Association. University hospitals are specialty trusts with significant involvement in research and education. Their research puts them at the forefront of developments in care and connections with industry, while their work in education makes them central to providing the future workforce. The Walton Centre is the country's only specialist neurosciences hospital, providing comprehensive neurology, neurosurgery, spinal, pain management and rehabilitation services at our site in Liverpool, and in satellite clinics across the north west and North Wales.

### 3.9 The Walton Centre operates on first patients using cutting-edge navigation in complex spinal surgery

Spinal patients at The Walton Centre can now benefit from a groundbreaking new surgical robotic navigation system which is one of the first of its kind to be used in the NHS. The 'ExcelsiusGPS®', manufactured by Globus Medical UK Ltd, enables patients spend less time in theatre and potentially reduce recovery time after major spinal surgery. The system involves a rigid robotic arm, tracked and fully navigated by a camera, which is then programmed to follow a trajectory pre-planned by our surgeons. This allows them to facilitate placement of spinal screws and interbody cages to an incredibly high level of precision.

### 3.10 New clinic making a difference for MND patients

A new service aimed at reducing the impact of one of the most devastating symptoms of Motor Neurone Disease (MND) is being piloted at The Walton Centre. Swallowing problems, known as dysphagia, affect at least two-thirds of all people with MND during the course of their illness. This can either result in choking and chest infections if food, drink or saliva goes backwards, or drooling if forwards. As well as significant health consequences, the impact of symptoms like drooling can result in considerable quality of life issues.

### 3.11 Tracheostomy Ted helps young visitors understand rehabilitation

Following the admittance of a patient, James, who had suffered a stroke caused by a massive bleed on the brain, Speech and Language Therapists worked with him and his family to demystify the impact of him having a tracheostomy.

After lifesaving surgery and treatment, James spent weeks in intensive care, and could only blink and use his big toe to communicate when he woke up. For a large part of his rehabilitation he had a tracheostomy which unsettled his young children and became difficult to explain. His Speech and Language Therapists saw how difficult this must have been and created 'Tracheostomy Ted' a teddy bear with its own tracheostomy, to support the patient and his young family.

### 3.12 Lighting innovators Circada launch first pilot at Trust to improve staff and patient wellbeing

Lighting firm Circada kickstarted its campaign to change people's relationships with their natural body clock with the launch of the inaugural pilot. The Walton Centre was the first Trust in the UK to

take part. Circada's lighting technology works by changing the colour of the lighting throughout the day to match the daily and seasonal pattern of the sun, with superior and tailored light matched to our biological needs throughout. Following the installation of the Circadian lighting system into part of the intensive therapy unit (ITU) at the hospital, a three-month pilot was undertaken. This will benefit patients and staff, and potentially improve patient flow by reducing the time spent in ITU.

### 3.13 Saving the day with the HALO service

In October 2021, Liverpool Football Club Women's goalkeeper, Rylee Foster, was involved in a serious road accident in Finland, and was thrown from a vehicle at high speed. She sustained several fractures to the bones in her neck as well as multiple serious injuries to the rest of her body. She was stabilised at a local hospital and flown back to Liverpool a week later. It was at that point that clinicians at LFC asked for experts at The Walton Centre to review her scans.

She was asked to come to the Trust immediately and was fitted with a Halo jacket, an external fixation device, which consists of an external metal frame that attaches to the head with four screws. Once fitted, it reduces the weight off the head on the neck and stops any movement of the neck, allowing the fractures to heal and repair. Without this, Rylee would have risked severe injury, maybe even paralysis. After several months in the Halo scans showed that Rylee's fractures were healing and she continues to recover.

### 3.14 Neurologist appointed to leading research programme

One of our Consultant Neurologists has been appointed to the North West CRN Advanced Research Scholars Programme. This programme is aimed at equipping tomorrow's clinical research leaders with the skills, knowledge and experience needed to become the Principal and Chief Investigators of the future. The Walton Centre has a proud tradition of delivering high-quality clinical neuroscience research, in collaboration with our local universities and commercial partners, to improve patient outcomes and experiences.

As one of our five strategic ambitions in our three-year Trust strategy, it is a key area of focus, particularly attracting and developing highly skilled and motivated people, who want to support our research and innovation ambitions.

### 3.15 Professor of Pain Medicine at the Institute of Life Course and Medical Sciences

One of The Walton Centre's Pain Medicine Consultants, Andreas Goebel, attained a professorship with the University of Liverpool, after demonstrating substantial progress in research into causes and new treatments for chronic primary pain. His research includes developing an understanding the role of the adaptive immune system in causing severe, seemingly unexplained, chronic pain, focusing on Complex Regional Pain Syndrome (CRPS) and Fibromyalgia Syndrome (FMS).

### 3.16 Overview of performance in 2022/23 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 | 2020/21 performance | 2021/22 performance | 2022/23 performance | 2022/23 target |
|---|---|---|---|---|
| Incidence of MRSA | 0 | 0 | 0 | 0 |
| Screening all inpatients for MRSA | 96.55% | 97.94% | 97.38% | 95% |
| Incidence of Clostridium difficile | 7 | 8 | 7 | 8 |
| All cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery | 100% | 100% | 94% | 100% |
| All cancers: 62 days wait for first treatment from urgent GP referral to treatment | 100% | 100% | N/A | 85% |
| All cancers: Max waiting time of 31 days from diagnosis to first treatment | 100% | 100% | 100% | 96% |
| All cancers: Two week wait from referral date to date first seen | 98.9% | 100% | 99.5% | 93% |
| All cancers: 28 Day faster diagnosis | N/A | 98.75% | 98.97% | 70% |
| Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway | N/A | N/A | N/A | N/A |
| Maximum six week wait for diagnostic procedures | 19.33% | 0.30% | 0.37% | 1% |
| Certification against compliance with requirements regarding access to health care for people with a learning disability | Fully Compliant | | | |

### 3.17 Overview of performance in 2022/23 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 2022/23 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% |
| 2022/23 | 210 | 4.40% |
| Change 2021/22 - 2022/23 | 9 | -0.16% |

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
- A morbidity consultant lead has recently been appointed who has identified time within their job plan to review this process

**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 annual CQC National Inpatient Survey 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 received their results for the 2021 survey in October 2022 and have been identified as performing **'Much 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 Walton Centre Trust scored **Much better than average** in one of the 10 sections and **Better than average** in five sections
- The results highlight a 47.4 % response rate (previously 56% in 2020) with an average response rate of 39 % for other organisations.
- The Trust was rated 11th out of 134 Trusts nationally for overall positive patient experience, this is not comparable as the questions and data differed somewhat to the previous year.
- The questions had slightly changed for the 2021 survey and the CQC benchmark methodology to provide Trusts with more detailed results and the scores were categorised as:
  - Much better
  - Better
  - Somewhat better
  - Same
  - Much worse
  - Somewhat worse

| National Inpatient Survey question | 2017 Result | 2018 National Comparison | 2019 Result | 2020 Result | 2021 Result | 2022 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 | Better | Results available Oct 2023 |
| 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 | Somewhat better | Results available Oct 2023 |
| 3. Were you given enough privacy when discussing your condition or treatment? | 8.6 | About the same | Slightly worse | 84% Better | Somewhat better | Results available Oct 2023 |
| 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 | Better | Results available Oct 2023 |
| 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 | About the same | Results available Oct 2023 |

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 **45.98%** and a recommended rate of **98.09%** which is excellent.
For outpatients, the internal target of 90% recommended rate was exceeded at **94.46%** with a response rate of **5.76%,** there is not set internal KPI for average response rate is around 4.5%.

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

A business plan is currently underway with the aim to introduce SMS messaging to increase the response rate in 2023/24.

<u>Patient and family experience initiatives</u>

- The complaints policy was updated and reviewed in 2022
- Undertook a full review and re-design of the complaints module on Datix with the aim of more accurate reporting
- Engagement with divisions to implement escalation process to support staff in resolving concerns in the first instance
- In 2022 bespoke complaints training/support was provided for admin teams and prospective ward managers as part of the Aspiring Ward Manager Programme
- Patients, families and staff stories in various formats continue to be 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.

- In 2022/23 the Trust Board received a story from a different service line each month supported by the Patient and Family Experience, and Communications and Marketing 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
- Various engagement events with external stakeholders including Healthwatch Sefton, Liverpool and attendance at various support groups including MND Wirral and Liverpool took place throughout 2022/23
- Volunteer website pages reviewed and updated to include new volunteer profiles
- Volunteer profiles installed on the main corridor to support the Why Walton? step of the six steps of the Patient and Family Centred Care journey
- New volunteer roles including Volunteer Therapy Dog, trolley service extended to staff and patients in the Sid Watkins building, new mobile library service commenced
- Carers passport relaunched to support families of patients
- New training developed for Cheshire and Merseyside Rehabilitation Network
- Introduced Transgender Awareness Sessions for all Trust staff
- Transgender Awareness workshop planned for Trust Board in April 2023
- Health and Safety Training for doctors reviewed to include the claims process
- Transgender, non-binary and gender fluid patient policy developed in partnership with Genderspace UK
- Patient and Family Experience staff are represented on the Trust staff network groups including LBGTQ+ and Disability Group
- Plans are underway for the Trust to recruit two Patient Safety Partners in line with PSIRF
- Home from Home Welcome Pack has been reviewed to include a QR code to take families to the website
- Home from Home Website information also has been updated
- Claims process reviewed to include clinical lead & claims manager to triage claim at earlier opportunity
- More in depth information included in junior doctors and Medical Health & Safety Training to provide education to staff
- Three patients with long-term conditions recruited for Neuroscience Programme Board in July 2022 and provided with support prior to, during, and post meetings
- Well-led focus group held in February 2022 as part of the Trust's overall well-led review
- Arteriovenous malformation focus group attended by staff member from PFET and volunteer
- Trust volunteer recruited to support with C.H.A.T Project is working with Liverpool College to develop a virtual reality software education tool aimed at young adults to increase awareness of the Consequence of Head Injury Acquired in Trauma
- Trust Volunteers formed part of the PLACE assessment
- Patients and families involved in providing feedback on plans for redesign and development of areas including new infusion suite on Sherrington Ward
- Partnership working with Mersey Society for Deaf People, to develop ways of how to improve services for the deaf community

- Family member of patient with learning disabilities (LD) identified to support with new initiatives for LD including requirement and recruitment of LD nurse
- Relaunch of Patient and Family Centred Care in March 2023 with work plan to progress via small working groups

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

- A business case has been developed to introduce SMS feedback for Friends and Family Tests to continue to enhance and develop patient experience
- A specific workplan has been developed for the delivery of Patient and Family Centred Care for 2023/24
- Plan Trans Awareness sessions for 2023/24 with the aim for all disciplines of staff to attend

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

**Response:**

The Trust had a response rate of 42% for the 2022 national staff survey; the national average for acute specialist trusts in England for 2022 was 52%.

Within the survey, the percentage of staff who would recommend the Trust as a place to work scored 70.3% against an average of 68.6% and the percentage of staff who would recommend the Trust as a place to receive treatment scored 86.5% which was the same as the average.

The findings for 2022 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 higher than average in all elements of the NHS People Promise with the exception of “we’re always learning” which scored average but was an improvement on last years.

**Staff engagement**

Staff engagement is measured across three sub scores:

- Motivation
- Involvement
- Advocacy

The Trusts overall score for staff engagement is an improvement on last years score from 7.3 to 7.4 and is above the average of 7.2.

**Morale**

Morale is measured across three sub-scores:

- Thinking about leaving
- Work pressure
- Stressors

The Trusts overall score for morale remained the same as last year at 6.2 and is above the average of 6.1.

In addition to the annual staff survey, quarterly People Pulse surveys took place in April and July 2022 and January 2023. 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 2022 the results showed that 84.6% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 57.5% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

In July 2022 the results showed that 79.8% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 57.1% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

In January 2023 the results showed that 86.9% of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment and 69.2% of staff who completed the survey said they would recommend The Walton Centre to friends and family as a place to work.

**WRES**

Four key questions make up the WRES section of the staff survey as follows:

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months - this score has increased from 2021 for white staff and all other staff with a higher percentage increase for all other ethnic groups.
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months - this score is broadly similar to last year's for white staff and has increased by 2% for all other ethnic groups.
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion - this score has increased by over 4% for white staff and decreased by 2.5% for all other ethnic groups.

- Percentage of staff experiencing discrimination at work from manger/team leader or other colleagues in the last 12 months - this score has decreased by 1.8% for white staff and increased by 5.1% for all other ethnic groups - this question is of particular concern.

533 white staff responded to the survey and 53 staff from other ethnic groups.

**WDES**

Seven key questions make up the WRES section of the staff survey as follows**:**

- Percentage of staff experiencing harassment, bullying or abuse from patients/service users, relatives or the public in the last 12 months - this score has increased for staff with or without a long-term illness (LTC).
- Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months - this score has increased by 5% for staff with a LTC and has decreased for staff without an LTC.
- Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months - this score has decreased by 4% for staff with a LTC and has increased slightly for staff without an LTC.
- Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it - this score has increased for both groups of staff and by 12% for staff with an LTC.
- Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion - this score has increased for both groups of staff.
- Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties - this score has decreased by 4% for staff with an LTC and increased slightly for staff without an LTC.
- Percentage of staff satisfied with the extent to which their organisation values their work - this score has increased slightly for staff with a LTC and by 5% for staff without.

443 staff without an LTC responded to the survey and 135 staff responded with an LTC.

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 2023 survey. A Trust action plan and Divisional action plans will be formulated and approved by Board.

**Volunteers**

Volunteers are considered an important and vital part of the team.

Volunteer roles include:
- Meet and greet
- Infection prevention volunteers
- Outpatient volunteers in the outpatient department and Radiology
- Neurobuddy volunteers providing support in ward areas
- Trolley – Treats and Sweets service across the Trust
- Mobile Library Service

- Reading Buddies
- Visiting service
- Pet Therapy Service

In 2022/23 volunteers have benefitted from:

- Quarterly newsletters
- Volunteer Week celebrations in June 2022
- Engagement and staff/volunteer support with local foodbanks
- Volunteer of the Month
- End of year celebration
- Participation in Patient Led Assessment for Care of the Environment (PLACE)

In 2022/23 we successfully fully re-introduced our volunteer service following the pandemic with new exciting roles. This has resulted in supporting patients and families and we aim to build on this further in 2022/23.

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

- Present a further business case to expand the service of FFT to SMS and voice feedback with the aim to increase the response rates

**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 |
| 2022/23 | The Walton Centre | 98.44% | 98.43% | 98.69% | 98.88% |
| | 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:

- VTE risk assessments are conducted within six hours of admission by nursing staff. If a patient is identified as being at risk of a VTE nursing staff can implement the use of mechanical VTE prevention (anti-thrombolytic stockings) and medical colleagues review the patient in terms of pharmacological interventions (prophylactic medications).

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

- For any VTEs that do occur for inpatients at The Walton Centre a rapid review is triggered to be undertaken. Usually these are conducted by our medical team whereby a review of patient care, treatment and applied interventions are considered, noting any lapses in care and care delivery issues. Where required, actions are noted to address any practice issues and patients are fully informed of the harm that has occurred in line with the duty of candour process

## 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.

**The Walton Centre C. difficile infections per 100,000 bed days:**

| | 2017/18 | 2018/19 | 2019/20 | 2020/21 | 2021/22 | 2022/23 |
|---|---|---|---|---|---|---|
| The Walton Centre | 13.3 | 13.7 | 9.5 | 7.81 | 17.48 | 13.43 |

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

- In 2022/23 The Walton Centre had a total of seven C. difficile infections against the trajectory set by NHSE/I of eight. Although we would have hoped for a bigger reduction this compares favourably well in comparison to other Trusts within the region.

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

- Implementation of the Infection Prevention and Control (IPC) Framework
- Clear objectives have been set for year one of the IPC framework delivery plan
- We have applied for Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) to demonstrate we have strong antimicrobial stewardship
- Following the implementation of Tendable we will utilise the app to analyse and audit outcomes to identify good practices and areas of were changes are required
- Use of technology e.g. Hydrogen Peroxide Vapour (HPV) and UV machine to support environmental cleanliness
- We will implement a digital HCAI surveillance programme

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

Mersey Internal Audit Agency (MIAA) undertook an audit on Data Quality. The overall objective of the audit was to provide assurance that systems and processes are in place to accurately report performance against the Trusts key performance indicators.

The Trust were given moderate assurance that related to the reporting data for pressure ulcers (PUs) and healthcare associated infections (HCAIs).

Two areas of recommendation included implementing ICE (automated laboratory request/reporting system) and transferring the current checklist into a Standard Operating Procedure.

In response to these findings the Trust plans to implement ICE as part of the Cheshire and Merseyside implementation. We are in the process of engaging with the pathology network and Diagnostics Programme Board with regard to this, but as this is part of a regional solution there are some external factors which influence timescales. In addition to the above MIAA recommended both the tissue viability and infection, prevention and control teams ensure the current internal documentation being used is adapted into an SOP format.

**13. Rate of patient safety incidents per 1000 bed days**
**Response:**

In 2022/23 1565 incidents occurred against 52,122 bed days (as per NRLS figures) this equals 30.03 incidents per 1000 bed days.

The Walton Centre considers that this data is as described for the following reasons:
- Improved incident reporting across the organisation as a result of raised awareness and Training, bimonthly Datix newsletter, Governance bulletin and monthly incident reporting training sessions
- Improved timeliness of incident investigation completion
- Improved timeliness of implementation of actions identified from investigation

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
- Continue with Datix incident reporting 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
- Implement the new incident decision tool, currently in testing phase, to support the Trust's reporting requirements

## 14. Serious Incidents and Never Events

During 2022/23 there were a total of 6 serious incidents compared with 5 in 2021/22.

There were zero never events during 2022/23 and 2 during the previous reporting period.

All serious incidents are reviewed, with investigations scrutinised, at the Serious Incident Review Group which occurs bi weekly.

The Trusts Commissioners are liaised with frequently during investigations, with all of the 6 incidents reported during 2022/23 investigated within the appropriate timescales set our within our Incident Reporting Policy.

All 6 incidents reported during 2022/23 complied with the requirements of Duty of Candour.

## Annex 1

**The Walton Centre Foundation Trust 2022-23 Quality Account commentary**

Healthwatch Liverpool welcomes the opportunity to comment on the 2022-23 Quality Account for the Walton Centre. We base our commentary on this report, and relevant feedback and enquiries that we receive throughout the year.

In January 2023 we carried out an in-person listening event at the Trust for the first time since the start of the pandemic. The feedback we received was mostly very positive, especially about the staff and the care and treatment patients received.

We were pleased that nearly all the quality priorities that the Trust had set itself for 2022-23 were achieved. The priority to reduce complaints was not achieved; nevertheless it is positive to see the work the trust carries out to ensure that complaints lead to improvements.

Turning to the 2023-24 priorities we welcome the focus on staff supporting patients who have difficulties communicating as we did receive some feedback about this, and we hope that all staff who have contact with patients receive this training as soon as possible.

We were also pleased to see that for 2023-24 the Trust has chosen to introduce an end-of-life and bereavement model. This should provide increased support to patients and relatives at a very difficult time.

We think that the plans for a low stimulation room are excellent, and hope that this will lead to a sustained decrease in incidents of confusion and aggression, as this has a negative impact on other patients as well as staff.

We are looking forward to the Brain Tumour Optimisation Pathway being rolled out across the region including to Liverpool Trusts, as we believe this can make a substantial difference to the patients concerned and their relatives.

As the report mentions, pressure ulcers are preventable and we think it's right that the Trust has decided to make a reduction in pressure ulcers a priority again, especially considering that some patients spend a considerable length of time as inpatients under the Trust's care.

Recognising health and other inequalities including inequality of access to services is vital, and the report provides some examples of this. The visual impairment service review is a positive step.

Identifying that many patients with a visual impairment were not recorded as such is a start, and we look forward to learning more about the outcomes of the working group looking at access for people with a disability in the coming year.

We welcome that transgender awareness sessions are provided to all staff. The Trust acknowledges that it has work to do around the experiences of staff from Black, Asian and Minority Ethnic backgrounds as feedback from the Workforce Race Equality Standard (WRES) demonstrates. It will be good to learn about the actions the Trust takes to improve this.

We would like to congratulate the Trust for receiving better than average results in the national inpatient survey again this year, especially when considering that this is against a backdrop of sustained - and increasing - pressures across NHS services.

We were also pleased to see the high Friends and Family recommendation rates being sustained.

The report mentions several new initiatives in treatment and patient care and highlights some of the new cutting-edge treatments that have become available at the Trust this year, which can only be good news for patients.

The circadian lighting experiment on the Intensive Therapy Unit sounds really interesting; if successful this potentially could help to manage some of the disorientation patients can experience when in clinical environments.

We particularly liked ‘tracheostomy Ted’, the teddy bear that helped to explain to one patient’s children what a tracheostomy is and took away some of the fear.

We were pleased to see that the Trust has been strengthening connections with organisations such as the Motor-Neurone Disease Association and Merseyside Society for Deaf People in the past year, and has invited the Brain Charity staff back on-site. These connections are all likely to improve patient experience.

We congratulate The Walton Centre on its achievements in 2022/23 and we look forward to a continued positive relationship with the Trust over the year ahead.

# The Walton Centre NHS Foundation Trust

Healthwatch Sefton would like to thank the Trust for presenting the Quality Accounts at the NHS provider Quality Accounts session held on 18th May 2023. We would also like to thank the Trust for producing a Quality Account that is written in a concise and easily understood format.

We continue to attend the Trust's Patient Experience Group meeting and have the opportunity to feed in emerging issues.

The report provides an update on the improvement priorities for 2022 – 2023 of which 7 of the priorities were successfully achieved. It was reported the priority to reduce the number of complaints was not achieved, as complaint numbers had increased in line with pre-Covid figures. It is noted that the Trust has implemented measures to achieve this priority and the Patient Experience Team has extensively worked with both departments within the Trust, and patients / family to ensure a robust system is in place to investigate, manage and implement learning from complaints. We look forward to hearing future updates presented at the Trust's Patient Experience Group meetings.

Under the priority of Patient Experience, we are pleased to see that the Trust has prioritised increasing patient discharges before 12 midday by 10% to overall improve patient and family / carer experience. The introduction of the TTO's (To Take Out – prescribed medication) being completed the day before planned discharge is welcomed by Healthwatch Sefton as a positive contribution to well-planned and appropriate/safe discharge of patients. We look forward to hearing updates on this at the Trust's Patient Experience Group meeting.

We are pleased to hear about the introduction of the SWAN model (end of life bereavement care) and believe this will improve patient care and family experience.

The report has detailed the excellent work and commitment of the Trust to deliver quality care to patients and their families.

Healthwatch Sefton will continue to work in partnership with the Trust to ensure patient feedback is heard, listened to and acted upon.

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Cheshire and Merseyside

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Ms M Olsen (interim Chief Nurse)
Ms J Kane (Quality Manager)
The Walton Centre NHS Foundation Trust and Charity
Lower Lane
Liverpool
L9 7LJ

**2nd June 2023**

Dear Ms Olsen and Ms Kane

**Re: Quality Accounts 2022 - 2023**

I am writing on behalf of Cheshire and Merseyside ICB representatives along with NHSE/I Specialist Commissioning who had the opportunity to jointly comment on the Walton Centre Foundation Trust draft Quality Account for 2022-23. Partners express their thanks for the Quality account presentation that was delivered to Cheshire and Merseyside commissioners for 2022 – 2023 on Thursday 18th May 2023.

This letter provides the response from NHS Liverpool place as lead commissioner on behalf of Cheshire and Merseyside ICB colleagues.

Cheshire and Merseyside ICB recognise the pressures and challenges for the organisation and the local health economy in the last year. The Trust affirmed the outstanding outcome for the second occasion following a CQC inspection.

We note the Priorities, key achievements and progress made in 2022 – 2023:

1. The Trust achieved seven out of nine priorities for 2022 / 2023, the remaining two were partially achieved. MUST target of 98% was narrowly missed by 2%. The commitment of the Trust to further enhance some of the schemes throughout 2023 / 2024 was seen as a positive action.

2. The pilot Brain Tumour Optimization Pathway has identified good collaborative working with St Helens and Knowsley Hospital Trust. The audits findings identified areas to improve the reduction of unneeded steps. The Trust have expressed the planning to extend the initiative across other Cheshire and Merseyside Trusts. This will improve the patient journey and experience for the wider Cheshire and Merseyside ICB population.

3. The training programme Cheshire and Merseyside Rehab Network achieved the goal to improve patient experience and deliver the safe and high-quality care. The panel are keen to review the outcomes impact following the evaluation.

4. The Trust's collaboration with other organisations continues to be evident in the 2023 / 2024 priorities most notably the End of Life and Bereavement model with Liverpool University Teaching Hospital.

On behalf of Cheshire and Merseyside ICB / Liverpool place have noted and accepted the Trust's ambition and intention to continue the work in relation to maintaining focus upon 2023 / 2024 priorities – the use of lung ultrasound, the introduction of electronic quality boards on each ward and staff training to support people with communication difficulties as examples.

Cheshire and Merseyside ICB / Liverpool Place recognises the challenges for providers in the coming year. We look forward to continuing working with The Walton Centre Foundation Trust during 2023 – 2024 as you continue to deliver improvement in service quality, safety, and patient experience, as well as continuing to strengthen integrated partnership working to deliver the greatest and fastest possible improvement in people's health and wellbeing within a strong, safe, and sustainable health and care system.

Cheshire and Merseyside ICB / Liverpool Place would like to take this opportunity to say thank you to The Walton Trust FT staff for their care, courage, and commitment to the ensuring the people of Liverpool, Cheshire and Merseyside receive high quality, safe and effective care and for your on-going commitment locally to system partnership working.

Yours sincerely

**Jane Lunt**
**Associate Director for Quality and Safety Improvement**
**Liverpool Place.**

## QUALITY ACCOUNT 2022-23

## GOVERNOR'S COMMENTARY

The 2022-23 Quality Account is a comprehensive document that demonstrates that the Trust continues to make good progress in most areas, and above all, continues to provide excellent and innovative services to its many patients. The Walton Centre Governors welcome the opportunity to comment on the Quality Account Statement for 2021-22.

The document demonstrates many achievements and innovations. To highlight a few (from many):

- The new Motor Neurone Disease clinic
- The Circada lighting pilot
- Acquiring University Hospital status

These are worthy of special praise, though it is the case that across this annual Account there is a great deal deserving praise.

There is a commendable degree of transparency, although we are aware that there are challenges for the Trust and these are not always highlighted in the same way through the document.

As a public document we would welcome additional context setting about the scale and nature of the work of The Walton Centre; this would be particularly helpful for those readers who may not be as familiar with the Trust as we are as Governors. This a complex document to understand and presentation of some of the data provided in graphic form would also be helpful.

The staff and leadership of the Trust have much they can be proud of, as we the Governors are proud of them.

For and on behalf of the Governors,
The Walton Centre NHS Foundation Trust

Dr J P Taylor
Lead Governor
June 2023

## 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 7th April 2022 to 1st June 2023
  - Papers relating to quality reported to the Board over the period 7th April 2022 to 1st June 2023
  - Feedback from Cheshire and Merseyside ICB including NHSE/I Specialist Commissioning 13th June 2023
  - Feedback from Governors dated 21st June 2023
  - Feedback from local Healthwatch organisations – Liverpool dated 6th June 2023 and Sefton dated 7th June 2023
  - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 1st June 2023
  - The National Patient Survey dated November 2022
  - The National Staff Survey for 2022 presented to Trust Board on 6th April 2023
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2023
  - 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

Signature of Chair

Max Steinberg CBE

Date - 28th June 2023

Signature of Chief Executive

Jan Ross

Date - 28th June 2023

## Glossary of terms

| | |
|---|---|
| ALA | Aminolevulinic acid |
| AMS | Antimicrobial Stewardship |
| ANTT | Aseptic Non-Touch Technique |
| AP | Advanced Practitioners |
| ARC | Applied Research Collaboration |
| BMUS | British Medical Ultrasound Society |
| CAUTI | Catheter Acquired Urinary Tract Infection |
| CMP | Case Mix Programme |
| CNS | Clinical Nurse Specialist |
| CQC | Care Quality Commission |
| CQUIN | Commissioning for Quality and Innovation |
| CRN | Clinical Research Network |
| CRPS | Complex Regional Pain Syndrome |
| CS | Clinical Standards |
| CSF | Cerebrospinal Fluid |
| CSRT | Community Specialist Rehabilitation Team |
| CT | Computerised Tomography |
| CTS | Carpal Tunnel Syndrome |
| EEG | Electroencephalogram |
| EMG | Electromygraphy |
| EPR2 | Electronic Patient Record System |
| EVD | External Ventricular Drainage |
| FEES | Fiberoptic Endoscopic Evaluation of Swallowing |
| FFFAP | Falls and Fragility Fractures Audit Programme |
| FFT | Friends and Family Test |
| FMS | Fibromyalgia Syndrome |
| FTSUG | Freedom to Speak Up Guardian |
| FND | Functional Neurological Disorder |
| GPICS | Guidelines for the Provision of Intensive Care Services |
| HAI | Hospital Acquired Infection |
| HCA | Health Care Assistants |
| HES | Hospital Episode Statistics |
| HTA | Human Tissue Authority |
| ICNARC | Intensive Care National Audit and Research Centre |
| ICU | Intensive Care Unit |
| IPC | Infection Prevention and Control |
| IR(ME)R | Ionising Radiation (medical exposure) Regulations |
| KPI | Key Performance Indicator |
| LFT | Liver Function Test |
| LHP | Liverpool Health Partners |
| LIMS | Laboratory Information Management Systems |
| LITT | Laser Interstitial Thermal Therapy |
| LNBW | Liverpool Neuroscience Biobank at The Walton Centre |
| LTC | Long Term Condition |

| | |
|---|---|
| LVIS | Low Profile Visible Intraluminal Stent |
| MDT | Multidisciplinary Team |
| MIAA | Mersey Internal Audit Agency |
| MND | Motor Neurone Disease |
| MR | Magnetic Resonance |
| MRSA | Methicillin-Resistant Staphylococcus Aureus Bacteraemia |
| MSSA | Meticillin Sensitive Staphylococcus Aureus |
| MUST | Malnutrition Universal Screening Tool |
| NACEL | National Audit of Care at the End of Life |
| NCABT | National Comparative Audit of Blood Transfusion |
| NEAD | Non Epileptic Attack Disorder |
| 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 |
| NRLS | National Reporting and Learning System |
| NRP | Neurology Rolling Programme |
| NCV | Nerve Conduction Velocity |
| PAC | Patient Access Centre |
| PAT | Personal Appliance Testing |
| PCV | Procarbazine, lomustine and vincristine |
| PDR | Personal Development Review |
| PFET | Patient and Family Experience Team |
| PIFU | Patient Initiated Follow Up |
| PLACE | Patient-Led Assessments of the Care Environment |
| PSIRF | Patient Safety Incident Response Framework |
| RANA | Rapid Access to Neurology Assessment |
| RCA | Root Cause Analysis |
| RCS | Royal College of Surgeons |
| RCR | Royal College of Radiologists |
| REC | Research Ethic Committee |
| RGC | Regional Governance Committee |
| ROC | Receiver Operator Characteristic |
| SAH | Subarachnoid Haemorrhage |
| SBNS | Society of British Neurological Surgeons |
| SDD | Same Day Discharge |
| SJR | Structured Judgement Review |
| SMART | Surgical and Medical Acute Response Team |
| SOP | Standard Operating Procedure |
| SSI | Surgical Site Infection |
| SSNAP | Sentinel Stroke National Audit Programme |
| SUS | Secondary Uses Service |
| TARN | Trauma Audit and Research Network |
| TAT | Turnaround Time |
| TTO | To Take Out |

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| VISN | Visual Impairment Service Review |
| VR | Virtual Reality |
| VTE | Venous Thromboembolism |
| WCFT | The Walton Centre NHS Foundation Trust |
| WDES | Workforce Disability Equality Standard |
| WRES | Workforce Race Equality Standard |
| WRTB | Walton Centre Research Tissue Bank |