The Walton Centre
NHS Foundation Trust

Council of Governors

Thursday 9 March 2021

Agenda and Papers

Excellence in Neuroscience

MEETING OF COUNCIL OF GOVERNORS
AGENDA
Tuesday 9th March 2021
13:30 to 15:00

Virtual Meeting Via MS Teams

The Walton Centre NHS Foundation Trust

Ref	Time	Item	Owner	Purpose *
STANDING ITEMS				
1	13:30	Welcome and Apologies	J Rosser Chair	N/A (v)
2	13:35	Minutes of the meeting held on 10 December 2020	J Rosser Chair	Approve (d)
3	13:40	Action Log	J Rosser Chair	Information (d)
4	13:45	Declarations of Interests in relation to the agenda	J Rosser Chair	N/A (v)
REPRESENTING MEMBERS INTERESTS				
5	13:50	Lead Governor's report	B Strong Lead Governor	Information (d)
6	13:55	Chair's Report	J Rosser Chair	Information (v)
STRATEGY AND PERFORMANCE				
7	14:05	Covid-19 Update	H Citrine Chief Executive	Assurance (v)
8	14:10	Q3 20/21 Integrated Performance Report	Executive Directors	Assurance (d)
REGULATORY/GOVERNANCE				
9	14:25	Terms of Reference - COG Steering Committee	P Buckingham Interim Corporate Secretary	Decision (d)
10	14:30	Council of Governors Elections	P Buckingham Interim Corporate Secretary	Information (d)
11	14.35	Council of Governors – Register of Interests	P Buckingham Interim Corporate Secretary	Information (d)
12	14:40	Business Performance Committee Chair's Reports	D Topliffe NED	Assurance (d)
13		Quality Committee Chair's Report	S Crofts NED	
14		Audit Committee Chair's Report	S Rai NED	
15		Charity Committee Chair's Report		
16		RIME Committee Chair's Report	S Crofts NED	
Information Items Papers to Note / For Information These items are provided for noting by / or for information to the Council of Governors, they do not require approval or a decision to be made. Governors are asked to read the papers prior to the meeting and may raise any questions in the Council of Governors meeting but these items will not formally be presented				
17	14:55	Quality Report 2019/20	L Salter Director of Nursing	Information (d)
CLOSE OF MEETING				
18	15:00	Any other business	J Rosser Chair	N/A

Please Note – The Governors Pre-meeting will take place on
Friday 5th March 2021 via MS Teams

*** v = verbal, d = document p = presentation**

The Walton Centre NHS Foundation Trust

UNCONFIRMED

Minutes of the Council of Governors Meeting

Thursday 10 December 2020

Virtual meeting held on MS Teams

Present

Janet Rosser (Chair)

Governors

Barbara	Strong (Lead Governor)	Amanda	Chesterton
Colin	Cheesman	Rich	Cottier
Jonathan	Desmond	Cameron	Hill
Stella	Howard	John	Kitchen
Chris	Sutton	Jan	Vaughan
Stan	Winstanley		

In Attendance

Seth	Crofts	Non-Executive Director
Su	Rai	Non-Executive Director
Nalin	Thakkar	Non-Executive Director
Karen	Bentley	Non-Executive Director
David	Topliffe	Non-Executive Director
Hayley	Citrine	Chief Executive
Mike	Burns	Director of Finance and IT
Jan	Ross	Director of Operations and Strategy
Michael	Gibney	Director of Workforce and Innovation
Andrew	Lynch	ED&I Lead
Julie	Kane	Quality Lead
John	Baxter	Executive Offices (Observing)
Carol	Miller	Membership Manager/Corporate Governance Assistant (Minutes)

Apologies

Nicola	Brown	Alison	Astles
Doreen	Brown	William	Givens
Rhys	Davies	Natalie	Dill
Melissa	Hubbard	Ella	Pereira
Nanette	Mellor	Melanie	Worthington
Adrian	Wells		
Lisa	Salter	Director of Nursing and Governance	
Lindsey	Vlasman	Acting Director of Nursing and Governance	
Jane	Hindle	Corporate Secretary	

COG 33 20/21	**Apologies** Apologies were received and noted as above.
COG 34 20/21	**Welcome and Declaration of Interests:** The Chair welcomed all those at the meeting. No questions on notice had been received prior to the meeting. It was confirmed that the meeting was quorate.

	Declaration of Interests The Non-Executive Directors declared an interest in agenda item: 12, Non-Exec Directors Appraisals and Remuneration.
COG 35 20/21	**Minutes of the meeting held on 17th September 2020 :** **Action Tracker and Matters Arising** The minutes of the previous meeting were agreed as a true and accurate record with 2 minor amendments: • COG 22 20/21 Ms Strong had joined the Lead Governors Association. • COG 24 20/21 Additional COVID costs covered issues such as: - staffing/sickness - PPE from external sources. Matters arising: The following items were updated: • **COG 13a 20/21 Governor Effectiveness Review** e-learning package to be devised. - It had been agreed to provide a series of vlogs/podcasts to support governors in their role. The first would feature the Trusts work around innovation and was due in January 2021. • **COG 19 20/21 Research Innovation and Medical Education Committee** - Update on Neurological Implications of COVID research would be presented at the March 2021 meeting; and - Governors were requested to email Ms Rosser with aspects which they would like to be included. The following item was closed: • **COG 13b 20/21 Governor Effectiveness Review** Governor Handbook to be added to VBr Documents - Item added to library. **Action**: Governors to email Ms Rosser with aspects of Neurological Research of the implications of Covid they would like to be covered in the presentation. **Minutes of the Annual Members meeting held on 17th September 2020:** The minutes of the previous meeting were agreed as a true and accurate record.
COG 36 20/21	**Questions on notice received from the public and governors Q2/ Q3 2020/21** Ms Rosser explained that the report was presented for information and contained questions which had been raised by governors and staff. In response to a question from Mr Cheesman, Ms Rosser and Ms Citrine explained that the purpose of the document was not to detail all questions and queries received into the Trust as this would be labour intensive and inappropriate. Ms Rosser suggested that the document be reviewed by the COG Membership and Engagement Group. **The Council of Governors:** Noted the report. **Action**: COG Membership and Engagement Group to review the report format.
COG 37 20/21	**Lead Governors Report** Ms Strong updated governors on activity during the last quarter. On behalf of the Council of Governors Ms Austin-Vincent was formally thanked for her 5 year service as Partnership Governor for the Cheshire and Merseyside Neurological Alliance. New governor Ms Worthington and NEDs Ms Bentley and Mr Topliffe were welcomed.

	• Chairs briefings continued to provide a helpful mechanism for staying in touch. Attendance had been disappointing at times and governors were recommended to attend whenever possible; • As part of the Lead Governors Association, Ms Strong had attended 2 out of 3 days of the Health Service Journal virtual summit on Integrated Care which had focussed on the lessons learned from the pandemic. Covid had highlighted and exacerbated health inequalities but also enabled and improved partnership working and the enhanced use of technology. • The Lead Governors Association had held email discussions which included the difficulty in achieving a representative membership, the differing tenure of Lead Governors across Trusts and the benefits of a Deputy Lead Governor role. Ms Rosser reiterated the thanks given to Ms Austin-Vincent, her experience and knowledge had been an asset to the Council of Governors which would be missed. She also highlighted the usefulness of HSJ events and raised the possibility of implementing a governor attendance rota. **Action**: Lead Governor to assess the possibility of alternate governor attendance at HSJ events.
COG 38 20/21	**Chairs Report** Ms Rosser updated the governors on: 2 new Non-Executive Directors: • Their responsibilities had been agreed and objectives would be set once they had completed their familiarisation of the Trust; - Karen Bentley had a background in behavioural change and transformation, HR strategic leadership, project management and quality coaching. - David Topliffe had valuable transferable skills and knowledge from industry and a previous Non-Executive Director role. Governor Elections: • The election would run from June 2021 to August 2021. It was noted that the number of governor vacancies was impacting on meeting quoracy: - 14 seats were eligible for election across all constituencies, 5 were vacancies and 9 were eligible for re-election; and - There were also 6 Partnership Governor Vacancies. National NHS position: • National Long Term Plan in place; • Usual winter pressures were being exacerbated by Covid; and • The Integrated Care Partnership across Cheshire and Merseyside was assuring mutual aid. NHS England had produced a nationally driven engagement paper on proposals for the future organisation of the NHS, including: • The replacement of Clinical Commissioning Groups with Integrated Care Systems statutory bodies e.g. Cheshire and Merseyside ICS operational from April 2021; • ICS centralised funding from April 2021 but there was no indication of distribution or allocation process; and • The Legislative framework was expected to be in place by April 2022.

	In response to questions from Ms Strong and Mr Cheesman, Ms Rosser and Ms Citrine advised that the proposals within the paper were high level. Initial step was the consultation prior to any legislation that is likely to be put in place and details would be addressed in the future. An ICS would encompass all providers e.g. Acute, Mental Health, Place based Partnerships and Local Government. Trusts currently retain their own constitutions however the longer term approach within ICS's were unclear and the diffentiation between foundation and non foundation trusts. Currently the model of the COVID Cheshire and Merseyside Command and Control approach and in-hospital and out of hospital cell had found strong partnership working across C&M. The direction of travel was to have one rather than the nine current CCGs in the health care partnership.
COG 39 20/21	**COVID-19 Update** Ms Citrine updated governors on the regional Covid situation: • Front line staff were being regularly tested; • Vaccination had started for patients over 80 and Trust staff who were shielding and BAME so higher risk had been identified as the first priority lists;, Liverpool University Foundation Trust (LUFT) was one of 8 regional hubs based on the Aintree site which had meant we had been able to access vaccines earlier and supported with Walton staff working with Aintree staff vaccinating; • Visiting was restricted and would be over the festive period • Covid Tranche 2 - Command and Control, in and out of hospital cells and Governance, Gold Command and elective restoration being put in place; - Mutual aid across Cheshire and Merseyside, including Walton accommodating all Head and Neck cancer patient referrals into Theatres, extended criteria to accommodate Spinal patients from LUFT. - Collaborative Research, Education and Innovation across C&M - Specialist Trusts would be Covid free and continue with essential elective work and assist acute Trusts with cancer patients; • Working with specialist trusts more closely. - In relation to the Specialist Hospital Trusts working together Walton was leading on procurement; - Informatics support being put in place. In response to a question from Mr Winstanley, Mr Gibney explained that the impact on staffing levels was due to availability to attend the centre as opposed to underlying sickness levels, higher levels of testing across the region had resulted in a higher number of staff self-isolating, although dependent on role, some unavailable staff were still able to work from home. In response to follow up questions from Ms Chesterton, Ms Howard and Ms Strong, Ms Citrine and Ms Ross clarified that it was unlikely that patients would be temporally allowed home for Christmas leave as the Trust was not in a position to facilitate self-isolation of patients upon return to the Trust to ensure the safety of all patients. Patients and staff would receive the Covid Vaccination in-line with National protocols and programmes for storage, distribution and priority.
COG 40 20/21	**Chief Executives Performance Report 20/21** Ms Rosser explained that whilst the Quarterly Performance Report was presented at the COG, monthly reports were also available in the public Trust Board meeting papers. Ms Citrine updated governors on the current position for quality and safety: • Good position for health care associated infections and improvement work

	had taken place in areas that required closer focus resulting in improvements; • Increase in pulmonary embolisms (PE) – Noted as a complication associated with Covid patients. Only one non-Covid patient had a PE, although all were investigated. Going forward incidence in PE will be separated for COVID and NON-COVID patients; and • Increase in safeguarding incidents due to increased reporting. Ms Ross updated governors on the impact of Covid on activity: • Plans in place to increase activity; • Elective care decreased activity not expected to improve due to increased infection control protocols; • Actions were in place to mitigate increased referral to treatment time targets; and • All cancer targets had been met. Mr Burns updated governors on the current financial position: • Funding had changed at Q3 to a fair share basis allocation across the region; • At month 7 the Trust reported a surplus against a planned deficit; and • Latest plan forecast indicated a performance of £1.1m deficit, £0.4m better than plan at the end of year. In response to a question from Mr Winstanley, Mr Burns clarified that the reported bad debt was a result of treating emergency overseas patients; Ms Rai offered assurance that this was monitored at Audit Committee which would be covered in minute COG 46 20/21. **The Council of Governors:** Noted the report.
COG 41 20/21	**Non-Executive Directors Appraisals and Remuneration** The Non-Executive Directors left the meeting. In their capacity of holding the NEDs to account, Ms Rosser confirmed that 3 NEDs had undergone appraisals; 2020 objectives had been fully met and agreed for 2021. The Board Remuneration Committee had agreed to implement the national uplift for Executives from April 2020 of 1.03%. Historically, to ensure equity across the Board, NED uplifts mirrored the national recommendations for Execs. Governors were asked to approve the recommendation for Non-Executive Directors uplift of 1.03% from April 2020. **The Council of Governors:** Approved Ms Chesterton left and the meeting was no longer quorate.
COG 42 20/21	**The People Plan and ED&I update** Mr Gibney updated governors on the Trusts actions on the National People Plan. Covid had impacted the progress made on several areas but action plans were in place: • Focus on investment: - Supply lines, - Postgraduate Neuroscience programme, apprenticeships, - Continuing professional development (CPD) support and time. • Challenge of providing flexible working for some clinical roles; and • The introduction of Carer Passports. • In relation to BAME inequalities for staff, a review of HR processes was being undertaken and shared with the strategic BAME Advisory Committee. Some

of these demonstrated need for further equality action; however other areas such as staff disciplinary procedures by ethnicity did not identify any bias in the Trust.

Mr Lynch offered additional assurances that BAME staff in leadership positions was monitored via the Workplace Race and Equality Standard (WRES). There was no disproportionate representation within medical staff at the Trust but there was under representation above non-Clinical Band 7 and 8 roles; Mentoring, recruitment strategies and initiatives were planned to address this.

Mr Lynch provided governors with an update on the Equality, Diversity and Inclusion agenda:

- Covid had impacted disproportionality on BAME communities and the Trust had introduced risk assessments and mitigations for all staff;
- The number of BAME patients was disproportionate to the local population and actions needed to be taken to understand and address this;
- Black Lives Matter had highlighted disparities and structural racism;
- BAME staff network enabled staff to inform policies and actions;
- Strategic BAME Committee chaired by the Chief Executive, reports directly to the Board; and
- Membership of the Cheshire and Merseyside Healthcare Partnerships Steering Group looking at barriers to healthcare equality and vaccinations.

In response to a question from Ms Strong, Mr Lynch explained that , in relationship to the local population, BAME patients were not being seen within tertiary care in the number expected; common themes that might explain this included; language barriers, knowledge of NHS systems, stigma and delays in seeking medical intervention. Post Covid, the Trust had plans to engage with BAME communities on education and awareness of neurological conditions.

Mr Lynch left the meeting.

In response to a question from Ms Bentley, Ms Citrine confirmed BAME outreach initiatives were supported within existing resources and that Regional Specialist Trusts had been approached to discuss the possibility of pooling resources and investing further.

At the request of Ms Rosser, Ms Rai gave governors an overview of the Regional BAME Assembly, set up in 2020 to address Covid inequalities, by Bill McCarthy, North West Regional Director for NHS England/Improvement and chaired by Evelyn Asante-Mensah OBE, Chair of Pennine Care NHS Foundation Trust. Its membership of 70 comprised of Executives, NEDs, GPs and CCGs representation. Its mission was for the NHS to become an exemplar Anchor Institute and to drive out racism.

Themes emerging to date included staff retention and promotion and access to NHS services including translation and literacy. There were 3 key areas, allocated regionally, assessing service access, outcomes and post treatment:

- Manchester - Maternity Services;
- Lancashire - Mental Health; and
- Cheshire and Merseyside - Cancer services.

Funding would be available through the Assembly for community outreach work and initiatives. The work was being replicated and assisted by the Trust BAME Committee.

Professor Thakkar added that the work would also benefit patients from areas of

	social and economic deprivation who had similar outcomes and highlighted the impact on and biased data outcomes of, clinical studies which were not inclusive. **The Council of Governors:** Noted the report
COG 43 20/21	**Selection of Quality Account Priorities** Ms Kane presented an overview of the priorities for governors to select for 2021. Governors had been provided with a voting slip which they should return via email to Ms Miller by 17th December 2020. Covid had resulted in delays in achieving 2 of the 2020 Quality Account Priorities: • Improve the number of staff trained in Immediate Life Support; - Postponed until 2021/22, and - Training by external agencies not delivered due to Social Distancing measures. • Introduce FOCUS; - Training by external agencies postponed until 2021/22. On track: • Introduce the Road to Recovery; - A planned clinic in Wales was postponed due to Covid, and - Plans are in place to deliver the clinic virtually. All other priorities were achieved and feedback had been very positive. **The Council of Governors:** Noted the report **Action:** Governors to send completed voting slips to Ms Miller by 17/12/20
COG 44 20/21	**Chairs Reports – Business Performance Committee** Ms Rosser presented the report and advised that there had been 3 meetings in the last quarter and the following matters were highlighted: • 6 months extension of ISS facilities contract; - Large contract which covers cleaning, catering, bistro, portering and security, and - Full Tender process, - New contract from 1st October 2021. • Approval of Guide XT Agreement; - Demonstrated Board Committees could approve agreements on behalf of the Board, dependent on approved financial limits. Non-Executive Director Mr Topliffe would Chair BPC from 2021. **The Council of Governors:** Noted the report
COG 45 20/21	**Chairs Report – Quality Committee** Mr Crofts reported that there had been 3 meetings in the last quarter and the following matters were highlighted: • Good outcomes on Peer Review of Major Trauma Network; • Board to undertake work on improving patient letters, experience and access for patients with visual impairments as a result of a Patient story; • Good work undertaken by support staff to ensure continued Outpatient Department service during Covid; and • Spinal Service presentation highlighted collaborative working and the roles of Specialist nurses and Advanced Practitioners **The Council of Governors:** Noted the report

COG 46 20/21	**Chairs Report – Audit Committee** Ms Rai reported that there had been 1 meeting in the last quarter and the following matters were highlighted: • Recommended amendments to the Scheme of Reservations and delegation; • Expansion to committee remit in order to receive assurance from clinical areas and • Assurance that £56k Bad Dept written off for overseas patients who had since left the country did not impact on the financial performance of the Trust. South Sefton CCG had covered 75% of the debt. **The Council of Governors:** Noted the report
COG 47 20/21	**Chairs Report – Research, Innovation and Medical Education Committee** Mr Crofts reported that there had been 1 meeting in the last quarter. The following matters were highlighted: • Covid had reduced recruitment to commercial studies resulting in a significant financial challenge; • Redeployed resources to support wider system research with Liverpool Health Partnership around Covid studies and public health outcomes; and • Medical Education Review conducted by GMC and Health Education England - exceptional feedback on outcomes and from students on their experience. **The Council of Governors:** Noted the report
COG 48 20/21	**Chairs Report - Charity Committee** Ms Rai reported that there had been 1 meeting in the last quarter. The following matters were highlighted: • NHS charities together donation of £145k with the majority of the monies being used for staff health and wellbeing initiatives; • Difficult period for fundraising with events being cancelled which had led to a £12k funding gap; • Approved applications for Training and Development funding and long service awards; and • A Risk Management Policy and associated risk register to be developed to manage, monitor and mitigate risk. **The Council of Governors:** Noted the report
COG 49 20/21	**Winter Plan** Ms Ross updated governors on the Trust Winter Plan highlighting the additional challenge presented by Covid. • Winter Plan, Emergency and Resilience, Brexit and Covid planning combined; • Additional resource required for mutual aid support for Acute Trusts in the Cheshire and Merseyside Partnership, especially those with A&E departments; • Plan to relax threshold for admissions criteria for rehabilitation services and the Major Trauma Network criteria; • Working with Aintree Hospital to offer key neurology support; and • All returns to the A&E delivery Board would encompass all 3 aspects of the Winter Plan. **The Council of Governors:** Noted the report

COG 50 20/21	**Any Other Business** **Brexit** Ms Ross assured governors that the Trust had participated in ongoing Brexit planning. There were no concerns for the Walton Centre. Procurement of goods would be managed nationally and local plans were in place as part of Emergency and Resilience planning. The Trust had submitted a return of 'Green for Readiness'. **CQC Visit** Ms Citrine updated governors on a recent CQC visit as a result of CQC interest in mental health and mental health provision in Acute Trusts and an issue raised externally around safeguarding. The Trust and an external reviewer had raised an issue for clarity regarding the increase in mental health support required within the Trust and patients transferred to Mersey Care NHS Foundation Trust. A virtual visit had taken place and relevant staff were interviewed and patient case notes assessed. CQC provided initial feedback and thanked the Trust and staff for their cooperation. The CQC had a clearer understanding of the complexity of the Trust patients and the difficulty in applying the Regulations. There was a fuller understanding of the overlap in some neurological conditions and mental health concerns and the need to prioritise physical health. Areas for improvement were all achievable and action plans were in place. **The Council of Governors:** Noted the report
COG 51 20/21	**Review of Meeting** The Chair thanked governors for their participation and attendance and invited them to provide feedback on the meeting. In response to a question from Mr Cheesman, Ms Rosser and Ms Citrine acknowledged that the meeting had been longer than expected and requested that governors provide feedback and ideas on how virtual meetings could be improved. Any outstanding questions could be raised with Ms Hindle or Ms Miller outside of the meeting. **Action**: Governors to provide Ms Rosser with ideas for improving virtual meetings
COG 52 20/21	**Date, time and venue of next meeting** The next meeting of the Council of Governors will be held on 9th March 2021.

Council of Governors
Matters arising Action Log:

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
02/06/20	COG 13a 20/21	**Governor Effectiveness Review** e-learning package to be devised	J Hindle	In progress **<u>Dec 2020</u>** It has been agreed to provide a series of vlogs/podcasts to support governors in their role. The first will feature the Trusts work around innovation and is due in January. Innovation Podcast sent to Governors and NEDs 22/12/20	~~October 2020~~ March 2021	
10/12/20	COG 36 20/21	**Questions on notice received from the public and governors** COG Membership and Engagement Group to review the report format	Governors	To be reviewed at next Membership and Engagement Group meeting in March 2021	June 2021	
10/12/20	COG 37 20/21	**Lead Governors Report** To assess the possibility of alternative governors attendance at HSJ events	B Strong	Verbal update given at Governor pre-meeting on 05/03/21	March 2021	
10/12/20	COG 43 20/21	**Selection of Quality Account Priorities**	J Kane	Governors to submit completed voting slips by 17/12/20 11 voting slips received and forward	December 2020	
10/12/20	COG 52 20/21	**Review of Meeting**	Governors	Governors to provide suggestions on improving virtual meetings to Ms Rosser Suggestions received and actioned	January 2021	

The following items have been deferred to a future meeting due to operational pressures during the COVID Pandemic

13/01/20	COG 42/19a	**Patient Story** To explore the possibility of Walton Charity funding for overnight accommodation.	J Ross	Closed – no longer relevant due to the increased availability and use of virtual appointments and meetings	Closed	
13/01/20	COG 42/19b	**Patient Story** The procedure for proactive appointment allocation to be explored	J Ross		Closed	
13/01/20	COG 42/19c	**Patient Story** To provide an update on the Trust's Digital Strategy, specifically around patient care to be included in a future agenda	M Burns		Closed	
13/01/20	COG 44/19a	**Chairs Briefing** Explore the feasibility of table Microphones for meetings	J Hindle		Closed	
17/09/20	COG 19 20/21	**Chairs Report – Research, Innovation and Medical Education Committee** Update on Neurological implications of COVID research, to be presented to a meeting at a later date when available	S Crofts	To be added to March 2021 Agenda Governors to contact Ms Rosser with areas to be included Deferred until information available	~~January 2021~~	

Lead governor's report to Council of Governors
March 2021

Introduction

This report updates governors with significant events or developments in which the Lead Governor has been involved since the last COG meeting (held 10th December 2020).

1. Chair's virtual briefings with governors

These briefings continue to be helpful, informative and well received by governors. The most recent covered the following topics and discussion points:

- Forthcoming governor elections
- Governor pre - meetings before the full COG meeting
- Annual Members Meeting planning
- Covid 19 update
- Discussion about how information is presented to governors
- Brief outline of new health White Paper
- New consultant appointments and vacancies
- Reminder of request for governors to submit content for "Neuromatters"
- Invitation from Colin Cheesman (CC) for governors to join the West Cheshire and North Wales Neurological group. Governors to contact CC for details if interested

2. New (Interim) Corporate Secretary

Welcome on behalf of the Walton Centre governors to Paul Buckingham, who started in January as interim Corporate Secretary, covering the secondment of Jane Hindle to Liverpool University Hospitals NHSFT.

3. Governor Engagement Questionnaire

On January 12th following up on the questionnaire that was sent to the governors in May 2020, and after discussions with the Chair and Corporate Secretary, I sent out a second engagement questionnaire to all governors. This was to obtain their views, for example, in relation to the fulfilment of their role during the pandemic, how they were managing with on-line meetings, and feedback on other issues. Specifically, they were asked about the timing of the CoG meetings and the governors' pre meet.
A reminder was sent out on 23rd January. However, there was a low response to this questionnaire. Only nine out of 21 governors responded.

Of those governors that did respond, the majority (7) were in favour of trying the governors' informal pre-meet on a different day from the CoG meeting. Therefore, we shall try this approach for the March CoG meeting but I think we should maintain a flexible approach in future.

The full results of the questionnaire are presented in a separate document which will be circulated to the governors, the Chair and the Corporate Secretary.

4. Trust Web Site Engagement Session

On 27th January along with one other governor, I attended one of two on-line workshops offered to trust governors where they could become involved in the development of the new trust web site. This was a valuable session where we were able to give feedback on the current web site and make suggestions for improvements and fresh ideas for the new site.

5. NHS Providers Governor Workshop 1st February 2021

I attended this on-line workshop which primarily covered:

- Update on governor support and forthcoming governor training offered by NHS Providers *(please see web site links below at the end of this report)*

- Strategic policy headline briefing including:

    - Covid19 update
    - White Paper for a new Health and Care Bill and how it affects the role of governors *(link below)*
    - Proposed changes to the way the CQC functions and a move away from regular physical inspections *(link below)*

- Two governor showcases from trusts that have

    - Increased membership among young people
    - Developed a Governors' Charter

- Breakout sessions

6. Council of Governors' Steering Group

- **Appointment of External auditor**

The Steering Group was convened on 2nd February 2021 to review the applications for External Auditor for the Walton Centre in order to make recommendations to the CoG at the meeting on 8th March.

- **Terms of Reference**

It had been decided in early 2020 to change the function of this group and convene it on an as-and-when basis. The Steering Group had not met since 6th February 2020.
However, it has become clear that there are some important and necessary functions of the Steering Group that mean it should be maintained on a regular, if infrequent basis. With this in mind, the Corporate Secretary has drawn up revised draft terms of reference for the group. These terms have been circulated to Steering Group members for comment.

7. Lead Governors' Association

The Lead Governors' Association functions as a national group in which members can share ideas and good practice, discuss relevant issues and provide mutual support.

- **NHS England Consultation on Integrated Care Systems (ICS)**

The Chair of this group collated views from fellow lead governors and formulated a response to the consultation on behalf of the association. (Previously circulated to all governors)

8. Membership and Engagement Group

This group has not met since 27th July. The date for the next meeting will be confirmed after the new Head of Communications takes up post.

9. Useful links : For more information please see:

- Support for governors governors@nhsproviders.com
- Training https://nhsproviders.org/training-events
- NHS White Paper : Integration and Innovation: working together to improve health and social care for all :-

  Link to White Paper

- CQC Consultation:

  Link to Consultation

The Walton Centre NHS Foundation Trust

Governors Report for the Period Ending December 20

Glossary

- **Open Pathway. Target 8.2 weeks**

The Walton Centre is taking part in a Referral to Treatment pilot scheme where performance is measured by average patient waiting times in weeks. A requirement of this scheme is that performance is shown by average waiting time instead of against the 92% standard. Open pathways, or incomplete pathways are where the patient is still awaiting first definitive treatment (either as an Outpatient or Inpatient). In order to sustain delivery of the standard the average wait of these patients must be under 8.2 weeks.

- **I&E (Income & Expenditure).**

The Income and expenditure account records the Income received from undertaking patient care and other sources of Income including medical training. This is offset by the cost of running the organisation.

- **CIP (Cost Improvement Programme).**

The NHS is required to make efficiency savings on an annual basis. The efficiency requirement is reflected within the national tariffs set each financial year. The target is expressed as a % of the expenditure budgets of the organisation.

- **Capital Target.**

Capital expenditure is expenditure on building and equipment within the organisation.

- **Use of Resource Risk Rating (UoR)**

NHS Improvement introduced the Single Oversight Framework in October 2016. This incorporates 5 ratings:

- Capital service cover - the level of income available to fund the Trust's capital commitments;
- Liquidity - the level of cash available to fund the Trust's activities;
- I&E margin - the % of the Trust's surplus/(deficit) in relation to its income;
- Variance on the I&E margin - the % variance of the I&E margin against plan; and
- Agency Expenditure – The percentage of Agency Expenditure compared to the Trust Agency Ceiling control total.

Scoring 4 (poorest) to 1 (best) against each metric, the overall finance and use of resources score is a mean average of the scores of the individual metrics under this theme – except that if a provider scores 4 on any individual finance and use of resources metric, their overall use of resources score is at least a 3.

Finance

As a result of COVID-19, and the national response required to manage this, NHSI/E announced that 2020/21 business planning was suspended and that a new financial framework would be in place for the 1st 4 months of 2020/21. This initial plan was extended till the end of September (month 6).

The financial regime then moved into the next phase, with the trust being monitored against a year-end forecast deficit of £1.5m submitted in October (a revised forecast was submitted on 18th November with a planned year end deficit of £1.3m).

From October, the key changes from reporting in April – September (Month 1-6) were:

- 'Block' funding received for COVID related costs & growth (based on fair share of sector funding) for M7-12 rather than being reimbursed monthly via retrospective top-up;
- No retrospective monthly top-up funding will be received to bring Trust to breakeven;
- No national requirement for Trusts to report a breakeven position although there is a requirement for the Cheshire & Merseyside Healthcare Partnership to deliver a breakeven position by the end of the year.

At the end of quarter 3 2020/21, the Trust reported a surplus position ahead of the revised plan submitted in November 2020. However, at the end of December, the Trust was forecasting to deliver a £0.5m year-end deficit positon. This is a £0.8m improvement on the planned £1.3m deficit positon. A summary of the Trust COVID-19 expenditure for Quarter 1, 2 and 3 is below. At the end of the December, just over £2.3m had been incurred in response to COVID-19.

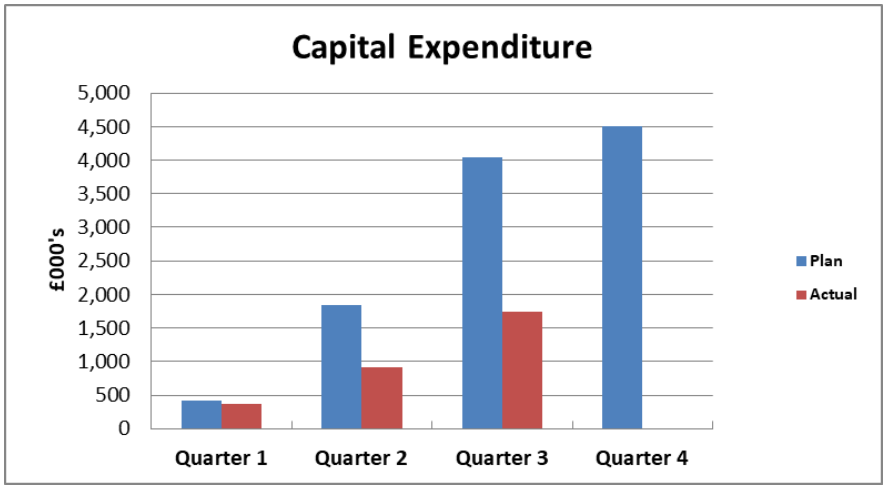
COVID -19 Expenditure YTD	Dec-20 Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	1,030
Annual leave provision (Junior Doctors)	52
PPE	648
Decontamination	31
Remote working	283
ITU	42
Other	226
TOTAL	**2,312**

* (Other includes Aintree Car Parking £184k, Staff Uniforms £7k, ACC storage contribution £10k. Well Being First Aid Trianing £11k)

Efficiency Savings

Due to the current financial arrangements mentioned above, and response to COVID-19, there have been no requests to deliver efficiency savings as in previous years. However, the Trust continues to review opportunities to reduce its cost base and develop new ways of working, especially during this challenging time. Work has been started to look at potential efficiency schemes for 2021/22.

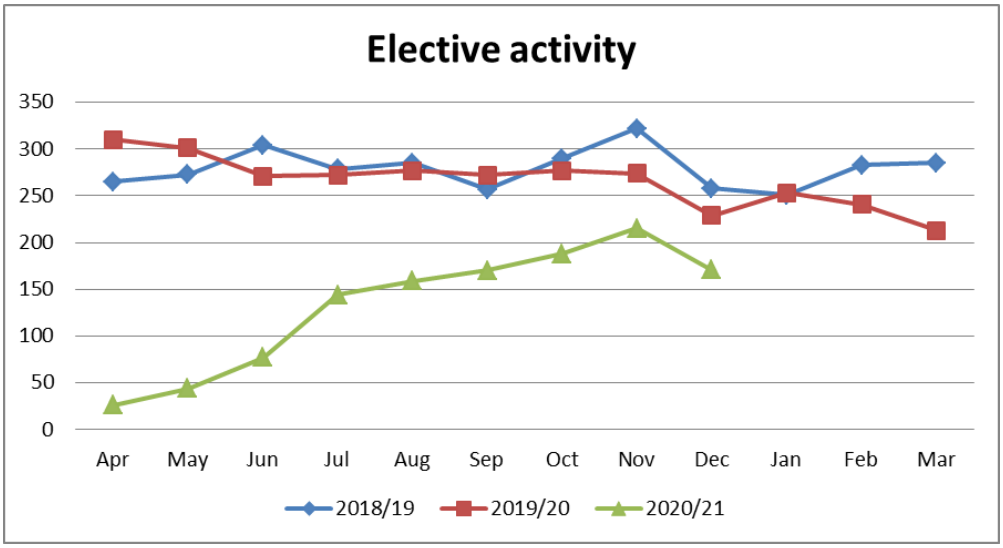
Capital

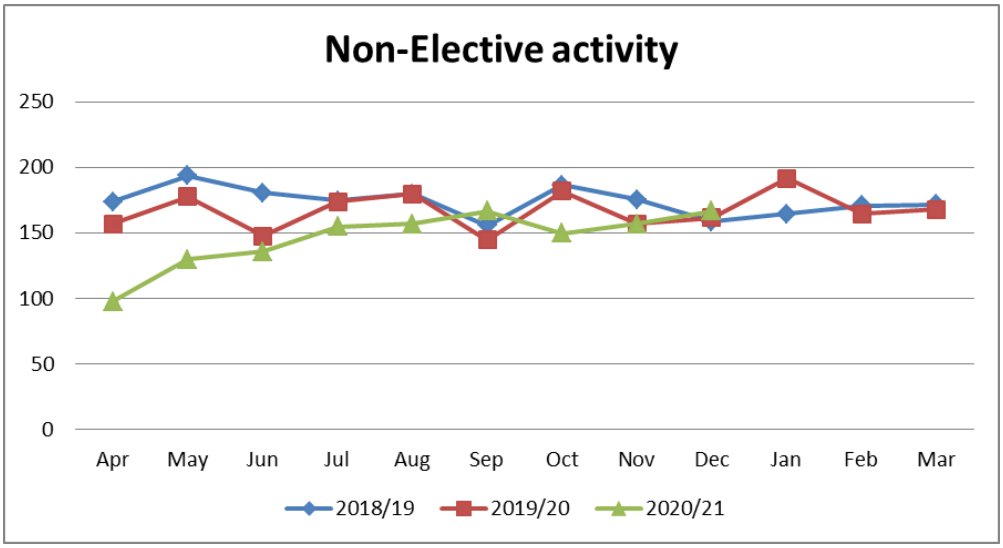


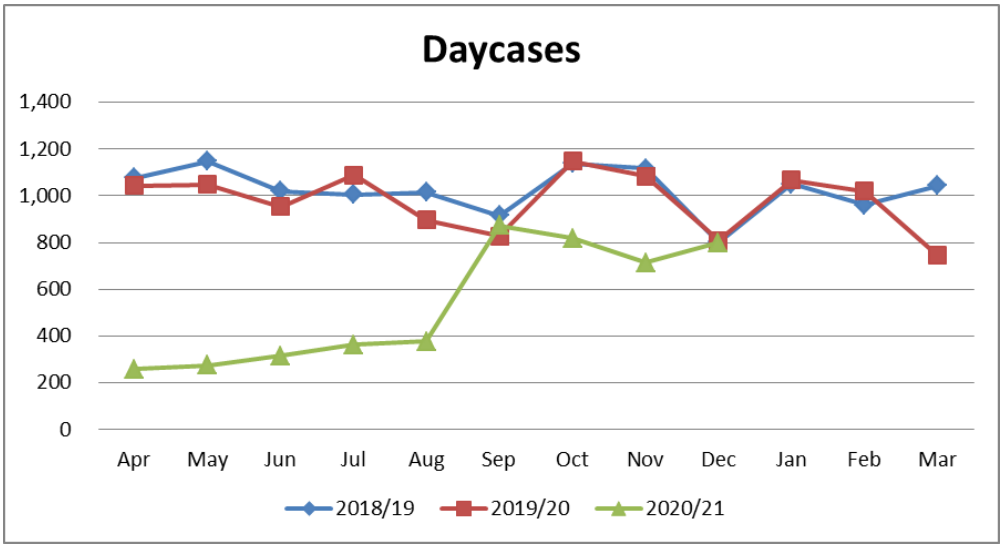
Capital expenditure at the end of quarter 3 was £1,467k against a plan of £3,858k, £2.391k below plan. The YTD underspend it due to capital expenditure that will be incurred in the last quarter of the financial year (on replacement MRI machine, CT scanner and other surgical/ diagnostic equipment), whilst the capital plan was profiled equally in 12th for the financial year.

Activity

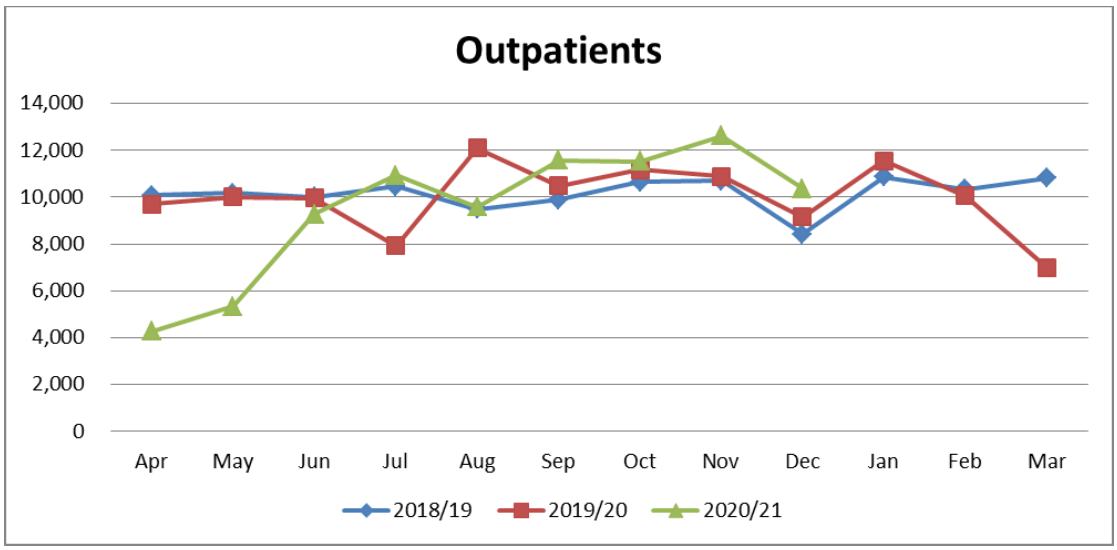
Inpatient & Day Case Activity: Inpatient activity remained at similar levels in Q3 2020/21 to Q2.






Daycases
1,400
1,200
1,000
800
600
400
200
0
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
2018/19
2019/20
2020/21

Outpatient Activity: Outpatient activity remained consistent in Q3 2020/21.



Welsh Activity v Plan for Quarter 3 2020/21

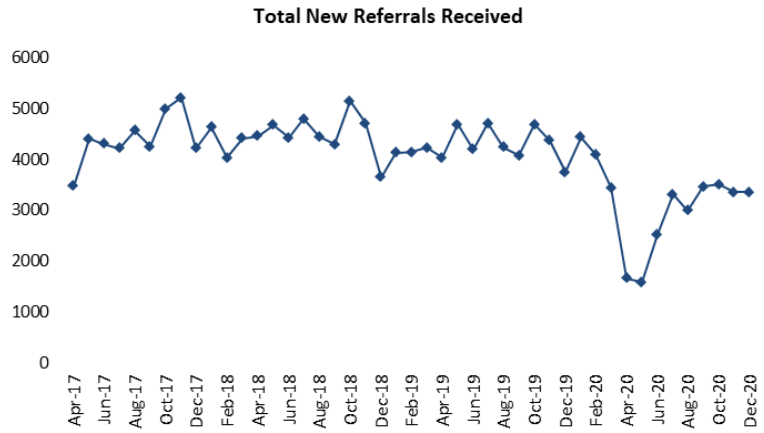
Q3 2020/21

Patient Category	Plan	Actual	Variance
Day Case	225	196	-29
Inpatient	229	145	-84
Outpatient	5620	4853	-767

Referrals for outpatient appointments

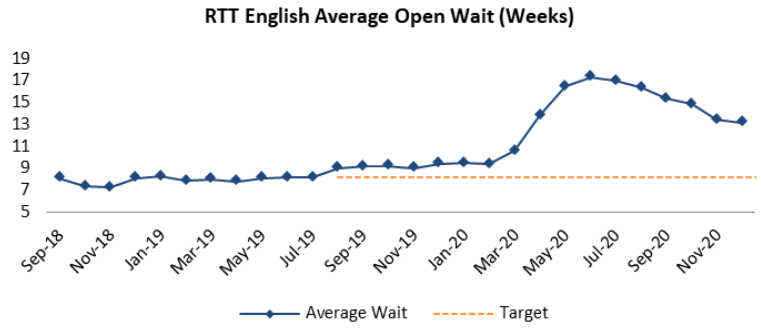
Clean referrals exclude referrals that are created by consultants retiring or transferring part of their practice to a colleague as part of service development or reorganisation and give a clearer indication of growth in demand for our services.

Referrals continued to recover in Q3 2020/21 following the drop due to Covid-19.

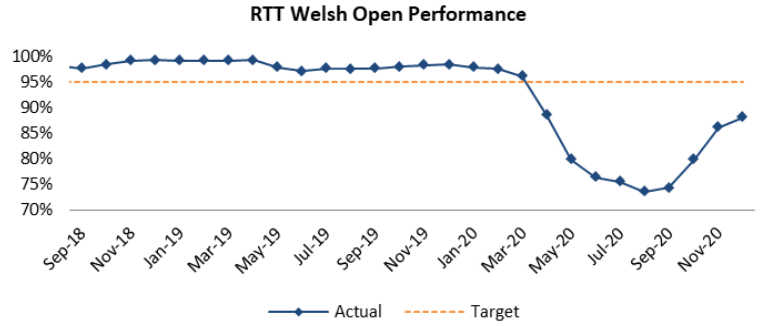


RTT (Referral to Treatment)

The Walton Centre is taking part in a Referral to Treatment (RTT) pilot scheme, where performance is measured by average patient waiting times in weeks. A requirement of this scheme is that performance is shown by average waiting time, rather than against the 92% standard and that the backlog cannot be shown. Performance at the end of Q3 20/21 is 13.17 weeks. Performance has improved through the quarter following a deterioration of performance due to Covid-19

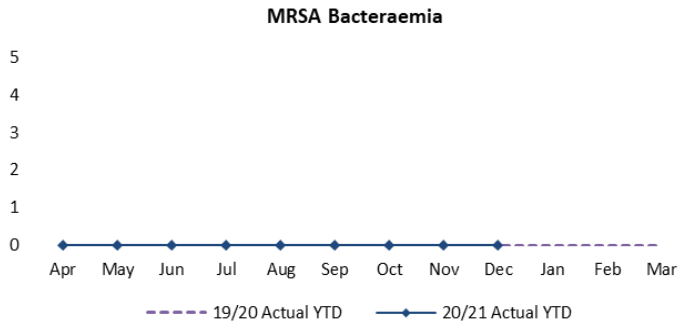


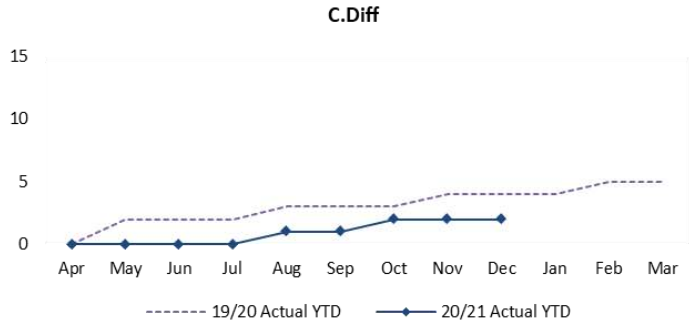
Welsh RTT performance continues to be monitored against the 95% standard, with performance below the standard at 88.16%. Performance against the Welsh RTT target has stabilised throughout the Quarter following a drop in performance due to Covid-19. There have 105 breaches of the 36 week maximum wait target.



Infection Rates

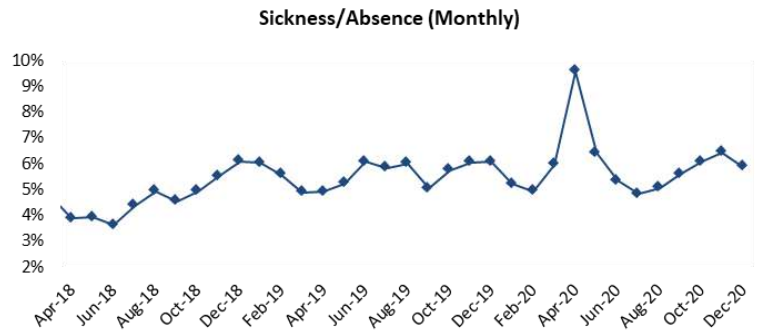
No cases of MRSA Bacteraemia were reported during Q3 2020/21. The Trust has reported 2 cases of Clostridium Difficile against the PHE year-end threshold of 7 cases for 2020/21.

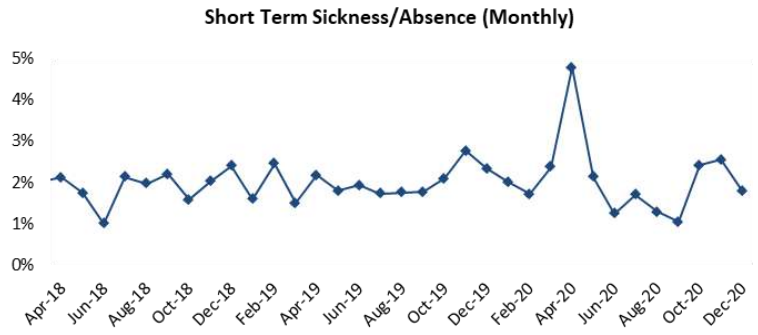


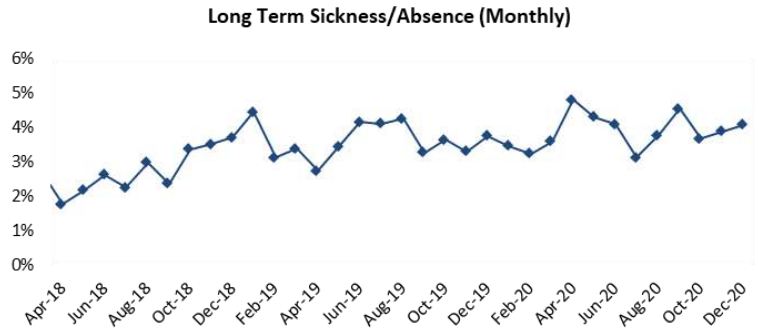


Workforce

Monthly sickness/absence rate is 5.88% which is above the revised target of 4.75%. The breakdown between long term and short term sickness as at 31st December is as follows: 4.08% on long term sickness and 1.80% on short term.

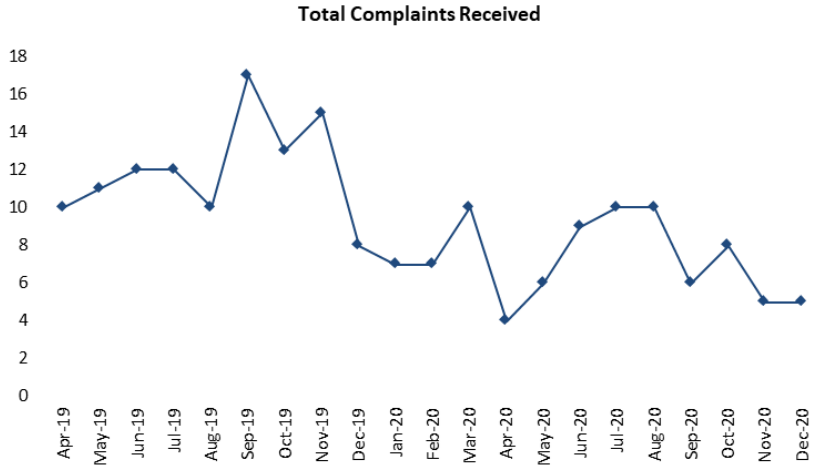


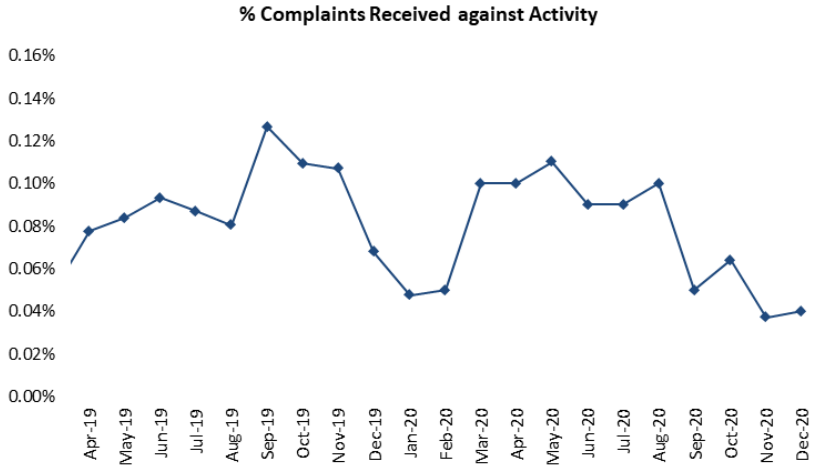




Complaints

The Executive team receive a detailed monthly report in relation to complaints. Trends and themes are discussed and challenged. A Quarterly report is also provided to the Patient Experience Group. Q3 2020/21 has seen 18 complaints reported.

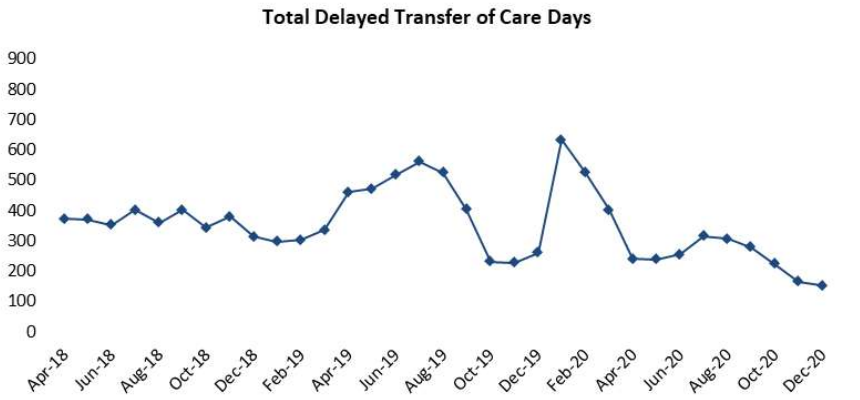




Efficiency Measures

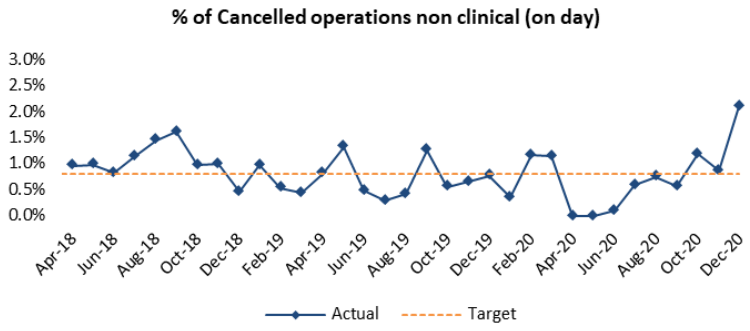
Delayed Discharges / Delayed Transfers of Care (DTOC):

The total Delayed Patient days has remained consistent during 19/20 and 20/21



Cancelled Operations: The number of cancelled operations in Q3 2020/21 has increased compared to Q2 in 2020/21.

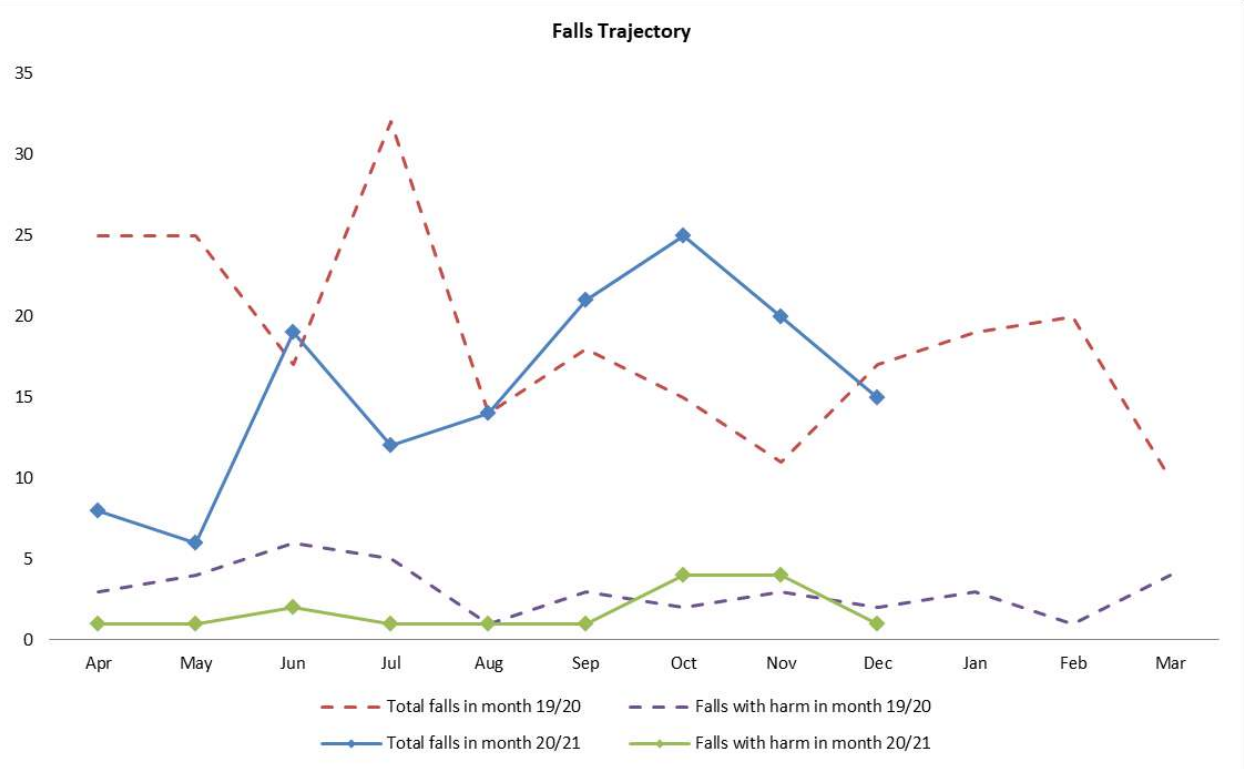
	Number of non-clinical cancellations
Q2 2020/21	13
Q3 2020/21	40
Variance	27



Safety Indicators

Patient Falls:

Our goal is to achieve a year on year improvement with the prevention of falls and falls with harm.



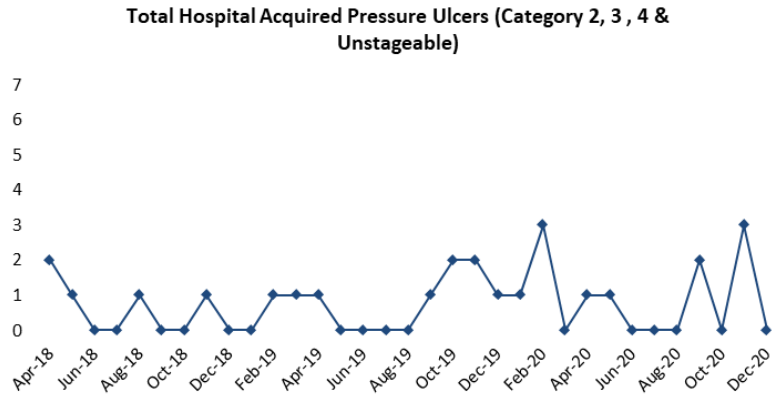
In 20/21 there has been 140 total falls of which 16 were minor harm. This compares to 174 total falls at this stage of 19/20. There has been no moderate harm falls within the Trust in 20/21.

A monthly falls analysis report is currently compiled by the Falls prevention steering group then disseminated to local departments/wards highlighting any themes/trends in month, lessons learnt and any good practice for sharing. Patients at risk of falls are being correctly identified and there is evidence that measures are being taken to reduce the risk. Falls at the bedside and in bathrooms are most common; more patients who have fallen have capacity and choose to take the risk of mobilising on their own. Follow up questionnaires are done in real time to try and establish the reasons for the fall and any actions that can be taken to reduce future risk.

Pressure Ulcers

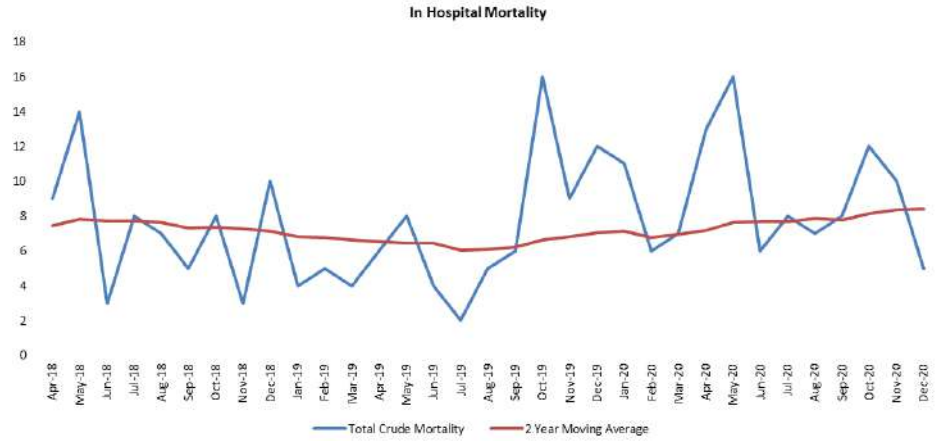
In Q3 2020/21 there was two Walton Centre acquired pressure ulcer.

Below is a graphic representation of our position to date



Mortality

Crude mortality reduced in December 20. All cases are subject to detailed clinical review and discussion at Quality Committee and no cause for concern identified.



The Walton Centre
NHS Foundation Trust

REPORT TO THE COUNCIL OF GOVERNORS
9 March 2021

Title	Terms of Reference - Council of Governors Steering Committee
Sponsoring Director	Name: Mr Paul Buckingham Title: Interim Corporate Secretary
Author (s)	Name: Mr Paul Buckingham Title: Interim Corporate Secretary
Previously considered by:	

Executive Summary

The purpose of this report is to seek Council of Governors approval of revised Terms of Reference for the Council of Governors Steering Committee.

The Terms of Reference for the Council of Governors Steering Committee were last reviewed on 15 June 2017 and are therefore significantly overdue for review. A revised draft Terms of Reference was prepared by the Interim Corporate Secretary and was circulated to Committee members for review and comment. All members of the Committee who responded endorsed the revised approach as a positive development. However, one respondent noted the advisory nature of the group, working on behalf of the wider Council, and suggested that the title of 'Steering Committee' could be misleading and/or misinterpreted. For this reason, a change of title to Council of Governors Advisory Committee was proposed.

A copy of the revised Terms of Reference is included for reference and consideration at Annex A to this report.

Related Trust Ambitions	N/A
Are there any risks associated with this paper?	N/A
Related Assurance Framework entries	N/A
Are there any associated legal implications / regulatory requirements?	N/A
Equality Impact Assessment completed?	N/A
Action required by the Committee	The Council of Governors is recommended to: • Approve the revised Terms of Reference included at Annex A to this report subject to a change in title to Council of Governors Advisory Committee.

REPORT TO THE COUNCIL OF GOVERNORS

9 March 2021

Terms of Reference – Council of Governors Steering Committee

Purpose

The purpose of this report is to seek Council of Governors approval of revised Terms of Reference for the Council of Governors Steering Committee.

Background

The Terms of Reference for the Council of Governors Steering Committee were last reviewed on 15 June 2017 and are therefore significantly overdue for review. A review process was initiated in 2020 but completion was deferred due to the national pandemic situation. The Interim Corporate Secretary discussed the position with the Lead Governor on appointment in January 2021 and subsequently commenced a review of the Terms of Reference.

Current Situation

The review which was initiated in 2020 had intended to limit the role of the Steering Committee to meeting on an ad hoc basis with no specific functions or role. Following discussion with the Lead Governor and Trust Chair it was agreed that there was a continuing need for such a group, that the group should meet at least twice a year and that specific functions should be identified to define the purpose of the Committee.

A revised draft Terms of Reference was subsequently prepared by the Interim Corporate Secretary and was circulated to Committee members for review and comment. All members of the Committee who responded endorsed the revised approach as a positive development. However, one respondent noted the advisory nature of the group, working on behalf of the wider Council, and suggested that the title of 'Steering Committee' could be misleading and/or misinterpreted. For this reason, a change of title to Council of Governors Advisory Committee was proposed.

A copy of the revised Terms of Reference is included for reference and consideration at Annex A to this report.

Recommendation

The Council of Governors is recommended to:

- Approve the revised Terms of Reference included at Annex A to this report subject to a change in title to Council of Governors Advisory Committee.

COUNCIL of GOVERNORS STEERING COMMITTEE

Terms of Reference

1.0 AUTHORITY

1.1 The Council of Governors Steering Committee is constituted as a sub-committee of the Council of Governors. Its terms of reference shall be as set out below, subject to any future amendment(s) by the Council of Governors.

1.2 The Council of Governors Steering Committee, hereinafter referred to as 'The Committee' is authorised by the Council of Governors to act within its terms of reference.

2.0 ROLE

2.1 The purpose of the Committee is to support the Council of Governors through analysis, consideration and scrutiny of matters referred to the Committee and to make recommendations to the Council of Governors as required. Standing functions of the Committee are set out in para 2.2 to 2.5 below.

2.2 The Committee will consider proposals from Trust management in relation to the appointment of an External Audit service provider and make appropriate recommendations to the Council of Governors.

2.3 The Committee will scrutinise any proposals for amendments to the Trust's Constitution and make appropriate recommendations to the Council of Governors. The Committee will function as a 'task and finish' group on behalf of the Council of Governors at periodic reviews of the Constitution and will make appropriate recommendations on outcomes to the Council of Governors.

2.4 The Committee will act as a review group for the preparation of Council of Governors-related narrative for statutory reports. Working with the Corporate Secretary to review narrative for the Council of Governors section of the Annual Report & Accounts and with the Director of Nursing & Governance to review narrative for the Council of Governors response to the Annual Quality Report.

2.5 The Committee will work with the Corporate Secretary to develop mechanisms which will both assist Governors to discharge their statutory responsibilities effectively and enable Governors to become better informed about the activities of the Trust.

2.5 The Committee will work with the Corporate Secretary to identify training needs and prepare development programmes for the Council of Governors.

3.0 MEMBERSHIP

3.1 Membership

The Committee shall consist of:

- The Lead Governor (Chair)
- Any Governor who expresses an interest in becoming a member, up to a maximum of 9 Governors. Should more than 10 Governors express an interest, membership will be determined by a vote by the Council of Governors.

In attendance:

- Corporate Secretary
- Membership Manager

3.2 The Committee will be deemed to be quorate provided that at least three Governors are present.

3.3 In the event of absence of the Lead Governor, the Governors present shall nominate one of their number to Chair the meeting.

3.4 There will be a standing invitation for the Trust Chair to attend and participate in meetings. Other individuals may be invited by the Chair to attend meetings in relation to specific agenda items.

4.0 FREQUENCY OF MEETINGS

4.1 Meetings will be held on a six-monthly basis. Additional meetings may be convened as required subject to agreement by the Committee Chair and the Corporate Secretary, seeking advice from the Trust Chair if required.

4.2 Meetings will ordinarily be held at a venue on the Walton Centre hospital site. However, depending on the prevailing circumstances and to reduce unnecessary travel time, meetings may also be held virtually using a Trust-designated electronic meeting system.

5.0 MINUTES AND REPORTING

5.1 The minutes of all meetings of the Council of Governors Steering Committee shall be formally recorded and will be submitted for approval at the next meeting of the Committee.

5.2 A Chair's report shall be presented to the Council of Governors following each meeting of the Committee.

6.0 REVIEW

6.1 The terms of reference will be reviewed by the Committee on an annual basis and outcomes from the review will be submitted to the Council of Governors for approval.

Date approved by the Council of Governors:

The Walton Centre
NHS Foundation Trust

REPORT TO COUNCIL OF GOVERNORS
Date: 9th March 2021

Title	**Council of Governors Elections**
Sponsoring Director	Janet Rosser, Trust Chair
Author (s)	Paul Buckingham, Interim Corporate Secretary
Previously considered by:	None

Executive Summary

In accordance with guidance published by NHSE/I in March 2020, Governor elections did not take place during 2020 with a decision being taken to defer the scheduled elections to 2021 due to the national pandemic situation. This approach was endorsed by the Council of Governors.

The pandemic situation continues, and NHSE/I, in guidance published on 26 January 2021, has again provided Trusts with the option to further delay elections. However, the current level of vacancies on the Council of Governors presents a risk of achieving a quorum for meetings, a situation that would be exacerbated by further deferring the elections. Consequently, it has been decided that elections will take place between June – August 2021 in accordance with the timetable included at s11 of the report.

Action required by the Council of Governors:	The Council of Governors is recommended to: • Receive the report and note the timetable for Council of Governors elections in 2021.
Related Trust Ambitions	1. Deliver best practice care and treatments on our specialist field. 2. Provide more services closer to patient's homes, driven by the needs of our communities, extending partnership working. 3. Be financially strong, meeting our targets and investing in our services, facilities and innovations for patients and staff. 4. Lead research, education and innovation, pioneering new treatments nationally and internationally. 5. Adopt advanced technology and treatments enabling our teams to deliver excellent patient and family centred care. 6. Be recognised as excellent in our patient and family centred care, clinical outcomes, innovation and staff wellbeing
Risks associated with this paper	None identified
Related Assurance Framework entries	None
Equality Impact Assessment completed	Not applicable
Any associated legal implications / regulatory requirements?	

Council of Governors' Elections 2021

Executive Summary

1. Governor elections for both public and staff governors are held from June to August each year. The elections cover both vacant seats and governors eligible for another term of office.

2. In March 2020 all Trusts were advised by their regulatory body NHSE/I that because of the COVID outbreak they could, amongst other things, stop or delay governor elections where necessary but they did not give guidance about the implications of breaching constitutional and legal requirements.

3. The Council of Governors approved the Trust recommendation to delay the 2020 elections until 2021 and to extend 2 governor terms for a further year. This paper updates Governors on the subsequent position for 2021 elections.

Background

4. Where there is a vacant seat on the Council of Governors (for example where a governor has resigned) or where a governor is seeking to be re-elected for a second or third term, the Trust holds an election. This carries both a financial cost in paying the external independent organisation which runs the election and a resource cost i.e. the time of Trust staff involved in the process.

Constitutional and legal requirements

5. The Trust's constitution provides that:

    a. There should be 33 governors- 17 public governors, 4 staff governors and 12 appointed governors from specific organisations.

    b. Each governor can hold office for 3 years and is eligible for re-election at the end of each 3 year term but subject to an overall maximum of nine years. This is also reflected in the Monitor Code of Governance which provides that elected governors must be subject to re-election at regular intervals not exceeding 3 years.

    c. Elections must be conducted in accordance with the Model Election Rules which provide the mechanism by which the elections must be conducted and which form part of the Trust constitution.

    d. Where a vacancy arises the Council of Governors may either call an election within 3 months to fill the seat or (if applicable) invite the next highest polling candidate at the last election to fill the seat until the next election or leave the seat vacant until the next election if the governor's unexpired term of office is less than nine months.

Current Council of Governors position

6. Due to the number of vacancies and eligible seats for re-election, the 2021 election will involve a substantial time commitment for those involved in the election process, the Corporate Governance Assistant in particular. The 3 eligible staff seats will also require a commitment and engagement from Trust staff who are impacted by the additional work associated with COVID

7. Guidance issued by NHSE/I on 26 January 2021 enables Trusts to again defer or cancel Governor elections in 2021 due to the continuing pandemic situation. However, the current level of vacancies present a risk of achieving a quorum for meetings, a situation that would be exacerbated by further deferring the election. Consequently, it has been decided that elections will take place in 2021 using both postal and online voting methods.

8. There are 15 eligible seats:

Seat duration		Term at election	Constituency	Current Governor or reason for vacancy	
Sept	Aug			First name	Last Name
Incumbent has confirmed intention to stand for re-election					
2020	2023*	3	Merseyside	Barbara	Strong
2020	2023*	3	Merseyside	Jonathan	Desmond
2021	2024	3	North Wales	John	Kitchen
2021	2024	2	North Wales	Stan	Winstanley
2021	2024	2	Staff - Clinical	Amanda	Chesterton
Vacant Seats					
2021	2024	1	Cheshire	Resignation	21/10/2019
2021	2024	1	Cheshire	Incumbent not standing for re-election	
2021	2024	1	Cheshire	9 year limit	07/09/2021
2021	2024	1	Merseyside	Resignation	01/09/2020
2021	2024	1	Merseyside	Incumbent not standing for re-election	
2021	2024	1	Merseyside	Incumbent not standing for re-election	
2021	2024	1	Merseyside	Incumbent not standing for re-election	
2021	2024	1	North Wales	Resignation	05/01/2021
2021	2024	1	Staff - Non Clinical	Resignation	04/02/2020
2021	2024	1	Staff - Nursing	Resignation	12/11/2019

* Seats deferred from 2020. If re-elected their term will be for 2 years to comply with the requirements of the constitution para 12.4

9. There are also 6 appointed governor seats vacant which do not require an election.

Constituency Membership data

10. The table below details the number of members within each eligible constituency at February 2021:

Member Category	Number of seats	Constituency	Total	Previous Election	
				Year	Turnout
Public	3	Cheshire	721	2019	11.3%
	6	Merseyside	2572	2019	9.9%
	3	North Wales	1267	2018	Uncontested
Public Total			**4560**		
Staff	1	Clinical	257	2018	5.1
	1	Non-Clinical	389	2019	Uncontested
	1	Nursing	648	2018	5.1
Staff Total			**1294**		
Grand Total			**5854**		

Draft Election Timetable

11. Governor terms start at the Annual Members meeting held in September. In order to align all meetings with the business needs of the Trust, the Annual Members meeting for 2021 has been scheduled for the 2nd week in September which has bought the Election timetable forward by 10 days.

Draft Election 2021 - Timetable	Dates
Notice of Election / nomination open	Monday **7th June 2021**
Nominations deadline	Monday **12th July 2021**
Summary of valid nominated candidates published	Wednesday **14th July 2021**
Final date for candidate withdrawal	Friday **16th July 2021**
Notice of Poll published	Thursday **29th July 2021**
Voting packs despatched	Friday **30th July 2021**
Close of election	Friday **20th August 2021**
Declaration of results	Monday **23rd August 2021**
Council of Governors and Annual Members Meeting	**Tuesday 7th September 2021**

Recommendation

12. The Council of Governors is recommended to:

- Receive the report and note the timetable for Council of Governors elections in 2021.

Become a Governor

NHS
The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre Needs YOU!
Nominate yourself as a Governor in our upcoming elections and you could help the country's only specialist neurosciences trust continue to deliver 'Outstanding' care and treatment.

Anyone can be a Governor
As a Governor you will represent patients, Trust members and people within your area by attending meetings, committees and contributing to a range of areas that feed into this highly regarded NHS service. Nominate yourself via the link below and be part of a CQC-rated 'Outstanding' hospital.

More information is available about the role of Governors and the election on our website - **www.thewaltoncentre.nhs.uk/governor-elections.html**

Delivered by Royal Mail

2 ROYAL MAIL
POSTAGE PAID GB
HQ 13085

Nominations Deadline	**5pm 12th July 2021**
Voting Opens	29th July 2021
Voting Closes	20th August 2021
Role starts*	**7th September 2021**

Nominate yourself at www.ersvotes.com/waltoncentre2018
Nomination forms can be completed on-line and must be submitted to the Returning Officer by **5pm on Monday 12th July 2021**

*Subject to a satisfactory standard disclosure from the Disclosure and Barring Service (DBS)

The Walton Centre
NHS Foundation Trust

REPORT TO COUNCIL OF GOVERNORS
Date: 9 March 2021

Title	**Governor's Register of Interests**
Sponsoring Director	Janet Rosser, Trust Chair
Author (s)	Paul Buckingham, Interim Corporate Secretary
Previously considered by:	None

Executive Summary

In line with the provisions of the Standing Orders for the Council, this paper sets out the current list of declared interests from Governors. Governors are required to notify the Corporate Secretary of any new or changed interests, and update the public Register. An annual exercise is carried out to ensure that all Governors confirm that their entry on the register is up to date.

Governors are requested to review the declarations set out in the table included in this report and advise the Corporate Secretary of any amendments that may be required. Governors are reminded that any member with a conflict of interest in relation to any agenda item must declare the interest at the start of the meeting, and should withdraw from the relevant item whilst it is being considered.

Related Trust Ambitions	
Risks associated with this paper	N/A
Related Assurance Framework entries	
Equality Impact Assessment completed	
Any associated legal implications / regulatory requirements?	
Action required by the Council	The Council of Governors is recommended to: • Receive and note the Council of Governors Register of Interests 2020/21 • Advise the Corporate Secretary of any amendments required to register entries.

Council of Governors Register of Interests 2020- 2021

Name	Interest Type	Nature of Interest	Date Declared
Adrian Wells Public Governor Merseyside	Loyalty Interest	Helen Wells is my wife but has held the position of Deputy Director of Finance at the Walton Centre NHS Foundation Trust since September 2016	22/01/2019
Alison Astles Public Governor Cheshire	Nil Declaration		10/09/2019
Amanda Chesterton Staff Governor Clinical	Nil Declaration		22/02/2021
Barbara Strong Public Governor Merseyside	Nil Declaration		19/05/2020
Cameron Hill Public Governor Rest of England	Nil Declaration		17/02/2021
Chris Sutton Public Governor Rest of England	Outside Employment	BT PLC Major Corporate Accounts Mobility Specialist	19/05/2020
Colin Cheesman Public Governor Cheshire Emailed to check 22/02/21	Loyalty Interests	Member and Adviser Parkinson's UK, 215 Vauxhall Bridge Road, London, SW1V 1EJ [includes Chester & District Branch]	25/05/2020
	Loyalty Interests	Trustee Chester Voluntary Action, The Bluecoat, Upper Northgate Street, Chester, CH1 4EE	25/05/2020
	Loyalty Interests	Member and Adviser The NeuroTherapy Centre, River Lane, Saltney, Chester, CH4 8RG	22/02/2021
	Nil Declaration		17/02/2021
Doreen Brown Public Governor Merseyside	Nil Declaration		18/02/2021
Ella Pereira Partnership Governor Edge Hill University	Nil Declaration		17/02/2021
Jan Vaughan Partnership Governor Merseyside & Cheshire Clinical Network	Nil Declaration		31/03/2020
John Kitchen Public Governor North Wales	Outside Employment	Liverpool Heart and Chest Hospital Member of SURE group	17/02/2021
Jonathan Desmond Public Governor	Outside Employment	Unpaid Town Councillor Maghull Town Council	14/04/2019

Name	Interest Type	Nature of Interest	Date Declared
Merseyside			
Melanie Worthington Partnership Governor Cheshire & Merseyside Neurological Alliance	Nil Declaration		17/02/2021
Melissa Hubbard Public Governor Cheshire	Outside Employment	University Hospital of North Midlands consultant paediatrician	27/12/2018
Nanette Mellor Partnership Governor The Brain Charity	Nil Declaration		17/02/2021
Natalie Dill Public Governor Merseyside	Outside Employment	Orgánico I own a small candle making company from home. I produce a charity candle in aid of The Walton Centre Charity where I donate my 20% profit to this charity	19/05/2020
	Outside Employment	Full time Staff Nurse since January 2010. Cheshire and Wirral NHS Foundation Trust	19/05/2020
Peter Clegg Partnership Governor Liverpool University	Outside Employment	University of Liverpool Dean	09/04/2019
Rich Cottier Public Governor Merseyside	Nil Declaration		17/02/2021
Rhys Davies Staff Governor Medical	Nil Declaration		24/03/2020
Stan Winstanley Public Governor North Wales	Nil Declaration		18/02/2021
Stella Howard Partnership Governor North Wales CHC Joint Committee	Loyalty Interest	Maggies Cancer Support Centre Clatterbridge Wirral. Volunteered but haven't been able to participate for awhile	16/04/2019
	Loyalty Interest	Sister a patient attending the Walton Centre	16/04/2019
William Givens Public Governor Merseyside	Nil Declaration		19/02/2021

REPORT TO COUNCIL OF GOVERNORS
9 March 2021

Report Title	**Chair's Assurance Report – BPC 26 January 2021**
Sponsoring Director	David Topliffe – Chair of Business Performance Committee
Author (s)	Jan Ross, Director of Operations and Strategy
Purpose of Paper:	
The Business Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. The paper provides an update to the Council of Governors of the Business Performance Committee held on 26 January 2021.	
Recommendations	Governors are requested to: • Note the summary report

1.0 Items for the COG's information and assurance

- When activity recovery planning resumes it is recognised this will be done in parallel with a plan to balance the recovery and well-being of our staff.
- IT Business Scanning Business Case approval.
- Recommendation on ISS Facilities Management Contract extension.

The meeting consisted of a slimmed down agenda, specific proposals presented for approval alongside a consent agenda.

The Committee received the following updates:

a) Integrated Performance Report

Operations – The IPR continued to focus on activity in December however the improvements seen in the paper would start to decline due to the stepping down of all but P1 and P2 activity. Diagnostics work was continuing but would start to reduce, to support safe staffing levels. Average Wait in December has improved but it must be noted has now deteriorated. The 52 week breaches stood at 128 and was starting to decline however due to the current situation those patients were not being seen and treated. The Committee were updated on mutual aid and how the reduction in elective operations had enabled critical care to surge to support the wider region, the Trust is also supporting spinal and head and neck cancer work from LUFT, as well as keeping delayed transfers of care from other Trusts across C&M.

In response to a query around 52 week breaches the Committee were assured these patients would receive a clinical review and asked if their clinical status had changed. The majority were P4 patients under the 'Other' category which was Pain.

Finance – The finance regime had changed in M7 meaning that retrospective top up payments would no longer be applied to bring trusts back to breakeven position. At M9 the Trust reported an in month £190k surplus against a planned deficit of £339k (so £529k better than plan). Income saw an over performance of £493k in month which was £654k above plan YTD. Operating expenditure in month was underspent by £108k and £256k YTD.

Capital spend was £173k (£256 YTD) in M9 with no further in-month Covid capital spend. Excluding Covid spend (which would be refunded as per NHSI/E guidance) capital spend was £2,630k underspent. Part of the underspend was due to the plan being profiled in 12ths when a large proportion of spend will be incurred later in the year. The largest element of spend the Bi-plane scanner was due to be on site in March. It was noted that this payment would be secured in March and the Trust's cash flow would reduce accordingly. The Trust had also reduced additional

funding in relation to critical infrastructure, a CT Scanner, E-roster monies and was awaiting the outcome of a digital aspirant bid with NHS Digital.

Cash balance at the end of December was £40.9m equating to 118 days of operating costs. This had decreased by £1m since November. The cash position also included an additional monthly block payment received in December relating to January as part of the new financial arrangements for Covid.

Workforce – The Committee were updated on the underperformance on sickness absence figures and nursing turnover and the reasons for this. The cumulative impact that Covid had had on staff was discussed, not just on the current acute absence levels, but more generally the chronic impact of the demands of the last year were recognised. When planning resumes on what will inevitably be a long recovery of operational performance from a lower base that December had achieved, this ought to be done in parallel with a plan to manage the recovery and well-being of staff.

b) CQUIN Quarterly Update

Update received that due to Covid CQUIN funding had been suspended and was expected to follow the financial framework going forward.

c) Quality Improvement Programme Update

Update received that during the period between the first and second Covid wave some work had taken place on service improvement. The transformation work would continue and the Trust would follow the national direction of travel going forward.

d) Trustwide Risk Register (scores 12 and above)

The Committee received the Risk Register which included the top risks and any new and emerging risks identified. Also included were Covid risks that could potentially have an impact on the Trust's business and performance. The Committee noted the 7 red risks and 16 amber risks.

The Committee were briefed on the recently established Operational Management Board and the reasons why it had been put in place to cover any gaps in delivering operational service and provide a forum for all Divisions to have awareness of what was taking place.

e) E Rostering Update and Business Case

The Committee approved the replacement of the e-rostering system noting the bid for capital funding to support the roll out was successful. The Trust had been awarded £280k from DHSC. Chair's action had been taken to approve in December 20.

Ms Hall, E Roster Lead, updated on the current position and the reasons for implementing a new e-rostering system. It was asked if the lesson learnt from this could be captured and applied in other areas going forward.

f) Mass Spectrometer Business Case

The Committee approved the replacement of the liquid chromatography tandem mass spectrometer analyser in the Neuroscience Laboratories. It was confirmed that maintenance costs would be covered through revenue in the laboratories budget. Chair's action had been given in December 20 to approve at a cost of £200k.

g) Anaesthetic Ventilators Business Case

The business case to approve the purchase of 15 bedside ventilators and 2 transport ventilators to replace existing equipment in critical care that had exceeded their expected useful life was approved at a cost of £460k. Initially the anticipated purchase was split between 2 financial years but it was now planned to replace all machines in 2021/22 and have the ventilators in place in April 2021 (assumed within the 2021/22 capital plan).

h) IT Case Note Scanning Business Case

A business case was presented to the Committee in relation the scanning of patient case notes. The case related to mass scanning of patient records to synchronise with the current Electronic Patient Record (EPR) system. The total value of the business case was £592k, with planned spend of £203k in 2020/21 and £389k in 2021/22. In accordance with Standing Financial Instructions, the overall value of the business case necessitates approval by Board of Directors.

However, the Committee noted that funding for the project would come from central funding allocated by NHS Digital (Digital Aspirant Funding) with an associated commitment for expenditure in financial years 2020/21, 2021/22 and 2022/23. The Committee noted that the timescales for securing Board approval posed a risk to utilisation of 2020/21 funding due to timescales in the project plan for the scanning programme with the likelihood that central funding would be withdrawn in subsequent years if the planned level of scanning, and expenditure, was not undertaken in 2020/21.

The Committee noted that the planned level of expenditure in 2020/21, circa £203k, represented a justified, self-standing scope (irrespective of whether the rest was approved) and was within the Committee's delegated financial limit and agreed a pragmatic approach based on approval of the 2020/21 element of the business case, to facilitate commencement of the project, with a decision on the overall business case to be taken by the Board of Directors on 4 February 2021.

An addendum to the Business Case would be circulated to members of the Committee for agreement via email.

i) Synertec Business Case

The Committee received a business case providing an overview of the hybrid mail solution which would be provided by Synertec. This was previously approved in December 2019 by the Executive Team, with an expected Go Live date of April 20 but this was subsequently delayed due to Covid. The Committee received the reason for the proposed changes and recommendation for an initial 6 month trial period before a decision was made in regard to a long term solution.

The net total value of £107k for 6 months was approved.

j) Items presented under Consent Agenda

- Nurse Bank Agency Turnover Update Paper – received and noted by the Committee.
- Website Development Update – received and noted by the Committee.
- People Strategy – considered and noted by the Committee.

The Committee also received and noted several Chair's Report from the sub-committee meetings that had taken place.

k) AOB Extension of the ISS Facilities Management Contract(s) until March 2022

Update in Private Section of the Chair's Report.

2.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan, except that a few non-time-critical items have been deferred, such as ToR update and reviews of some sub-strategies. These will be rescheduled via an update of the annual work plan as soon as overall demands allow.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 March 2021

Report Title	**Chair's Assurance Report – BPC 23 February 2021**
Sponsoring Director	David Topliffe – Chair of Business Performance Committee
Author (s)	Jan Ross, Director of Operations and Strategy
Purpose of Paper:	
The Business Performance Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. Full minutes and enclosures are made available on request. The paper provides an update to the Board of the meeting of the Business Performance Committee held on 23 February 2021.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

- Operational Performance Recovery plan to be developed and presented at the next meeting which aims to incorporate an appropriate staff recovery plan.
- The current financial arrangements to continue to for Q1 21/22 and possibly Q2. An exercise is being undertaken looking at exit run rates for 20/21 to calculate what the Q1 block income payments will be.
- The proposal of the commercial strategy being a subject for a forthcoming board development session.
- The procurement of multiple capital items with short lead time to maximise capital spend before 20/21 year end.

The meeting consisted of a slimmed down agenda, specific proposals presented for information or approval alongside a consent agenda.

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Integrated Performance Report

Operations – The Trust had seen a decline in activity and average wait was below target and there had been some deterioration in the 52 week performance. A Recovery Plan was being drawn up and that would be presented to the Committee at the March meeting.

Workforce – Recruitment had continued over the past year and the first virtual recruitment day had recently taken place with 15 applicants shortlisted and 5 offers returned. Sickness was currently 5% with total staff unavailable at 7.5%. Staff who were shielding were continued to be monitored and a shift in staff unavailable was not expected to drop until shielding came to an end. An update was given on the vaccination programme and the commencement of the second dose. An area of concern was around PDRs and Appraisals and the work around improving this was detailed.

Work going forward would be on incorporating staff health and wellbeing into the recovery plan and what the key priorities would be and how staff could feel supported.

Finance – At M10 the Trust reported an in month £90k deficit against a planned deficit of £158k. The Committee were asked to note that M10 forecast is £0.6m surplus so an improvement of £1.1m from the January forecast – this was due to improvements seen in both M9 and M10. There was an income under performance of £297k in month and expenditure in month underspend of £365k.

Capital of £281k was incurred in M10 which was £96k above plan and £2,534k underspent YTD. A large proportion of spend will be incurred later in the year. Cash remained in a healthy position with the balance at the end of January at £41.3m.

The current financial arrangements would continue for at least Q1 of 21/22. An exercise is being undertaken looking at exist run rates for 20/21 to calculate what the Q1 block income payments would be.

b) Estates Return Information Collection (ERIC) Annual Report

The Committee received a briefing document based on the annual ERIC providing an overview of what ERIC is and the main drivers behind the data collection. The report compared the Trust data submitted for 2019/20 against peer trusts with similar sized estates based on gross internal area. The Estates Manager updated that this was the first report produced of this kind and although there had been some learning from the statistical analysis there was the problem around how data was interpreted by peers and the difficulty in getting direct comparisons.

Discussion took place around:

- How the ERIC data feeds into NHSI Model Hospital and what processes are in place to view these metrics for a more broader focus around use of resources;
- Benchmarking with other trusts and the recent contact with Queens Square, London, in order to use that trust as a comparator for a number of different services; and
- The need to have a form of benchmarking in place that would meet the expectations of NHSI when a use of resources assessment is looked at in a Well Led Review.

c) Communication, Engagement and commercial Update

The Committee received the update from the Head of Commercial Engagement and Marketing and were informed on the commercial and innovation work that was relatively new to the Trust. It was considered that discussion around the Trust's commercial strategy be a subject for wider discussion at BPC going forward. Projects currently in place were detailed as well as initiatives coming through. The work of the Communication Team both internally and externally was referenced with Covid 19 dominating both activities. The website development was a project that continued to take up a lot of work for the team however the commencement in post of a Communications and Marketing manager next month was welcomed.

The Committee discussed at length the commercial agenda and how the trust was probably behind the curve on this but going forward would need to think less about commissioner income streams and explore more areas of commercialisation and return on investment. It was considered to be a potential agenda for a board development session.

d) Terms of Reference - Staff Partnership Committee

The annual review of the Terms of Reference were approved. It was noted there were no major changes.

e) Capital Programme Update

The Committee were updated that the planned 20/21 capital spend had progressively increased to £7m funded by an 'original' system allocated budget of £4m plus a range of other central budget allocations which have been progressively granted capital, mainly late in the year.

Where capital projects were funded through PDC, these could not continue beyond March as this funding could not be carried forward. Projects funded internally would need to spend up to allotted allocations or the pressure would be carried forward into 2021/22.

Further support has now been given to spend up to a total of £8.7m provided justified projects can be completed by end of March. Spend phasing has therefore ended up disproportionally skewed to year end (c. £6.5m in Q4).

An opportunity has arisen to take on an additional neurosurgery service. The related capex could be implemented in 21/22 and to 'create headroom' in the anticipated 21/22 capital budget, other planned 21/22 items with short lead times are being urgently brought forward to procure in 20/21. The support to 'overspend' by £1.7m in 20/21 as noted above relates to this. Achieving this significant amount of expenditure in a short time scale involves intense focus and aligned action across the organisation.

The Committee discussed how to approve any items before the next meeting on 23 March. It was agreed rather than Chair's action, any business cases would be emailed to voting members of the Committee to gain overall approval before final decisions / authorisations were made.

f) Items presented under Consent Agenda

Four Chair's Reports from sub groups that had taken place were received and noted.

3.0 Progress against the Committee's annual work plan

The Committee continued to follow its annual work plan this month. Some deferred items from the January meeting were put on the agenda. Some deferred items required rescheduling on the cycle of business for 2021-22.

REPORT TO COUNCIL OF GOVERNORS
9 March 2021

Report Title	**Chair's Assurance Report – Quality Committee 17 December 2020**
Sponsoring Director	Seth Crofts, Non-Executive Director
Author (s)	Lindsey Vlasman Acting Director of Nursing
Purpose of Paper:	
The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. The paper provides an update to the Council of Governors of the meeting of the Quality Committee held on Thursday 17 December 2020.	
Recommendations	Governors are requested to: • Note the summary report

1.0 Items for the COG's information and assurance

- Risk assessments for Neurology Division
- MSSA the Trust is already at the trajectory for the year. On-going investigations are in place.
- There have been 3 category 2 pressure ulcers which are being investigated. The Tissue Viability Specialist Nurse has now commenced at the Trust.
- Staffing/specialist teams staff shortages.
- CQC inspection for the Mental Health Services

The Committee received the following updates:-

a) Medical Director's update
Updates were provided with regards to the Covid-19 vaccine and lateral flow testing. There were no further updates to add.

b) Patient Story
The patient story highlighted the stresses felt by a relative unable to visit her mother (a long term patient) during the Covid-19 pandemic. There is a need to review current visiting guidelines to support patients and families during the Christmas period. The senior nursing team already had an awareness of the patient and their family and have put a plan in place for visiting in exceptional circumstances.

c) Integrated Performance Report (IPR)
The IPR was received and noted. Attention was brought to the risk assessment scores for MUST in the neurology division. The team are working on this with Mr. Foy. There were 3 category 2 pressure ulcers for which investigations are underway. The Tissue Viability Specialist Nurse has now commenced in post and is working on key objectives. It was noted that complaints have reduced. Mr. Foy provided an overview on how the process works for the IPR and of the inclusion of the new slide for patient journey parameters.

d) Quarterly Pharmacy KPI Report
A review of the Quarterly Pharmacy KPI report was provided by J. Sparrow.

e) Quality Committee Effectiveness review

The group were informed about undertaking the Quality Committee effectiveness review to ensure that the committee are fulfilling its terms of reference. Members requested to complete the review and return for collating. Electronic document is to be circulated.

2.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.
It was noted that Quality Committee needs to review and approve all sub-committee Terms of Reference and dates for each need to be added to the work plan.
Equality, Diversity and Inclusion to be added to the work plan.

REPORT TO COUNCIL OF GOVERNORS
9 March 2021

Report Title	**Chair's Assurance Report – Quality Committee 21January 2021**
Sponsoring Director	Seth Crofts, Non-Executive Director
Author (s)	Lindsey Vlasman Acting Director of Nursing
Purpose of Paper:	
The Quality Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. The paper provides an update to the Council of Governors of the meeting of the Quality Committee held on 21/01/21	
Recommendations	Governors are requested to: • Note the summary report

1.0 Items for the COG's information and assurance

- From IPR & IPC Q3 reports - MSSA infections have exceeded the trajectory figure. A lot of investigative work has already taken place and a paper will be presented to Quality Committee when further findings have been collated.
- Mortality & Morbidity Q3 report – RAMI data

The Committee received the following updates:-

a) Medical Director's update
An update on the current Covid-19 pandemic situation was provided. The Trust now has 32 Covid positive patients, 6 of whom are on critical care. Whilst there are challenges with regards to patient flow and with nurse staffing, no concerns were raised about the quality of patient care. The Trust continues to liaise with the Critical Care Network with regards to mutual aid.

b) Integrated Performance Report (IPR)
The IPR was received and noted. Attention was brought to the increase in MSSA infection incidents which year to date total 12 cases, exceeding the yearly trajectory of 8. A quality improvement group has been created to further investigate causes.

Risk Assessments for Neurology remain red but assurances were provided that the risk assessments are being undertaken but may not be within the specified 6 hours. The Divisions are working with Informatics to find an improved way of recording this.

Nursing staff turnover figures were discussed. Turnover currently stands at 13.23% which is above the 10% national average. It was noted that due to being a specialist trust, turnover can be higher and that a long term plan is place. The higher percentage for Neurology was due to a number of internal promotions to Specialist Nurse positions.

c) Mortality & Morbidity Q3 Report
Dr. Nicolson provided an overview of the report and Mr. Foy clarified RAMI data.

d) Infection, Prevention & Control Q3 Report
Ms Vlasman presented the report and highlighted the following points:-

- MSSA infections and on-going work around this.
- There was one incident of C. Difficile

- The flu campaign succeeded in vaccinating 81% of staff. The aim was to reach 90% but the campaign needed to close early so that the Covid-19 vaccination programme could commence.
- The Covid-19 vaccination programme has now been extended to include all staff. LUHFT have been very supportive and the system is well organised. Initial figures indicate that already over 600 WCFT have received their first vaccination.

e) Quality Accounts
Ms Vlasman presented the Quality Accounts noting the full 2019/20 Quality Accounts were last reviewed at the Quality Committee in May 2020. Since this time there have been some amendments which were included in the papers. The report has been managed differently this year due to the COVID 19 pandemic and is out of line with the usual schedule. The Committee approved the Quality Accounts which will now go for publication.

f) Pathology Quality Assurance Dashboard
The report was received and Ms Hayes provided an overview of the dashboard.

g) Governance and Risk Management Q3 report
The report was received and noted. Mr. Fitzpatrick drew attention to the two separate events which led to harm to staff (fracture wrists) following incidents with patients, adding that restraint training is being provided for staff. E-Coli incidents have been added to the GAF in order to monitor trends.

Ms Gurrell provided an overview of complaints and concerns. The main themes for concerns were related to the referral process and general hospital enquiries.

h) Patient Experience Group Terms of Reference (Tor)
The slight amendments to the ToR were noted and the ToR were approved by the QC Committee

i) Clinical Effectiveness Terms of Reference (ToR)
The ToR for Clinical Services & Effectiveness Group were approved by the QC Committee

2.0 Progress against the Committee's annual work plan
The Committee continues to follow its annual work plan.

REPORT TO COUNCIL OF GOVERNORS
9 March 2021

Report Title	**Chairs Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Paul Buckingham, Interim Corporate Secretary
Purpose of Paper:	
The Audit Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. The paper provides an update for the Council of Governors of the meeting of the Audit Committee held on 19th January 2021	
Recommendations	Governors are requested to: • Note the summary report

1.0 Items for the COG's information and assurance

The Committee highlighted the impact of COVID on progress against audit plans and the introduction of an expanded Value for Money audit, as part of the audit of the 2020/21 financial statements, which would require additional work and will result in an increased audit fee. The Committee also noted that an external audit tender process was in progress and the Committee had considered the terms of reference for this which would be recommended to the Board.

The Committee received the following updates:

a) Internal Audit Progress Report Q3

The Committee received the internal audit progress report for Q3 and noted that a review of the Key Financial Systems had been finalised and that a Fit and Proper Persons audit review was at the reporting stage. An overview of recommendations from the Key Financial Systems audit was provided and it was noted that the audit provided substantial and high assurance with one medium and one low recommendation. The Fit and Proper Persons audit report had been shared with the Trust and discussions had taken place around initial responses and actions. Additional evidence was being identified prior to the report being finalised..

b) Internal Audit Recommendations Report

The Committee received the internal audit recommendations report and it was noted that work would be undertaken within the relevant teams to review each recommendation to clarify if anything had been completed, superseded or was incorrect and had not been communicated to the internal audit team.

c) MIAA External Quality Assessment Report

The Committee received the external quality assessment report providing assurance of MIAA conformance to the public sector internal audit standards. An overview of the process undertaken was provided and it was noted that the report provided assurance that MIAA was fully compliant with the relevant standards.

d) Counter Fraud Progress Update

The Committee received the MIAA counter fraud progress report covering the period from July 2020 to January 2021 and noted that 29 local fraud alerts and 6 national fraud alerts had been published during the reporting period. One fraud report had been closed with no further action appropriate and no additional reports had been received. NHSCFA had launched a Fraud Prevention Guidance

Impact Assessment in October 2020 and an overview of the guidance within the assessment was provided.

e) External Audit Progress Report

The Committee received the external audit progress report and noted the requirement of a new Value for Money audit following a review and update of the code of practice by the National Audit Office. Guidance around this was still being finalised and it was recognised that this would require a fee variation for 2020/21. A summary of audit deliverables was provided however it was noted that the timetable for 2020/21 had not yet been finalised. An overview of key reports published affecting the healthcare audit sector was also provided.

f) External Audit Plan and Fees

The Committee received an update on the external audit plan and associated fees and noted that the base audit fee had been agreed however this had not factored in additional works due to COVID and work was underway to mitigate any additional costs incurred. It was noted that a fee for the additional works related to the Value for Money audit had yet to be agreed but would be confirmed as soon as possible.

g) Financial Systems Benchmarking Challenge Questions

The Committee received the responses to challenge questions posed following the recent financial systems benchmarking exercise undertaken by MIAA.

h) Tender Waivers

The Committee received a report of tender waivers made in quarter 3 of 2020/21. There had been 2 occasions where a waiver had been provided. One waiver related to turnkey works required for the Biplane replacement programme. The other waiver related to pre-installation turnkey works required for the CT scanner replacement programme. It was recognised that the Trust's liability insurance would not cover the works being undertaken by anyone other than the suppliers of the equipment.

i) Losses and Special Payments Report

The Committee received the losses and special payments report and an overview of each compensation payment was provided. The report also included the figures for 4 overseas debts written off by the Trust that had been approved at the previous Audit Committee meeting. It was clarified that clinical negligence payments were agreed by legal teams if they fell outside of CNST standards and payments for personal effects required a receipt or proof of costs of what the item was before a level of payment was agreed.

j) 2020/21 Financial Accounts Timetable

The Committee received an update on the preparation of the financial statements for 2020/21 and an overview of additional submission deadlines confirmed following completion of the report was provided. Key changes to the Department of Health and Social Care Group Accounting Manual (DHSC GAM) were highlighted and assurances were provided around the Trust continuing to be a going concern. It was noted that revenue determination had moved to allocations rather than being based on activity and NHSE/I may issue guidance on how this should be described in financial accounts.

k) Review of Committee Terms of Reference

The Committee completed the annual review of its Terms of Reference and agreed an amendment at s4.3 to clarify that the attendance of deputies at meetings related to management representatives rather than Committee members. The reviewed Terms of Reference are included at Annex A for approval by the Board of Directors.

l) Review of Standing Financial Instructions (SFIs) and Scheme of Reservation and Delegation

The Committee noted the record of amendments for each document following detailed discussion held at the previous meeting and an overview of each amendment provided. The Committee approved the amendments and the documents would be uploaded to the Trust intranet.

m) Committee Cycle of Business 2021-22

The Committee reviewed and agreed the annual cycle of business for 2021/22 and noted that an additional meeting would need to be scheduled in June 2021 to review the annual financial statements and associated auditor's reports prior to approval by the Board of Directors.

n) Committee Effectiveness Review

The Committee discussed the different approaches available to complete the annual effectiveness review of the Committee and agreed to proceed with a self-assessment approach, based on checklists included in the Audit Committee Handbook, which would take place at the next meeting in April 2021.

2.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan and there have been no deferred matters during the year. Areas of focus for the coming meeting would be:

- Internal audit plan for 2021/22 for approval
- Annual accounts update
- Tender waivers
- Counter fraud annual plan for 2021/22
- Counter fraud annual report
- Financial accounts 2019/20
- Compliance with Foundation Trust Code of Governance
- Clinical audit plan
- External visit update report
- Quality account
- Annual report on registers of interest
- Annual self-assessment of committee effectiveness

REPORT TO COUNCIL OF GOVERNORS
9 March 2021

Report Title	**Chair's Assurance Report**
Sponsoring Director	Su Rai – Non-Executive Chair
Author (s)	Mike Burns, Director of Finance and IT
Purpose of Paper:	
The Walton Centre Charity Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. The paper provides an update to the Council of Governors of the meeting of the Walton Centre Charity Committee held on 14 January 2021.	
Recommendations	Governors are requested to: • Note the summary report

1.0 M Items for the COG's information and assurance

- Approval of the Walton Centre Charity Annual Report and Accounts.
- The review of the Charitable Projects Process was moving forward and would be presented to Trust Board mid-year.

The Committee received the following updates. Items listed in order of discussion.

a) Independent Review Statement from Grant Thornton
Following the completion of the Independent Examination Grant Thornton issued the unsigned Independent Examiners statement for the Walton Centre Charity accounts for the year ended 31 March 2020. There were no errors identified during the independent examination or matters to draw attention to the Committee members.

b) Annual Report and Accounts
The final version of the annual report and accounts for 2019/20 were presented to the Committee. The Trust Board had delegated approval to the Committee due to the timing of the next Board meeting taking place after the deadline for submission to The Charity Commission on 31 January 2021. A copy of the annual report and accounts would be circulated to Trust Board members for approval / comments following the meeting.

c) Annual Progress Summary from T&D Department
The Education Co-ordinator presented the Annual Report updating the Committee on progress made by staff members who had benefited from receiving a contribution from Charitable Funds towards study for professional development. The Committee agreed they would continue to receive the worthwhile report on an annual basis and asked for details of the contributions given to staff to be included in the Charity's Annual Report going forward.

d) Applications for funding from T&D Department
All 9 applications presented for funding from T&D were approved.

e) Summary Investment Reports:

a. CCLA - The Investment Manager from CCLA joined the meeting and gave a presentation of the performance of the investments including market information, fund holdings and transactions and ethical responsibility. The CCLA portfolio was valued at £580,894 at 31 December 2020 which was an increase of £21,103 from the previous position (Q3) reported in the November meeting.

b. Ruffer – Ruffer provided a summary of the current position of the portfolio as at 9 January which outlined that the fund had increased to £551,047 which was an increase of £38,375 from the last quarter.

f) Finance Report as at 31 December 2020

The report detailed the financial performance of the charity as at 31 December 2020 and showed that the fund had reduced by £79,157 from 1 April 2020. The report detailed the closing balances of the individual funds to enable the Committee to review the performance of these funds. The year to date income received was £390,216 which included £147,600 received from NHS Charities and year to date expenditure totalling £469,372.

g) Fundraising Activity Report

The Committee received the report and noted the contents. Ms Fletcher, Head of Fundraising, highlighted the following sections from the report:

- The Christmas Appeal this year had raised just over £6,000 to date including the profit from the Christmas cards. Special mention was made to staff, patients and their families on CRU and Lipton Ward who in lieu of their annual Christmas party, held a virtual bike ride from CRU to Blackpool raising just under £2,000 for their fund.

- A legacy of £7,000 had been received in the period under review, and the Charity will sign up for another year with Bequeathed, the on-line Will writing platform.

- Comparing income to date with the same time period last year, it was noted that not including the significant legacies received last year totalling £414,000, the income was actually up by £30,000. A contributing factor was the grants from NHS Charities Together, £147,600, but as this income is designated in the main for staff health and wellbeing, the biggest impact is on the Home from Home Fund and the Sid Watkins Innovation Fund which have both seen a decrease in income this year due to cancelled events.

h) Application for Biobank Ultra Low Freezer (Neuroscience Laboratories)

The application was presented by Khaja Syed (Biobank Manager) and Carrie Chadwick (Director of Neurosciences Labs) for the purchase of 2 x Haier Biomedical Freezers, Tutella remote sensor and subsequent Estates work totalling £25,846.72 (+VAT) from the General Fund. A presentation was made explaining the Liverpool Neuroscience Biobank at the Walton Centre had been established to promote multi-disciplinary basic and translational neuro-oncology and neurology research. It included archived and prospectively collected samples from patients who are investigated and all patients undergoing clinical procedures are invited to participate.

Due to the growth of the project the number of specimens being banked had increased and in order to ensure the infrastructure was in place to be able to accommodate future banking of CSF two additional ultra-low temperature freezers were required.

The Committee discussed the application at length. On costs were minimal and it was considered a valuable asset. The application was supported and it was noted the equipment would be VAT exempt.

i) Application for Neuropathology Specimen Imaging (Neuroscience Laboratories)

Neil Moxham, Pathology Manager, presented the application on behalf of Dr Piyali Pal for the purchase of a macro imager totalling £12,054.36 from the R&D Higher Study fund. The Neuroscience Laboratories provide a diagnostic Neuropathology service for Trust patients and a Neuroautopsy service to trusts and Coroners regionally. Neuropathologists are involved in the training of visiting pathology registrars and the Trust's own speciality registrar in Neuropathology. The equipment would greatly enhance the effectiveness training in tissue dissection and the image library would be available as a teaching resource.

The Committee approved the application noting it would not be able to link to EP2 and was for routine diagnostic work.

j) Staff Appreciation Gift (Amazon gift cards)

The Committee formally approved the application that was supported via email in December to award all staff with a £10 Amazon Gift card by way of a thank you for their hard work during a challenging year. All staff would benefit including ISS, junior doctors and student nurses. The application totalled £18,000 from the General Purpose fund.

k) Staff Appreciation Gift (presentation gift)

The Committee formally approved the application that was supported via email in December to award all staff with a presentation staff box by way of appreciation. The application totalled £11,707.20 from the General Purpose fund.

The Amazon vouchers were still in the process of being distributed and feedback had been positive. Mr Burns, on behalf of the Committee, thanked Ms Fletcher and the Procurement Department for their hard work.

l) Preparation of the Financial Statements 2020/21

The policies and assumptions made in preparing the 2020/21 financial statements were noted by the Committee and further consideration would be given to provisions / contingent liabilities, irrecoverable VAT and the allocation of support costs and overheads accounting policy notes. The Committee were asked to approve the accounting policies and confirm that they were satisfied that the accounts should be prepared on a going concern basis.

m) Home from Home Annual Report

The Committee noted the Annual Report which provided an update on usage of the accommodation during the last 12 months. Due to the national pandemic and the directive that visitors have not been allowed on site a decision was made to use the accommodation for staff following the national lockdown. Once visiting restrictions were lifted families of patients with exceptional circumstances were allowed to stay in the accommodation. Comments included that the Trust did not want to set a precedent for staff using the accommodation and that there may be tax implications for those members of staff. The £8k increase in costs for running the accommodation in the past year was thought to be due to a pay band increase of the Accommodation Manager and it was asked for this to be clarified.

n) Review of Charitable Projects Process

The following steps had been identified to support the Trust in prioritising significant projects eligible for charitable funding or fundraising focus:

- The Charity Committee will analyse the existing annual charitable expenditure to establish ‘charity business as usual’ spend per year, and subsequently agree a level of ‘reserve’ for potential projects / initiatives that may come forward over and above this. This will give the Committee a plan to work towards each year.

- To identify more significant projects which would require fundraising (level of funding to be agreed) the Charity will invite proposals from across all clinical disciplines with a clear annual deadline.

- Ms Fletcher will produce relevant documentation to support the process and communicate this to staff once completed.

o) Report on longer term commitments to the Charity

The Committee noted the longer term commitments but it was requested that this information (£444k committed) be reported as part of the finance report going forward. An explanation was provided on how this information was contained within the Finance Report.

p) Update on Risk Management Policy

The Head of Fundraising will be invited to attend the Corporate Divisional Risk meeting, where the Charity's risks will be discussed and reviewed on a regular basis. The minutes of these meetings are received by Quality Committee.

A risk register will be populated and loaded onto DATIX in order for the Head of Fundraising to submit reports to the Charity Committee at its quarterly meetings.

2.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.

REPORT TO COUNCIL OF GOVERNORS
9 March 2021

Report Title	**Chair's Assurance Report – RIME Committee 13/01/21**
Sponsoring Director	Seth Crofts – Non-Executive Chair
Author (s)	Mike Gibney, Director of Workforce and Innovation
Purpose of Paper:	
The Research, Innovation and Medical Education Committee continues to receive reports and provide assurance to the Board of Directors against its work programme via a summary report submitted to the Board after each meeting. The paper provides an update to the Council of Governors of the meeting of the Research, Innovation and Medical Education Committee held on 13 January 2021.	
Recommendations	Governors are requested to: • Note the summary report

1.0 Items for the COG's information and assurance

- At month 8 the Trust reported a £253k deficit position from R&D/NRC. There will be additional scrutiny on costs across the Trust in totality during the year ahead.

- An independent review of the department has been undertaken and the report is imminent. There are strategies and actions in place to address the issues and turn around the deficit and challenging situation faced by Research.

- The recent independent and external review of the NRC is expected to propose potential actions that needed to be considered within the context of the services ongoing and long term financial deficit. This would be the focus for the recovery of the performance of the service and will need to be implemented at pace.

- The development of a Biomedical Research Centre has been led by William Hope who has overseen the bid for funding. The need was identified for Mr Hope and leaders of the bid to interact with Walton clinicians to ensure awareness is raised and that the Trust sufficiently influences the future service. An additional meeting to review this may be required prior to the next RIME in March.

- BRC Walton roadshows are also to be reinstated.

2.0 Items for the Board's Information and Assurance

- Committee approved a prioritisation of focus on commercial activity going forward. However, it was noted the Trust must stay within its contractual responsibilities for participation in any other studies.

- Committee noted that there was significant assurance around the quality of learning throughout Medical Education at the Trust. This is clearly within the context of the COVID-19 pandemic.

- Pipeline Projects from Medical Innovation Group – Committee wished to highlight the volume and quality of current innovation projects that are nearing maturity.

3.0 Progress Against the Committee's Annual Work Plan

- From an R&D perspective, this situation puts even more emphasis on the Trust increasing its commercial income and reaching targets set as there is no flexibility in the system

The Walton Centre NHS Foundation Trust

REPORT TO THE COUNCIL OF GOVERNORS
Date: 9 March 2021

Title	**2019/20 Quality Account**
Sponsoring Director	Name: Lisa Salter Title: Director of Nursing and Governance
Author (s)	Name: Lisa Salter Title: Director of Nursing and Governance
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____

Executive Summary

The timescales and arrangements for completion of the 2019/20 Quality Account differed significantly from arrangements in previous years due to the Covid-19 pandemic. Ordinarily, content of the Quality Account is subject to review by External Audit, with a subsequent audit report on outcomes being presented to the Council of Governors. This requirement was removed in respect of the 2019/20 Quality Account as part of revised reporting arrangements established by NHS Improvement in response to the pandemic.

The initial 2019/20 Quality Account document was reviewed by the Board of Directors in July 2020. Feedback from stakeholders was subsequently incorporated in the Quality Account with the final version being presented to the Board of Directors on 4 February 2021. This final version is being shared with the Council of Governors for information.

Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	Risk to quality of care to patients and reputation
Related Assurance Framework entries	
Equality Impact Assessment completed	No – (please specify) _____
Any associated legal implications / regulatory requirements?	No – (please specify) _____
Action required	• Note the final version of the 2019/20 Quality Account.

The Walton Centre
NHS Foundation Trust

Quality Account

2019 – 2020

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 How well have we done in 2019-20?

2.1.1 Patient Safety
2.1.2 Clinical Effectiveness
2.1.3 Patient Experience

2.2 What are our priorities for 2020-21?

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 & 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

Part 3 Trust Overview of Quality 2019/20

Annex 1 Statements from Commissioners and Local Healthwatch Organisations

Glossary of Terms

Part 1 Statement on Quality from the Chief Executive

We are delighted to share the Quality Account 2019/2020 for The Walton Centre NHS Foundation Trust which demonstrates our continual drive and commitment to delivering excellent standards of quality care to our patients and their families, enabling, “Excellence in Neuroscience”. This report details our performance over the last year whilst also highlighting our key priorities for 2020/2021.

2019/2020 was an extremely proud year for The Walton Centre.

The Care Quality Commission (CQC) undertook an inspection, including well led, during March and April 2019. In August The Walton Centre received the fantastic news that it had been given an Outstanding rating again which was first gained in 2016. In the report the CQC cited that we were the first hospital in the North using intra operative MRI scanning during operations for adult patients, reducing the need for surgery. The high level culture of support for staffs health and wellbeing was observed and our partnership work with Shiny Mind and the Innovations Agency to create, with staff, a resilience app accessible to them 24/7 for support. The CQC praised the Trust for its work in collaborating across the local health economy, with partners such as the Liverpool Health Partners and the Joint Research Project. The report also highlighted the important work we all do in working together to bring care closer to patients and their families.

The CQC inspection demonstrated the Trust strategy is making good progress in delivering our vision and to meet our purpose by delivering best practice care and treatment, leading innovation, adapting advanced technology, enabling our teams to deliver excellent care and providing care close to patients’ homes and working in partnership with others.

The Trust received two ‘Centre of Excellence’ awards for spinal treatment and muscular dystrophy as well as a high commendation from international awards.

The Trust continues to deliver on quality care in relation to patient safety, clinical effectiveness and patient experience and our vision encapsulates this with our drive to achieve patient and family centred care. The Executive Team are committed to leading change to ensure patients receive outstanding care both within The Walton Centre and in the other hospitals and centres across Cheshire and Mersey where we deliver care.

The quality priorities for 2019/2020 have been achieved and are detailed within this Quality Account.

In addition, this year we have achieved:

- Top Industry Award
- International Engage Award (ShinyMind App)
- International Engage Lifetime Contribution Award
- BBC Two Hospital Episode
- Director of Clinical Academic Development – October 2019 (University of Liverpool)
- Applied Research Collaboration North West (ARC NW)
- CQC Inspection
- Launch of Childrens Book
- Official Opening of Garden Room
- Surgical Spine Centre of Excellence (SSCoE)
- Roy Ferguson Compassion Award
- Centre of Clinical Excellence Award
- Joined Rainbow Badge Initiative (ED&I)

Quality initiatives are discussed and debated through various Committees which include the Audit Committee, Quality Committee and Business & Performance Committee in order to ensure that quality assurance is achieved. These Committees report to Trust Board to ensure that patient safety is a priority and is progressed.

The Professional Nurses Forum, Quality Committee and Trust Board all receive information related to the quality agenda and progress of each indicator is assessed and rated as Red, Amber or Green against expected performance levels.

The daily Safety Huddle continues, which offers the opportunity for clinical and non-clinical staff across the Trust (regardless of role or band) to share concerns that have arisen during the previous 24 hours and that may occur in the next 24 hours. This huddle supports discussions each day to share learning and prevent harm to patients, families, visitors and staff. The CEO Huddle also continues to take place on a bi-monthly basis which also offers the opportunity for staff to ask questions and raise concerns they may have.

Staff within the Trust continue to deliver year on year improvements in care and this is recognised by their achievements of 2019/2020 whilst working in partnership with our patients and their families to meet and exceed expectations. The commitment to patient safety, clinical effectiveness and patient experience is appreciated and enables our successes. The contribution of our members and Governors who give their time voluntarily are extremely important to the hospital and we are grateful for their input and efforts.

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.

Hayley Citrine, Chief Executive

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

Towards the end of each financial year, the Trust works closely with various stakeholders to identify areas of focus for improvement for the forthcoming year. At this time it also allows the Trust to reflect on the year's previous performance against the identified quality improvement priorities.

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

All of the priorities were identified following a review by Trust Board on the domains of quality reported in 2018/19. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing our priorities for 2019/20.

The Trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care. The following section includes a report on progress against the three improvement priority areas for 2019/20.

2.1 Update for Improvement Priorities for 2019–2020

In February 2020, the Board of Directors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each priority was on target. At this review, quality priorities were identified and agreed for 2020/21. The improvement priorities all contained specific indicators which have been monitored over the last twelve months to provide evidence of sustainable improvement.

Performance has been managed through subcommittees to Trust Board. Operational groups within the Trust have been responsible for the implementation of the quality priorities and reporting to committees as required. Merseyside Internal Audit Agency (MIAA) has been fully engaged in the Trust during 2019/20, providing regular reviews and assurance via the Audit Committee and this process will continue into 2020/21. Bi-monthly quality meetings to review quality assurance reports have taken place with the commissioners, ensuring external scrutiny and performance management.

2.1.1 Patient Safety

Priority 1: Support Religious beliefs and cultures within the Theatre Department

Reason for Prioritising:
Whilst a lot of work has been undertaken for Equality, Diversity and Inclusion it has become apparent further work is required regarding cultural and religious beliefs.

The aim is to provide patients with an information leaflet regarding the products used within the theatre environment, for specific cultures, such as Jehovah Witnesses, to support patient religion / choice.

Outcome: Achieved
Each patient who attends Theatre has an assessment for any support required regarding their religious beliefs. A protocol has been devised to ensure staff are aware of the products and requirements for each religion.

Priority 2: Implement Aseptic Non Touch Technique

Reason for Prioritising:
An aseptic technique is used to deliver a wide range of care interventions to patient's e.g. intravenous medicines/fluids and wound care. Ineffective standards of aseptic technique are a significant cause of healthcare associated infection.

Aseptic Non Touch Technique (ANTT) is a recognised national standard that has been shown to support the reduction of healthcare associated infections.

Whilst there has been lots of work undertaken in respect of infection control, the introduction of ANTT will enhance infection prevention practice; improve safety and quality of care for patients.

Outcome: Achieved
Key staff have been trained in ANTT and are now able to cascade the training within their clinical areas.

Priority 3: Pre and post-operative discussions with the Theatre Team

Reason for Prioritising:
Whilst conversations take place during pre-operative assessments, patients often have further questions/anxieties regarding their forthcoming admission that may not necessarily be a clinical related question and may be related to the 'experience' of the day itself and the expectations of being in theatre. This priority is following feedback from the inpatient questionnaire in conjunction with the Head of Patient Experience.

The conversation will take place on the day of surgery, before the patient's procedure, and is separate to pre-operative assessments (which will take place prior to the admission). This will be part of a bespoke theatre patient experience proforma. This conversation will enable recovery staff to gain an understanding of the emotions, expectations and wellbeing of patients at that point, as we do not currently capture this additional information. The patient's journey will be followed to ensure we gather feedback regarding their experience to ensure we get a better understanding of the patient journey.

With the introduction of a pre and post-operative discussion with a member of the theatre team, we aim to ensure future patients have a positive and safe experience and an opportunity to ask questions they may not feel there is a place for in other appointments they may attend.

Outcome: Achieved
There is a process in place for all patients attending Theatre to be offered a pre-op visit prior to having surgery. During post operative discussions any issues/concerns raised regarding pain control a referral is made to the acute pain nurse.

2.2.2 Clinical Effectiveness

Priority 1: Introduce In-house Masters Neurosciences Training Module

Reason for Prioritising:
This is a level 7 Masters module that will provide an overview of the neuroscience speciality. It will be available to the multi-disciplinary team (MDT) to enhance staff knowledge of care and management of patients within the neuroscience specialty.

Outcome: Achieved
The module has successfully been rolled out and a course evaluation was undertaken with positive feedback. A further module is taking place in March 2020.

Priority 2: Contacting patients who require telemetry tests prior to admission to reduce the rate of DNAs (appointments where patients do not attend)

Reason for Prioritising:
EEG Telemetry is a type of long term EEG monitoring to aid the diagnosis of epilepsy. Telemetry tests require a hospital admission and during this time the patients is confined to bed (whilst their brain activity is monitored together with a video recording of the patient). Demand for this test is significantly high and waiting times can be long.
Patients referred for telemetry will be contacted to obtain a detailed clinical history. This will ensure the telemetry test is still warranted and the patient understands what the admission involves.

Patients can be on the waiting list for many months. Two weeks prior to admission the patient will be contacted again to ensure their seizure frequency has not changed/or seizure type changed. If it has changed then tests may no longer be required and the appointment can be re-allocated.

Outcome: Achieved
Patients who are due to attend the Trust for telemetry testing are now contacted to ensure the test at the time is still appropriate which has reduced the rate of DNAs.

Priority 3: Introduce the A3 methodology for Quality Improvement

Reason for Prioritising:
Whilst the Trust undertakes numerous projects to enhance patient care, the A3 Methodology supports a 'plan on a page' concept which will provide staff with a project plan to deliver clear defined outcomes.

Staff will have a streamlined approach to project delivery, saving valuable time and enabling success

Outcome: Achieved
A3 methodology is embedded across the Trust for all service improvement projects. Staff present their projects to the Executive Team.

2.2.3 Patient Experience

Priority 1: Introduce Patient and Family Centred Champions

Reason for Prioritising:
A scoping exercise will be undertaken to identify staff who would like to become a champion for patient and family centred care.

The role will involve supporting patients throughout their journey by way of undertaking shadowing, walkabout exercises and obtaining patient and family stories.

This will enable the Trust to ensure patients and families have the best possible experience.

Outcome: Achieved
Champions have been identified and promote PFCC across the Trust. Monthly meetings have been introduced which oversee a work plan of improvements.

Priority 2: Offer neurovascular follow up patients the opportunity to receive scan results via post

Reason for Prioritising:
These patients routinely have scans at 6 months, 18 months and 60 months post treatment. They often attend clinic simply to be told things are fine. At a patient's 6 month clinic appointment they will be offered the opportunity to receive the results of their scan via letter. If there is an issue with the scan they will be given a clinic appointment.

This will result in improved patient experience as no travel will be required and no expenses (as per previous feedback) whilst releasing further car spaces for others.

It should also free up some capacity within the outpatient department and reduce waiting times for appointments within the neurovascular service.

Outcome: Achieved

A neurovascular follow up service for patients to receive their scan results via a postal service has been introduced.

Priority 3: Refurbishing of Patient and Family Day Rooms within the ward areas

Reason for Prioritising:

The day rooms within the surgical wards will be refurbished into a patient and family centred environment which will support the healing process for patients and enable families to spend quality time with their loved ones.

The rooms will be equipped with a small kitchenette, dining area and comfortable seating.

Outcome: Achieved

The proposal for funding was approved and the refurbishment work in the patient and family day rooms is complete.

2.2 What are our priorities for 2020 – 2021?

In December 2019, the Board of Governors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each indicator was successfully implemented and monitored. After this review, quality priorities were identified and agreed for 2020/21 with the Quality Committee, Health watch and Specialist Commissioners identifying the final priorities from those initially identified.

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

Each of the priorities has identified lead/s who has agreed milestones throughout the year. Monthly meetings are held to review progress and support 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. Merseyside Internal Audit Agency (MIAA) will be fully involved providing regular reviews and assurance via the Audit Committee. Quarterly quality meetings are held with the commissioners to review quality assurance and provide external scrutiny and performance management.

2.2.1 Patient Safety

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

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

Outcome Required:
Increase the level of staff trained to deliver ILS across the Trust within the next 12 month period.

Priority: FOCUS – Free of Criticism for Universal Safety

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

Outcome Required:
The implementation of a Trust Wide Safety word for both staff and patients. The implementation of “Focus Points” within policy and procedure based on audit data, datix, serious incidents (not exhaustive) to further highlight safety and critical parts of a process.

Priority: Introduction of MITEL System

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

Outcome Required:

- Support with the workload of Patient Access Centre
- Improve patient experience as patients will have a voice over of their call position,
- Run efficient reports for the patient access team

2.2.2 Clinical Effectiveness

Priority: Introduce Multitom Rax 3D Imaging

Reason for Prioritising:

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

Outcome Required:

The Multitom Rax will be installed and will operational to ensure Robotic Advanced X-Ray (RAX) technology is available to deliver standing 3D spinal imaging.

Priority: HCA Apprenticeship Training

Reason for Prioritising:

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

Outcome Required:

To recruit at least 12 members of staff onto the HCA apprenticeship training within the next 12 months.

Priority: Bespoke Spinal Module

Reason for Prioritising:

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

Outcome Required:

For staff to have an enhanced knowledge of the spine and to be able to continue to deliver specialist care to our patients. This will also support with retention of staff onto a career pathway.

2.2.3 Patient Experience

Priority: Introduce the Road to Recovery

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

Outcome Required:
All patients will be invited to attend a programme which will be in their locality (Wales) and have the opportunity to participate in a road to recovery and rehabilitation programme, consisting of nursing staff, therapy staff and medical staff.

Priority: LASTLAP – Looking After Staff That Look After People

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

Outcome Required:
Staff support with health and wellbeing to look after and retain our staff. Different methods of working with patients who have reduced capacity and need further assistance with behaviours.

Priority: Outsourcing Mail

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

Outcome Required:

- To provide greater control and traceability of documents
- More efficient systems of working in the Patient Access Centre to support staff and patients

2.3 Statements of Assurance from the Board

During 2019/20, The Walton Centre provided and/or sub-contracted four relevant health services:

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation

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

The income generated by the relevant health services reviewed in 2019/20 represents 93.8% of the total income generated from the provision of the relevant health services by The Walton Centre for 2019/20.

2.3.1 Data Quality

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

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

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

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

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

2.3.2 Participation in Clinical Audit and National Confidential Enquiries

During 2019/2020, 10 national clinical audits and 1 national confidential enquires covered relevant health services that The Walton Centre provides.

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

The national clinical audits and national confidential enquiries that The Walton Centre was eligible to participate in during 2019/2020 are as follows:

2.3.3 National Audits

- Adult Critical Care (ICNARC / case mix programme)
- Severe Trauma – Trauma Audit & Research Network (TARN)
- National Emergency Laparotomy Audit (NELA)
- The Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Care at the End of Life (NACEL)
- UK Parkinson's Audit
- Falls and Fragility Fractures Audit Programme (FFFAP)
- National Comparative Audit of Blood Transfusion (NCABT)
- National Neurosurgery Audit Programme (NNAP)
- Getting it Right First Time (GIRFT) – Surgical Site Infection Audit

2.3.4 National Confidential Enquiries

- Dysphagia in Parkinson's Disease

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2019/2020 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit	Participation	% Cases submitted
Acute care		
Adult Critical Care (ICNARC / Case Mix Programme)	Yes	100%
Severe Trauma (Trauma Audit & Research Network)	Yes	100%
National Emergency Laparotomy audit (NELA)	Yes	100%
The Sentinel Stroke National Audit Programme	Yes	100%
UK Parkinson's Disease Audit	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
Getting It Right First Time Audit (GIRFT)	Yes	100%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
National Comparative of Blood Transfusion (NCABT) – Re-audit of the medical use of blood	N/A	N/A – No cases to submit
Older people		
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	N/A	N/A – No WCFT cases met the inclusion criteria
National Confidential Enquiry into Patient Outcome and Death		
Dysphagia in Parkinson's Disease	Yes	100%

The reports of 5 national clinical audits were reviewed by the provider in 2019/20 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

National Audit	Actions
Adult Critical Care (ICNARC / Case Mix Programme)	• Findings are discussed quarterly • The Trust will continue participating in the ICNARC/Case Mix Programme by submitting data for all patients admitted to Critical Care • A new admission booklet for ITU has been produced with digitisation of notes
Severe Trauma - Trauma Audit & Research Network (TARN)	• The Trust will continue to submit data to TARN and will review individual cases as appropriate
The Sentinel Stroke National Audit programme (SSNAP)	• A regional thrombectomy MDT group has been set up and meets quarterly to discuss and review all thrombectomy cases and regional pathway

National Audit of Care at the End of Life (NACEL)	• The published report is being reviewed collaboratively with the palliative care team at Aintree hospital, who provide our specialist palliative care service, this is being monitored by the End Of Life Committee
UK Parkinson's Disease Audit	• The findings demonstrated the Walton Centre is generally compliant with guidelines • A summary report will be produced and circulated to the relevant groups

2.3.5 Participation in Local Clinical Audits

The reports of 83 local clinical audits were reviewed by the Trust in 2019/20 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

Neurology Clinical Audits & Service Evaluations

Audit title	Actions
Documentation in outpatient letters (N 199)	• Doctors to be made aware that patients are increasingly using psychoactive medication that cannot be prescribed but may have an effect (both positive and negative) and may interact with prescribed medication – importance of documenting this • Further investigation to determine the scope of the problem
NICE guidelines in sleep and Parkinson's disease (N 180)	• Disseminate and discuss • Present at Grand round • Raise awareness of the importance of documenting about sleep disorders
Assessment of the variation in patients creatinine prior and during rehabilitation, looking at red flags and whether they were appropriate (N 178)	• AKI flags aren't always accurate for long stay patients due to limitations within the algorithm – When flag occurs an assessment needs to be in context of the patient history and presentation / rehabilitation team discussed and agreed • Presented within rehabilitation training and at a regional rehabilitation meeting
Evaluating prescribing of valproate to women of childbearing potential against Trust policy (N 231)	• Ensure valproate prescription templates are fully distributed to outpatients • Improve documentation of counselling that has taken place • Disseminated findings to Neurology grand round and Aintree medicines safety group
Audit of outcomes of X-ray guided LPs performed by Advance Practitioner Radiographer (N 258)	• Successful transition of service from consultant led practice to practitioner led practice • No actions necessary
Audit of WHO surgical checklists in radiology (N 254)	• Radiologists and radiographers reminded to complete team brief and checklists
Audit of standards of communication of radiological reports and fail safe notifications (N 259)	• Office manager reminded staff of correct procedure • Clinical Director raised at consultant radiologist meeting and reminded all to follow procedure • Policy CLO13 updated

An evaluation of compliance with report writing standards following video-fluoroscopy – re-audit (N 250)	• Reports continue to be fit for purpose with standards generally well adhered to Results were discussed at Speech and Language Therapy team meeting and staff encouraged to aim for 100% compliance in the areas where this has not been achieved
An evaluation of compliance with case note writing standards – Speech and Language Therapies (N 251)	• Case note standards are generally well adhered to for both acute and rehabilitation areas of the service • Results were discussed at Speech and Language team meeting and staff encouraged to aim for 100% compliance in the areas where this has not been achieved
Audit of biopsies and post-mortem tissue undergoing investigation for suspected encephalitis at WCFT (N 191)	• Dissemination of findings with discussion around evidence of this topic with clinicians and lab staff • Presented at Clinical Audit Half day
Audit of exam time to report availability to report availability (N 264)	• No actions necessary – continue monitoring and re-audit
Parkinson's disease kinetograph (PKG) influence the Parkinson's disease treatment (N 208)	• Discussed at movements disorders group meeting • Funding of the PKG monitor has been secured
On-going survey of patient satisfaction within clinical neurophysiology department (N 216)	• No actions necessary • Staff encouraged to hand out surveys
Re-audit of volume of prescribed enteral feed given in the rehab setting following pump training for therapists (N 229)	• Pump training continues to be effective • On-going training continues to be effective • On-going training as required for new starters / rotational staff will continue • Share results – submit to book of best practice
Audit of goal setting meeting processes of the hyper acute and complex rehabilitation unit (N 237)	• Escalate room availability issues for Lipton through risk register, HUB operational meeting and evaluation of room use • Speech Therapy and Psychology to work on flowchart for supporting patient attendance at meetings • Meet with nursing and medical staff groups to highlight issues around attendance and discuss support measures • Dietitians awareness of GAS processes and attendance at meetings • Dissemination of findings to appropriate staff groups • Present findings to HUB operational meeting
Review of all invasive telemetry patients including background history events / localisation and outcome (N 142)	• No specific actions required / MDT planning meetings with specific aims and audit measures • Future findings will contribute to patient information
Retrospective audit of early management of spasticity and outcome (N 185)	• Roll out spasticity ward round to Lipton ward

Audit of CT Pulmonary Angiograms (N 255)	• Education of staff of CTPA scanning technique and how to alter scanning parameters to improve the diagnostic quality of scans – presented to staff • Encourage patients who are well enough to do so to place their arms above their head to improve scan quality and reduce dose
Audit of medical ward round notes on Lipton ward (N 248)	• Develop and implement a ward round pro-forma that prompts to fill in key aspects – pro-forma developed and currently in use • Raise awareness of the outcomes of the audit and highlight the importance of good medical documentation
DOLS application process and documentation on CRU (N 276)	• Improvements in documentation and Ep2 documentation • Findings disseminated
Audit of the use of Comaneci device in the treatment of intracranial aneurysms (N 182)	• No actions necessary
Protected meal times and red tray policy audit (N 225)	• Ward managers to support staff to undertake mealtime co-ordinator role • Policy updated with changes / recommendations as discussed in the steering group meeting
An evaluation of patients experience of the long term conditions team using the CARE measures (N 227)	• No concerns were raised from this service evaluation and no actions are necessary
Evaluation of the usability of an MS self-reported assessment tool for people with multiple sclerosis (N 266)	• Findings disseminated • Findings presented by poster presentation at the MS Trust annual conference • Consideration of future use of the tool in WCFT service
An evaluation of provision of supported communication training to families of patients with acquired communication difficulties (N 278)	• Devise on-line training package that can be accessed remotely by families • Ensure that family training / education is planned by first goal setting meeting • Ensure that family training / education is recorded as a goal on goal attainment
Incidence of depression in headache patients at WCFT (N 228)	• Psychology / psychiatry input for headache patients – To expand psychology services
Antibiotic point prevalence audit (N 232)	• Discussion at the multidisciplinary stewardship meetings • On-going education to prescribers on induction and at weekly antimicrobial ward rounds
Speech Therapy referrals audit for rehabilitation for the complex rehabilitation unit and Lipton (N 196)	• Improve quality of note taking and documentation within the Speech and Language Therapy team – This has subsequently been raised through a wider case note audit • Issues around timely receipt of handover from external agencies – letter to local Speech and Language therapy departments / referring hospitals documenting direct contact details and most available times to receive handovers to ensure these are timely

Audit of compliance in Radiology of the WHO surgical checklist – re-audit (N 272)	• Complete, retain and scan onto CRIS all team brief documentation – staff reminded
Audit of Tracheostomy care quality indicators (N 265)	• Escalate to managers re: lack of input to tracheostomy ward rounds and number of patients requiring this • Complete staff training and roll out to 5 day service • On-going review of tracheostomy quality indicators
Clinical psychology 1:1 referrals after PMP assessment (N 277)	• Need to develop more consistency / clarity regarding 1:1 referrals for psychological work on the PMP and in outpatient work – Psychology team to develop appropriate documentation
A retrospective audit on protein provision on the intensive care unit (N 279)	• Update dietitians re new protein requirements • Present to neuro dietitians
Audit of the recording of CT doses and missing images (N 262)	• New PACS breach tool highlights when images have not been viewed on PACS • Reminder in staff monthly brief of what needs to be sent to PACS and staff to be careful around completion of scans • CT core trainers reminded staff • Findings circulated
Re-audit of contrast CT protocols adherence (N 256)	• Booking staff educated estimated glomerular filtration rate (EGFR) should be checked in all inpatients, and in outpatients who are diabetic or over 70 years of age • Match paper and electronic formats – new contrast policy finalised
Prolonged disorders of consciousness (PDOC) (N 260)	• Feedback results to the prolonged disorders of consciousness Committee • There is currently a PDOC working party that is reviewing both the inpatient and community input received by PDOC patient's within the network with the aim of developing a pathway for our PDOC patients. The gaps in service provision are to be presented to Cheshire and Merseyside Rehabilitation Network Strategic Board on 20th January. Therefore, the information obtained from the audit will hopefully be able to be used in the future for a wider service development. In addition, we are currently awaiting the publishing of new RCP guidelines which are expected in January 2020 to guide the pathway development.
Management of sialorrhoea with botulinum toxin (N 261)	• Agreed to document clear goals in the medical notes • Use as first line and sooner prior to trialling other medications – early identification and early injections
Review of cases of intracranial hypotension treated with IV caffeine (N 267)	• This is an off license medication for which there is very little safety / efficacy data – audit results to factored into IV caffeine pharmacy policy
MDT assessment of self-feeding (N 280)	• Liaise with teams regarding documentation compliance. Feedback audit outcome to team members. Trial weekly Interdisciplinary Team Feeding Group (IDT) • Create inventory of current. Research into other appropriate equipment. Identify essential equipment and source funding • Feedback audit outcome to team members. Encourage

	OTs to document feeding recommendations on nursing handover sign in patient room. Encourage SLTs to liaise with OT colleagues regarding specific recommendations for assistance / equipment. Trial weekly IDT feeding group
Audit of standards of communication of radiological reports and fail safe notifications – Re-audit – (N 273)	• Clinical Director reminded all consultant Radiologists to all follow the agreed department policy • PACS manager reminded office staff of correct policy and advised to adhere to it at all times
Audit of the accuracy of voice recognition software in radiology (N 263)	• Proof reading of radiology reports • Radiologists double check the VR report
Focus group testing of patient and family perceptions of rehabilitation goal setting meetings (N 268)	• **Issue**: Ongoing need to critically examine goal setting processes in Hyper Acute Rehabilitation Unit and Complex Rehabilitation Unit. **Action:** Will reconvene Goal Setting Meeting working party
Audit to assess the suitability of line algorithm for visualisation of NG tubes (N 274 & N 275)	• **Issue:** Update protocol on CRIS required. **Action:** Email staff and discuss at staff meeting
Neurology satellite ward consultation service (N 247)	• Update the satellite referral datasheet to include A & E as a place patients are seen, also, remove option of 'no further action required'
Audit of patient satisfaction in general department of Radiology (NRP 1)	• Report circulated • Patient experience boards updated
Standards for reporting and interpretation of ultrasound images in line with RCR and BMUS guidelines (NRP 2)	• Staff reminded all images are to be labelled in full
Audit of the need for an on call physiotherapy service (N 257)	• Yearly training and competences for prescribed use of cough assist training log trained staff MDA competency form • Look at initial costings for on call physiotherapy service / changes to service – Present to therapies manager • If appropriate consider business case / gathering of evidence
Standards for reporting and interpretation of fluoroscopy guided lumbar punctures (N 270)	• No issues or errors identified / no actions necessary Continue to send random sample of reports to consultant radiologists for double reporting on a quarterly basis
Audit to determine the need for occupational therapy assessment and intervention in neurovascular clinic (N 285)	• There is not always documented evidence that an occupational therapist has provided written or verbal advice regarding cognitive problems prior to discharge – feedback to senior lead occupational therapist • Submit a service evaluation application to complete a pilot occupational therapy clinic

Neurosurgery Clinical Audits & Service Evaluations

Audit title	Actions
Re-Audit of Dexamethasone Review Compliance of Blood Glucose Monitoring for Patients with Brain Tumours on High Dose Steroids (NS 190)	• Feedback to ward managers. • Ward Practice Facilitators to educate staff. BM chart to be added to EP2 to prevent missing charts/HCS's to obtain access.
The development of a metastatic spinal cord compression (MSCC) pathway with The Walton Centre (NS 202)	• Review of CT guided biopsy service within the Merseyside and Cheshire / North Wales MSCC network • Internal / External publication of MSCC policy
Making every contact count New nutritional screening tool (NS 207)	• Pre-operative strategies need to be considered to support weight loss in overweight and obese individuals • Introduction of a nutritional screening and assessment pathway within the outpatients department is required to identify all patients with high nutritional risk Combined dietetic and physiotherapist group interventions should be considered in the longer term that are aimed at increasing lean body mass and reducing body fat, particularly central adiposity.
Critical Care Nurses knowledge, skills and perceptions of aseptic technique and ANTT (NS 219)	• Aseptic clinical practice audit- direct observation of practice, 25 observations, critical care staff aseptic technique • ANTT implementation to include further theoretical education in ANTT plus practical based teaching prior to competency assessment • Focus theory on the following topics :- • Asepsis, ANTT in practice, Terminology in ANTT, Glove choice and risk assessment, basics of aseptic practice, key-part cleaning & key-part protection, aseptic fields.
Clinical outcome and management of patients with radiation-induced meningioma (NS 222)	• Convene with Clatterbridge earlier in the project regarding radiation treatment requests and not when the rest of the data has been collected. • Identify and contact off-site storage upon recognition of patient data there to enable it to be incorporated into the dataset. Continue to examine volumetric growth rates of the dataset acquired as a separate project.
The use and handling of surgical instruments in Theatre (NS 225)	No issues - All Staff are aware that there is a system in place that ensures the safe use and handling of surgical instruments.
The Use of Electrosurgery in Theatre (NS 226)	Spinal Lead and procurement to source smoke evacuators for Theatres
Post Anaesthetic Care in Theatres (NS 227)	• Estates and heating system upgrade completed and additional heaters provided if needed. • Look into the purchase of padded bed rails which has been difficult as Trust has so many different beds and not all padded bed rails are universal.
Accountable Items, Swab, Instrument and Needle	• Discuss with staff the importance of the Theatre Team engaging when counts are being performed.

Count (NS 230)	• Discuss with Scrub Staff the importance of informing the Surgeon that count is correct before closure of a cavity
Surveillance of weekend prescribing of antibiotics on Horsley (NS 232)	• Improve documentation of 'indication' and 'review / stop date' on prescription kardex. • Consider adding a 'printed' section for prescriber's name in addition to signature. • Feedback audit results to practice on Horsley, inclusive of all prescribers
Compliance with Trust guidelines for use of antimicrobial prophylaxis for elective neurosurgery (NS 235)	If Cefuroxime cannot be administered, then a combination of Teicoplanin and Gentamicin is recommended
Trust Consent to Treatment Audit 2018/19 (NS 236)	• No actions necessary
Review of overall activity regarding shunt admissions and procedure at WCNN during 01/04/18 – 20/09/18 (NS 238)	• Reiterated the operating surgeon is responsible for putting data on the registry • Provided assistance in reporting by highlighting draft operations that need completing to improve compliance
Audit of follow-up of small bands detected on serum protein electrophoresis (NS 240)	• Education for clinicians regarding the importance of follow-up and the potential for a small band on a polyclonal background to develop into a paraprotein. To be discussed at clinical audit meeting. Copy of audit report to be sent to the Divisional Clinical Director • Update the interpretation/reporting sections of the laboratory SOPs to clarify report comments and actions to be taken on receiving repeat samples with no obvious protein band detected. Note that these sections were initially included in 2017. Actions to be included in the SOP are: clinical scientist(s) to review all patient requests to ensure that immunofixation is performed on repeat patient samples with small band detected on a polyclonal background to confirm absence/presence of a paraprotein band.
HTA 59 Coroner's and Hospital Post Mortems Horizontal Audit 2018 (NS 241)	• No non-conformances were raised as part of this audit as the neuroscience laboratories have followed all instructions accordingly. • There is compliance with HTA rules and regulations.
HTA 61 Research Request Forms R1, R2 & R3 Horizontal Audit 2018 (NS 242)	No usage of R1 forms to be reviewed and discussed in Walton Research Tissue Bank Committee meetings.
Outcome of surgical management of glioblastoma & cerebral metastasis in patient over 75 years of age (NS 245)	• Appropriate for certain patients >75 y.o. with malignant tumours to be considered for debulking / resective surgery, provided they remain well enough for adjuvant radiotherapy.
Development of a prognostic score to reduce avoidable referrals for mild Traumatic Brain Injury (TBI) (NS 246)	• Begin to introduce and implement the scoring system locally at Walton Centre on a prospective basis • Liaise with other centres that have requested to use the score following its publication in the literature

BIOC 152: Vertical audit of CSF Xanthochromia test (NS 252)	No issues were identified.
HTA 60: REC & RGC approvals Audit 2018 (NS 253)	The process is going well no further actions are required.
HTA 62: Research Consent forms Audit 2018 (NS 254)	• Patients signing wrong line on consent forms to be raised with specialist nurses by the Biobank Manager. • Incorrect colour of consent form to be raised with Theatre staff. Laboratory staff will also review forms upon receipt and highlight any issues immediately with the tissue bank manager who will look to rectify ASAP. • The importance of patient signing the consent will be highlighted to both specialist nurses and theatre staff to avoid any invalidity of the consent forms by the Biobank Manager.
IMMU 62: Immunology vertical audit – Glycolipid antibodies 2019 (NS 255)	• The SOP needs updating • Staff need reminding that any change in process, no matter how minor, should be documented in the SOP
Medium term outcomes after trans-callosal approach for intra-ventricular tumours (NS 256)	Interhemispheric transcallosal approach is an acceptable approach to remove tumours in the lateral and third ventricles.
Patient views after potential CJD exposure (NS 258)	• In patients who were not being followed up by the neurosurgical services, a further routine follow up at six weeks and 1 year, either in person or by phone, that could be cancelled by the patient if not required For patients that described the most anxiety, more rapid access to phone or outpatient clinic appointment (less than two weeks), would have been helpful.
Audit of molecular data obtained on gliomas between January 2018 to May 2019 at the Walton Centre (NS 273)	• MGMT status for all high-grade gliomas. To consider hTERT testing for IDH-wildtype gliomas.
CSF cell count comparison audit 2019 (NS 275)	• Discuss the missing LCL differential counts at the SLA meeting to establish if there is an electronic reporting issue or if there is another reason why they were not done. • Include CSF cell count as a representative test for LCL in the annual referral labs audit.
Venous thromboembolism (VTE) prophylaxis prescribing in neurosurgical patients (NS 281)	• Auditing a new VTE prophylaxis policy to see if there are any improvements in the compliance. • Clear guidelines published and available. • Patients, unless clearly contraindicated, should have VTE pharmacological prophylaxis prescribed. • Discussion with the team involved responsible for individual patient care in cases which may be controversial; review of the documentation and a clear plan in the notes. • Familiarising staff, doctors and pharmacists with the new VTE policy.
HIST 315 Cytology VA audit (NSRP 2)	• No time was provided for when the sample was taken. • The sample was reported just outside the target

	turnaround of 3 days, this was due to extra immunohistochemistry stains being requested to confirm the diagnosis.
Specimen Acceptance Policy Audit 2019 (NSRP 6)	There are no recommendations, the percentage of samples that have the correct data set on both the pot and card is high and the details that are missing more frequently are the 'location' which isn't part of the minimum data set and can be found by ringing medical records.
Audit of accuracy of voice recognition software in Neuropathology 2019 (NSRP 3)	• Use of dictation templates where appropriate • Simultaneous review of reports at same time as dictation • Final review of reports before authorisation • Re-audit

Trust wide Clinical Audits & Service Evaluations

Audit title	Actions
Audit of patient preferences regarding sharing information with their partners, family members and / or carers – NICE CG 138 – Patient experience	• **Issue** – Documentation of patient preferences. **Actions** – raise awareness of the importance of establishing patient preferences and ensure they are recorded on Ep2. Circulate findings and NICE guidance recommendations regarding family involvement and sharing information. Disseminate findings to the nursing documentation group
Inpatient Health Records Documentation Audit	• Disseminate results • Develop summary sheet highlighting the record keeping standards to focus on improving compliance • Clinical audit team continue audit
Outpatient Health Records Documentation Audit	• Disseminate results to all medical staff and emphasise the importance of documenting within the case notes in accordance to the trust policy • Continue to audit
Inpatient Nursing Documentation Audit	• Disseminate findings to the nursing documentation group – to be fed back to nursing staff
Mental Capacity Act Audit	• To provide more in depth MCA / DOLS / LPS best interests training sessions – sessions have been arranged and will be ongoing • Presentation with complex scenarios and case law regarding MCA / DOLS / Consent is scheduled to be delivered to the clinical senate • Revised MCA DOLS process utilising a live working document to provide oversight of all DOLS applications and associated actions including mental capacity assessment. This will ensure timely actions and compliance with MCA DOLS processes

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

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

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

2.3.6 Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2019/20 that were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority was 1219 set against and yearly target of 1200.

In total there are currently 72 clinical studies currently open to recruitment at The Walton Centre. The Trust has a research pipeline of new studies in the set-up phase that will be ready to open at different points throughout the coming year.

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

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

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

During 2019/20 the Trust has worked collaboratively with the following networks and organisations to attract NIHR funding to deliver and disseminate clinical research and innovation to inform service transformation and improvement:

- Clinical Research Network: North West Coast (CRN)
- Liverpool Health Partners (LHP)
- Innovation Agency, the North West Coast's Academic Health Science Network
- North West Coast Collaboration for Leadership in Applied Health Research and Care (NWC CLAHRC) now the ARC (Applied Research Collaboration)
- Local Higher Education Institutions
- Other NHS organisations
- Pharmaceutical companies (industry)

The collaboration with all members of Liverpool Health Partners has resulted in the set up of the Liverpool SPARK – Single Point of Access to Research and Knowledge. We are delighted to be part of such an innovative approach to offering wider access to clinical trials for our patients and look forward to the SPARK becoming embedded in all Trusts throughout 2020/21.

2.3.7 CQUIN Framework & Performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2019/20 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 2019/20 and for the following 12 month period are available electronically at enquiries@thewaltoncentre.nhs.uk

A proportion of the Trust's income in 2019/20 was conditional upon achieving quality improvement and innovation goals. The total payment received against the CQUINS in 2019/20 equalled £620, 828. The total payment received in 2018/19 was £1,620, 000. The Reduction in CQUIN between the two years is due to a change in the national payment system, as funding was transferred from the CQUIN allocation into the national payment by results payment tariffs. In 2019/20 the amount of income that could be generated through CQUIN was 1.25% of clinical activity compared to 2.5% in 2018/19.

The CQUINS agreed for 2020/21 are the following:

- CUR
- Staff Flu vaccines
- Rehabilitation
- Shared Decision Making

2.3.8 Care Quality Commission (CQC) Registration

The Walton Centre is required to register with the Care Quality Commission and its current registration status is registered without conditions. The CQC had not taken enforcement action against The Walton Centre during 2019/20. The CQC undertook an inspection, including well led, during March and April 2019. The overall rating from the CQC was Outstanding.

During 19/20 the Trust continued to self-assess against the CQC regulations. The self-assessment is supported by a governance process which enables oversight of findings and identification of areas for further review and includes a process to escalate exceptions to the Quality Committee which is a sub-committee of the Board.

Ratings for The Walton Centre

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

2.3.9 Trust Data Quality

The Walton Centre submitted records during 2019/20 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

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

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

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

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

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

This year was the second year of the new Data Security and Protection Toolkit. The focus is now on the security of data, and incorporating the Network and Information Systems

Regulation 2018 (NIS) and the 10 Data Security Standards and is very different to the old IG Toolkit. Within the Toolkit there are 44 assertions and 116 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 has met all 44 assertions, mandatory evidence items and achieved standards met for the Data Security and Protection Toolkit, which was submitted to NHS Digital on 27th July 2020.

The Trust has implemented additional action plans to achieve another high score on the new Data Security and Protection Toolkit and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessments undertaken as part of the mandated 19-20 DS&P audit requirements has provided the Trust with a level of Substantial assurance for the tenth year.

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

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

The Walton Centre Internal Clinical Coding Audit 2019/20

Coding Field	Percentage Suspended due to COVID
Primary diagnosis	xx
Secondary diagnosis	xx
Primary procedure	xx
Secondary procedure	xx

The Walton Centre will be taking the following actions to improve data quality by continuing the monthly Data Quality and Systems Assurance Group meetings and overseeing Data Quality improvement. The group includes leads from all stakeholders within the organisation and reporting/monitoring feedback is provided via KPIs with full trend analysis.

The group reports to the Information Governance and Security Forum each month which is chaired by the Trust's SIRO. The KPIs, from the group, are shared within the monthly digital update and with the Executive Team each quarter and is presented by the Head of IM&T to the Business and Performance Committee.

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 2019/20 92 of The Walton Centre patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

17 in the first quarter

13 in the second quarter

37 in the third quarter

25 in the fourth quarter

By 31st March 2020 92 case record reviews and 0 investigations have been carried out in relation to 92 of the deaths included in item 2.3.10.1

In 0 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:

- 0 in the first quarter
- 0 in the second quarter
- 0 in the third quarter
- 0 in the fourth quarter

2.3.10.2 0 representing 0% of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

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

These numbers have been estimated using the structured judgement review methodology. Prior to the National Quality Board report on Learning from Deaths, The Walton Centre had a robust mechanism of mortality review where all deaths were reviewed in detail and reviewed in the mortality review group.

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

0 case record reviews and 0 investigations completed after 31.03.19 which related to deaths which took place before the start of the reporting period

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

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

0 representing 0% of the patient deaths during 2019/20 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services

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

The Trust continues to make progress with CS2. In the 7 day service audits from 2016-2019 the overall rate of compliance improved from 50% to 79%. The compliance rate at the weekends in the audits have consistently been high, demonstrating a Consultant presence for review throughout 7 days. As a specialist Trust there has been discussion with the 7 day services team regarding difficulties that arise for us with this standard. All patients who are transferred to The Walton Centre will have been seen and assessed in their local hospital, usually will have had investigations such as scans, and in neurosurgery admissions (which

are the vast majority) the diagnosis will usually be clear. All admissions are discussed with a Consultant prior to transfer and a management plan is formulated. There is a two tier middle grade on-call system in neurosurgery so there is always a senior trainee on-call. In some cases there is a clear plan for the patient on arrival and assessment by a senior trainee is considered clinically appropriate. Also, all patients admitted as an emergency will be initially assessed by a member of our MDT SMART (Surgical and Medical Acute Response Team) team, which consists of medical staff and outreach critical care trained nursing staff. Therefore, the differences in the service will reflect some difficulty with compliance with this standard in all patients, but there remains the aim to reach the target of 90%. 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.

There are the other clinical standards which the Trust continues to progress well with.

Feedback from local patient experience surveys and reports from listening events held by Healthwatch Sefton and Healthwatch Liverpool continue to be excellent on the standard of medical care. There have been no concerns raised over quality of care / Consultant presence on weekday or weekends. This is also not an issue which has arisen in patient complaints.

There is an MDT ward round for all neurosurgery and critical care patients. This comprises medical, nursing, ANP 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, ANP 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 away (TTA) are completed by the pharmacist or ANP. 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 TTA at weekends.

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

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

2.3.12 Speaking Up

The Trust's Freedom to Speak up Guardian (FTSUG) is proactive in ensuring staff members are given the opportunity to raise concerns. The FTSUG presents to clinical and non-clinical staff members during their induction. Each individual staff member receives a business card with specific contact details should they wish to raise a concern, arrange a meeting on/off site. Posters are displayed across the organisation and the Trust's intranet site also provides relevant information. Drop-in sessions are scheduled throughout the year across each of the areas within the Trust. There are also 3 FTSU Champions in post to support the guardian. There is a dedicated email address for those wishing to raise concerns. The FTSUG will agree the frequency of contact with the individual/s and following a meeting/investigation information will be gathered regarding speaking up, which has been positive to date. The FTSUG also undertakes exit interviews for those leaving the organisation in order to give staff the opportunity to raise any issues/concerns. The Trust has adopted the NHSI Raising Concerns Policy and has a Grievance Policy and Bullying and Harassment Policy which is readily available for all staff to access offering contact details such as email addresses, contact names and telephone numbers.

Part 3 Trust Overview of Quality 2019/20

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2019/20.

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	2016/17	2017/18	2018/19	2019/20
C Difficile	9	7	7	5
MRSA Bacteraemia	1	1	0	0
Ecoli	12	11	9	13
Minor and Moderate Falls	36	35	31	37
Never Events	3	2	2	1

Clinical Effectiveness Indicators

Mortality – Procedure	2016/17	2017/18	2018/19	2019/20
Tumour	8	8	8	11
Vascular	47	37	27	23
Cranial Trauma	21	21	14	32
Spinal	3	4	11	6
Other	15	14	17	20

Patient Experience Indicators

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

3.1 Complaints

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

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

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

3.1.2 Complaints Management and Lessons Learnt

We will always try hard to adapt our processes in order to manage complaints to meet the needs of each individual patient or family member, this may involve meeting with patients in their preferred place, including their homes in order to reach the best outcome for them.

Every informal concern and formal complaint is investigated and each complainant receives the outcome of the investigation. This can be in a detailed response from the Chief Executive / Deputy Chief Executive or at a meeting with the staff involved.

We ensure the responses to complaints are comprehensive addressing all the issues raised and are open and honest. We aim to provide meaningful apologies and acknowledge when we have knowingly or unwittingly hurt or upset a patient or family member. We aim to explain why we think a situation has happened and what we plan to learn to prevent a reoccurrence.

Every effort is made to address each issue highlighted within complaints to the satisfaction of the complainant, even if, after investigation, evidence reveals the allegations made within the complaint are unfounded. Outcomes from complaints are reported monthly to various committees and meetings within the Trust and to the Executive Team. Trends and actions taken are discussed in detail in the Governance and Risk Quarterly report, the monthly divisional governance and risk group meetings and Quality Committee. Any trends in subject, operator or area are escalated in real time to the Executive team.

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

Examples of lessons learnt from complaints during 2019/20 include improvements to the patient referral system/telephone system, improved communication processes with patients and families. In addition to this complaints form part of the consultant appraisal process and other individuals involved in complaints are required to personally reflect on the impact complaints have had on patients and families.

3.1.3 Complaints Activity

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

Complaints received 01 April 2019 – 31 March 2020

	Quarter 1 April–June 19	**Quarter 2** July–Sept 19	**Quarter 3** Oct– Dec 19	**Quarter 4** Jan–Mar 20
Number of complaints received	31	36	37	25

The Trust received 129 complaints during 2019/20 which was 36% increase compared to 95 complaints received during 2018/19. This increase in numbers is reflected in the subject matter mainly relating to appointment arrangements and communication.

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

3.1.4 Duty of Candour

The Trust fully acknowledges its duty of candour which supports one of its core values of openness. Incidents which fall into the requirements of the regulations for this are identified through the weekly scrutiny of the Datix system.

Relevant incidents are identified and entered onto a tracker which manages Trust compliance against the Duty of Candour regulations. All patients, or in some circumstances family members, who fall into the duty of candour requirements are offered an apology by the relevant clinician as soon as possible and this is recorded appropriately. The patient or family member receive a letter offering an apology which is signed by the Chief Executive. The letter includes an offer to receive a copy of the root cause analysis investigation.

3.2 Local Engagement – Quality Account

The Quality Account has evolved by actively engaging with stakeholders and using external feedback and opinion combined with thoughts and visions from staff within The Walton Centre. Trust Executives have also participated in discussions with the local health economy and sought views on the services provided by the Trust. 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 Trust has further developed relationships with charities including, The Brain Charity and Headway.
The Trust has actively engaged with Governors through a forward planning event on all aspects of quality including choice of indicators for 2020/21.

3.3 Quality Governance

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

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

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

- Deliver
- Invest
- Adopt
- Provide

- Lead
- Recognise

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

3.4 Top Industry Award – Nov 2019

Director of Finance for the Trust won Finance Director of the Year award for the Liverpool City Region.

3.5 International Engage Award (ShinyMind App)

The staff health and wellbeing app was highly commended in the prestigious Engage Awards. The app is available to every member of staff, ensuring they feel valued and connected, proactively supporting their wellbeing and resilience every day of the year.

3.6 International Engage Lifetime Contribution Award

The Trust's Director of Workforce and Innovation was honoured to receive the Lifetime Contribution Award for the work undertaken in staff and patient engagement. Each year the International Engage Media Awards, the largest of its kind in Europe, recognises outstanding engagement from companies all over the globe.

3.7 BBC Two Hospital Episode

Production Company Label 1 announced they will be returning to Merseyside to film a further series at The Walton Centre.

3.8 Director of Clinical Academic Development – Oct 2019 (University of Liverpool)

The Walton Centre's senior neurosurgeon has been appointed as Director of Clinical Academic Development which is aimed at improving health outcomes throughout the Liverpool City Region and beyond.

3.9 Applied Research Collaboration North West (ARC NW)

The Trust are poised to take part in the new research initiative into health inequalities which launches in October. The National Institute for Health Research (NIH) will be transforming research collaborations across the region into the ARC NW which is a national £135m health research programme announced earlier in the year.

3.10 CQC Inspection

Following the CQC inspection the Trust were delighted to be rated Outstanding by the Care Quality Commission (CQC) for a second time. This makes the hospital the only specialist neurosciences trust in the country to get the rating twice in a row.

3.11 Launch of children's book

The Pain Management Team produced a childrens book for relatives of patients with chronic pain.

3.12 Official opening of the garden room

The Metro Mayor officially opened the innovative garden room which is located in the Intensive Therapy Unit (ITU). This area acts as an outdoor extension for ITU patients, particularly those experiencing delirium which is a common condition for brain injured patients. The room is fully equipped with piped oxygen and suction systems so as long term ventilated patients can enjoy the greenery with family and friends.

3.13 Surgical Spine Centre of Excellence (SSCoE)

The Trust was awarded the European wide quality standard from Eurospine which means the hospital joined a certification programme for reputable spine institutions. The goal is to enhance the quality of spinal surgery and treatment and also to provide guidance for patients with spinal disorders.

3.14 Roy Ferguson Award

A pager system designed to alert relatives of patients in intensive care of any changes has won the Roy Ferguson Award. The annual accolade, set up in memory of a former patient, award thousands of pounds in funding to a project or idea that can demonstrate compassionate care for patients, their relative and carers.

3.15 Centre of Clinical Excellence Award

The Trust has been recognised by Muscular Dystrophy UK for providing outstanding care for people with muscle wasting conditions and was awarded the Centre of Clinical Excellence status by the charity. The award recognises excellence across a range of criteria including the care received by patients and helps to drive up the standards of clinical support for people with the conditions.

3.16 Joined Rainbow Badge Initiative (ED&I)

Staff signed up to wear the rainbow badge and pledge to be committed to creating a welcoming and open environment for LGBT staff, patients and visitors.

3.17 Overview of Performance in 2019/20 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	2018/19 Performance	2019/20 Target	2019/20 Performance
Incidence of MRSA	0	0	0
Screening all in-patients for MRSA	95%	95%	98.88%
Incidence of Clostridium difficile	7	9	5
All Cancers : Maximum wait time of 31 days for second or subsequent treatment: surgery	100%	94%	98.6%
All Cancers : 62 days wait for 1st treatment from urgent GP referral to treatment	100%	85%	100%
All Cancers : Maximum waiting time of 31 days from diagnosis to first treatment	99%	96%	100%
All Cancers : 2 week wait from referral date to date first seen	100%	93%	98.9%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	94.27%	92%	N/A
Maximum 6 week wait for diagnostic procedures	0.06%	<1%	0.17%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Fully Compliant		Fully Compliant

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

3.18 Overview of Performance in 2019/20 against NHS Outcomes Framework

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

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

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

- Our performance against these indicators
- The national average

- A supporting commentary, which may explain variation from the national average and any steps taken or planned to improve quality.

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

During 2019/20, the Walton Centre provided and/or sub-contracted four relevant health services. These were neurology, neurosurgery, pain management and rehabilitation.

3.19 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 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
2018/19	266	5.00%
2019/20	244	4.82%
Change	-22	-0.18%

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

Actions to be taken

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

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

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

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

Response:

This year our designated company carried out the National Patients Survey and a total of 62 questions were asked. Picker were commissioned by 74 other Trusts.

- 1250 patients were invited to complete the survey and 50% (613) completed this – the average response rate for other trusts being 44%, so we were slightly above average.
- The Trust were ranked 9th out of 74 in the overall positive score ranking with Picker this year. The overall positive score is the average positive score for all positively scored questions in the survey.
- The Trust's scores improved significantly for 43 questions which demonstrates an overall improvement.
- There were 3 questions where the Trust scored slightly below Picker average, these related to discharge

National Inpatient Survey Question	2016 Result	2017 Result	2018 National Comparison	2019 result
1. Were you involved as much as you wanted to be in decisions about your care?	8.0	7.8	About the same	About the same
2. Did you find a member of hospital staff to talk to about your worries or fears?	7.0	6.0	About the same	About the same
3. Were you given enough privacy when discussing your condition or treatment?	9.1	8.6	About the same	Slightly worse
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.6	5.1	About the same	Better
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.5	8.7	Better	Better

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

In addition, to the National Patient Survey, The Trust undertakes regular patient and family engagement through several methods including ward round to speak directly to patients and families in order to put any concerns right in real time. This will be continued over the next twelve months to ensure that we share both positive feedback and address any issues raise.

Friends and Family Test results for 2019/20 based on the question "How likely are you to recommend our service to friends and family if they needed similar care or treatment?" The recommend rate throughout 2019/20 was extremely positive with 97.8%-100% patients each month saying they would recommend the Trust.

Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
97.73%	97.86%	99%	97.77%	97.45%	98.04%	99%	98%	98%	98%	97.73%	Na*

*In March the FFT return was suspended until further notice due to Covid-19

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

APPLICABLE

Response:

The Trust had a response rate of 46% for the 2019 national staff survey; the national average for acute specialist trusts in England for 2019 was 58%.

Within the survey, the percentage of staff who would recommend the Trust as a place to work increased from 77% to 81% the best score within its benchmarking group and the percentage of staff who would recommend the Trust as a place to receive treatment" increased from 89% to 93% The reporting outputs for the 2019 Staff Survey have changed; results are themed across 11 areas as follows:

- Equality Diversity & Inclusion
- Health & Wellbeing
- Immediate Managers
- Morale
- Quality of appraisals
- Quality of care
- Safe environment (Bullying and Harassment)
- Safe environment (Violence)
- Safety Culture
- Staff Engagement
- Team Working

The 2019 results show two statistically significant change improvements in Immediate Managers and Safety Culture.

Some Key Highlights are as follows:

- Has your employer made adequate adjustments to enable you to carry out your work?- increase from 74.6% in 2018 to 86.7% in 2019- best score in the benchmarking group
- Does your organisation take positive action on health and well-being?- increase from 48.7% in 2018 to 50% in 2019- best score in benchmarking group for the 5th consecutive year.

- The support I get from my immediate manager- increase from 70.7% in 2018 to 78.6% in 2019- best score in benchmarking group
- My immediate manager values my work- increase from 70.9% in 2018 to 78.4% in 2019- best score in benchmarking group
- In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?- decreased from 8.4% in 2018 to 7.2% in 2019- best score in benchmarking group
- I am able to make suggestions to improve the work of my team/department- increase from 76.9% in 2018 to 80.9% in 2019- best score in benchmarking group

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

In Quarter 1, (June 2019) the Friends and Family Test was issued to approximately 400 staff using an online survey and 122 surveys were returned. The results showed that 97% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 87% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

In Quarter 2, (September 2019) the Friends and Family Test was issued to a further circa 400 staff with 186 being returned. The results showed that 98% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 85% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

Quarter 4 (March 2020) results had 172 complete the survey, 98% of staff were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family if they needed care or treatment and 84% of staff said they were 'extremely likely' or 'likely' to recommend the Walton Centre to friends and family as a place to work.

Key staff survey questions:

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

The Trust score for 2019 was 50% with the national average being 35% the Trust had the best score for an acute specialist trust for the 5th year.

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

The Trust score was 25.5% with the average score for acute specialist trusts being 19.1%.

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

KF26 Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months: (the lower the score the better)

The Trust score was 15.8% the average score for acute specialist trusts being 18.7%. This was a decrease from the 2018 score of 17.1%.

KF21 Percentage believing that Trust provides equal opportunities for career progression or promotion) for the Workforce Race Equality Standard: (the higher the score the better)

The Trust score was 77%% a decrease from 91% last year.

- 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 2020 survey. A Trust action plan and Divisional action plans covering all 11 themes will be formulated and approved by Board.

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

Rationale: The Trust does not provide mental health services

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

Response: * To be updated once National data published

YEAR		Q1	Q2	Q3	Q4
2016/17	Walton Centre	98.77%	98.68%	99.16%	98.9%
	National Average	95.64%	95.45%	98.16%	95.53%
2017/18	Walton Centre	99.09%	99.69%	98.34%	97.17%
	National Average	95.20%	95.25%	95.36%	95.21%
2018/19	Walton Centre	98.52%	99.00%	98.86%	96.78%
	National Average	95.63%	95.49%	95.65%	95.74%

2019/20	Walton Centre	98.79%	98.97%	98.85%	98.58%
	National Average	95.63%	95.47%	95.33%	Suspended due to COVID

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

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

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

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

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

Response:

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

WCFT Clostridium difficile infections per 100,000 bed days:

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

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

In 2019/20 The Walton Centre had a total of 5 Clostridium difficile infections against the trajectory set by NHSE/I of 8. To achieve such a reduction is a fantastic outcome which is a consequence of the outstanding work undertaken by all of the staff Trust wide.

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

- Setting clear objectives, implementation and monitoring of the Healthcare Associated Infection (HCAI) reduction plan
- Robust programme of infection prevention control audit
- Monitoring and reporting infection prevention outcomes to the Quality Committee
- The Infection Prevention Ambassadors programme to enable engagement of all staff groups to promote ownership, and support effective infection prevention in the clinical areas
- Use of technology e.g. Ultra V and Hydrogen Peroxide Vapour (HPV) to enhance our cleaning programmes
- The appointment of a antimicrobial pharmacist to support excellence in antibiotic prescribing and support education and training of clinical staff

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

13. Rate of patient safety incidents per 100 admissions

Response:

In 2019/20 1177 incidents occurred against 7,451 admissions (excluding OPD as per NLRS figures) this equals 14.05 per 100 admissions.

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

- Increased patient acuity
- Increase in capacity and activity

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

- The Trust investigates all incidents that are reported and ensures that any lessons learned can be shared across all relevant staff groups. Where there are found to be gaps in care delivery, processes and policies are updated and put in place to support the delivery of safe and quality care to ensure these incidents do not re-occur.

The Trust will continue to:

- Discuss all root cause analysis at the relevant meetings to ensure the sharing of learning Trust wide

- Conduct SBAR (Situation, background, assessment, recommendation) investigations where required
- Share lessons learnt via the Governance safety bulletin
- Improve the reporting of incidents through discussions at the Trust safety huddle
- Continue to Implement the use of the new ERCA (electronic root cause analysis) form

Annex 1

The Walton Centre NHS Foundation Trust 2019-20 Quality Account commentary

Healthwatch Liverpool welcomes the opportunity to comment on the 2019-20 Quality Account for the Walton Centre.

We base our commentary on this report, feedback and enquiries that we receive throughout the year, as well as our annual Listening Events that – prior to the Covid-19 pandemic - we carried out at each Liverpool Trust. We visited the Walton Centre in October 2019 and spoke to 27 patients and visitors. We received mostly positive feedback, especially about the care and welcoming staff.

The 2019-20 Quality Account highlights many successes; we would particularly like to congratulate the Trust on receiving an 'Outstanding' rating from the Care Quality Commission (CQC) for the second time.

We are also pleased that patient satisfaction at the Trust continues to be high, as it is in 6th place for overall patient experience in the National Inpatient Survey, which covers patients discharged in July 2019.

Several of the awards that the Trust has won this year confirm its focus on patient experience. Initiatives like the pager system for relatives of intensive care patients are certain to help improve their hospital experience at a difficult time.

The Trust achieved all its quality priorities for the year, many of which will further enhance patient experience; for example, we welcome that patients are given the opportunity to have pre-and post-operative discussions with the Theatre Team, taking individual wellbeing, expectations and potential anxieties into account.
Introducing Patient and Family Champions is another positive step, and we look forward to learning more about its impact once this has been fully established.

The patient experience indicators mentioned in the report provide a positive picture. Additionally, initiatives such as providing scan results by post where appropriate so that

patients don't have to travel needlessly are welcome. Contacting patients with appointment reminders is always to be encouraged, as we believe this both supports patients and reduces DNA rates.

The Trust has continued to address Equality, Diversity and Inclusion, and we welcome that the Trust has joined the Rainbow badge initiative, promoting an inclusive environment for LGBT+ staff, patients and visitors.
Ensuring that patients' religious beliefs are taken into account when deciding on treatment methods and the products used is another positive step.

The overview of audits shows some of the lessons learnt. For example, we are pleased that there is a renewed focus to ensure patients are asked what information they want to be shared with relatives and carers. We also note the efforts made to ensure staff are up to date with the Mental Capacity Act and Deprivation of Liberty guidelines.

We welcome that all cancer referral to treatment waiting times were met, and hope that this performance can be maintained during the Covid-19 pandemic.
The Trust is rightly proud of the reduction in C-Difficile infections it has achieved. However, the report does not provide much information about patient safety incidents, for example the types of incident and what level of harm (if any) the incidents caused, which would be welcome.

The priorities for 2020-21 include an upgrade to the phone systems, which should help to improve access for patients and relatives. We will be interested to learn the outcomes for the quality priorities that have been chosen.

Although for most of 2019-20 Trusts were able to operate as usual, the final quarter brought rapid changes to many services due to the Covid-19 pandemic. We look forward to next year's Quality Account reflecting some of these changes, and the impact this has had on patient care and patient experience.

Due to the pandemic we currently can't visit Trust sites and meet patients and visitors face to face to capture their feedback. We are working in different and new ways, for example by facilitating online focus groups. We look forward to working with the Walton Centre in 2020-21, helping to ensure that patients' voices continue to be central in celebrating good practice, and in feeding back if and where improvements could be made.

The Walton Centre NHS Foundation Trust

Healthwatch Sefton attended the Quality Account session held on Friday 9th October 2020 were the Trust presented their Quality Account 2019 -2020. Healthwatch Sefton would like to note that the presentation was clear and outlined all the information in a clear and understandable format.

Healthwatch Sefton would like to congratulate the Trust on the achievements during 2019 – 2020 including the CQC rating of 'Outstanding'.

The Trust has continued to work in partnership with Healthwatch Sefton and during this period there have been regular Healthwatch Sefton engagement stands held in both the main entrance to the Trust and the Sid Watkins building. A Healthwatch Sefton feedback report was produced covering the period of July 2019 – March 2020 in which the Trust scored an overall average of **4.5** out of **5** Healthwatch stars. Quality of Treatment, Staff attitude and Cleanliness each scored an individual rating of **5** out of **5** Healthwatch stars.

A particular issue raised by visitors to the Trust has been in relation to car parking. This included being able to find a space, disability car parking spaces close to the Sid Watkins building, pay station signage and access to the car park machine situated outside the Sid Watkins building. The car parking on this site is owned and operated by Liverpool University Hospitals NHS Foundation Trust. The Walton Centre has worked in partnership with Liverpool University Hospitals NHS Foundation Trust and Healthwatch Sefton to improve access for visitors which recently resulted in the pay station outside the Sid Watkins building becoming accessible for disabled visitors. The outdated car park signage was also removed from the Sid Watkins car park. Since Covid, the Trust has reported a decrease in visitor concerns / complaints relating to parking. We would like to thank the Trust for listening to patient feedback and acting upon this to improve the experience for all visitors travelling by car.

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

An impressive account of clinical effectiveness and safety.

From a layperson's perspective, it is good to see the introduction of patient and family centred champions to gather quality feedback rather than just relying on family and friends test cards. This perpetuates an ongoing assessment of what works well, what isn't working well, gathering better quality feedback from a patient's and family's perspective.

On the other side of the coin it is reassuring to see that LastLap has been introduced to allow a daily offload for staff to feedback on issues and concerns, not just for retention but to facilitate well-being and resilience amongst staff. This in turn leads to well staff providing excellent patient care.

Quality Account Statement – The Walton Centre NHS Foundation Trust.

South Sefton CCGs hosted a Quality Accounts Day on Friday 9th October 2020. Providers were invited to present their accounts and stakeholders were asked to provide feedback. Stakeholders included:

- South Sefton and Southport and Formby CCGs
- Liverpool CCG
- Knowsley CCG
- Healthwatch Sefton, Liverpool and Knowsley
- Health Education England
- NHS England/Improvement
- Sefton MBC
- NHSE Specialised Commissioning
- CQC

The Stakeholders appreciate the Trust's focus on quality and safety at a time of a global pandemic. They recognise this has required different ways or working during the COVID 19 period and is reflected in the accounts.

The above stakeholders welcomed the opportunity to jointly comment on The Walton Centre NHS Foundation Trust's Quality Account for 2019/20. The CCGs have worked closely with the Trust throughout 2019/20 to gain assurances that the services delivered were safe, effective and personalised to service users. The CCGs share the fundamental aims of the Trust and supports their strategy to deliver high quality, harm free care.

It is noted that the Quality Account that is being reviewed is a draft version and the stakeholders look forward to receiving the finalised account. The work the Trust has undertaken and described within this Quality Account continues to promote patient safety and the quality of patient experience and endorses the Trust's commitment to promote safety and quality of care.

The stakeholders acknowledge the Quality Account for 2019/20 and found it assuring that all quality aims from 2018/19 have been implemented and are fully embedded into practice. The Trust demonstrates continuous positive performance including working towards the 7-day working objectives. It was reassuring to note the sustained CQC 'Outstanding' rating for the Trust and the Trust should be commended on this.

The Patient Quality, Clinical Effectiveness and Patient Experience Aims for 2020/21 were notable and will likely have a positive impact on patient care. Patient experiences were gained (prior to COVID19 pandemic) through talking with patients and listening to their stories from pre-admittance and route through the centre.

It is notable that the Trust received two 'Centre of Excellence' awards for spinal treatment and muscular dystrophy as well as a high commendation from international awards.

Your news that the Neuroscience Research centre has secured new local collaborations which means that you are now able to offer your patients access to participation in Phase 1 clinical trials for the first time is commendable and supports the best care for patients with neurological conditions/

This is a comprehensive report that clearly demonstrates progress within the Trust. It identifies where the organisation has done well, where further improvement is required and the ambitions moving forward. We understand the Trust's Quality Strategy has a number of individual workstreams that will take into account patient feedback on progress made.
We have reviewed the information provided within the Quality Account and checked the accuracy of data within the account against the latest nationally published data where possible.

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

It is felt that the priorities for improvement identified for the coming year are reflective of how the Trust will further improve services to address the current issues across the health economy.

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

South Sefton and Southport & Formby CCGs
Signed

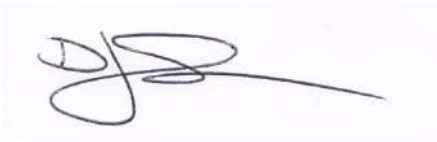
Fiona Taylor, Chief Officer Date: 20 November 2020

Liverpool CCG

Signed Date: 24 November 2020

Chief Officer

Knowsley CCG



Chief Executive Date: 24 November 2020

Specialised Commissioning (North West)

Signed  Date: 20 November 2020

Andrew Bibby
Regional Director of Health & Justice and Specialised Commissioning (North West)
NHS England & NHS Improvement – North West

Glossary of Terms

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

COG CYCLE OF BUSINESS 2020-2021			Quarter 1	Quarter 2	Quarter 3	Quarter 4
Agenda Items	**Action Required**	**Lead**	**June**	**Sept**	**Dec**	**Mar**
Standing Items						
Welcome and apologies	Information	Chair	✓	✓	✓	✓
Declarations of Interest	Information	Chair	✓	✓	✓	✓
Minutes of previous meeting	Decision	Chair	✓	✓	✓	✓
Matters Arising Action Log	Information	Chair	✓	✓	✓	✓
Patient Story	Information	Director of Nursing and Governance	✓	Clinician presentation at AMM	✓	✓
Governor Items						
Lead Governor Report	Information	Lead Governor	✓	✓	✓	✓
Questions on Notice from members and governors	Information	Chair	✓	✓	✓	✓
Governors Activity Report	Information	Lead Governor	✓	✓	✓	✓
Strategy and Performance						
Strategic Context - Chairs Report	Information	Chair	✓	✓	✓	✓
COVID Update	Information	Chief Executive				
Integrated Performance Report	Information	Chief Executive	✓	✓	✓	✓
Annual Review - Trust Strategy 2018 - 2023	Information	Chief Executive				
Equality Diversity & Inclusion Strategy	Information	Director of Workforce and Innovation			✓	
Patient Experience Strategy, Activity and Engagement update	Information	Head of Patient Experience	✓			
Quality & Safety						
Draft Annual Quality Account (incl. Auditors opinion)	Information	Director of Nursing and Governance	✓			✓
PLACE results	Information	Director of Operations and Strategy	✓			
Patient Experience and Listening Week Feedback	Information	Head of Patient Experience			✓	
National Inpatient Survey	Information	Director of Nursing and Governance		✓		
Staff Survey Results	Information	Director of Workforce and Innovation	✓			
Regulatory/Governance						
Annual Review of Trust Operational Plan	Information	Director of Operations and Strategy				
Annual Audit Committee Report	Information	NED Chair		✓at AMM		
Quality Account Priorities	Decision	Director of Nursing and Governance			✓	
Annual COG Effectiveness Review	Information	Corporate Secretary				✓
Annual Review of COG Sub-group Terms of Reference & Membership	Decision	Corporate Secretary				✓
Annual Declaration of Fit and Proper Persons	Information	Corporate Secretary	✓			✓
Annual Register of Interests	Information	Corporate Secretary	✓			
Governor Elections	Information	Corporate Secretary	✓			
Governor Election Results and welcome to New Governor	Information	Chair		✓		
Appointment of Trust Chair*	Decision	Lead Governor				
Appointment of the Chief Executive*	Decision	Chair				
Appointment of the Deputy Chair of the Trust*	Decision	Chair				
Bi-Annual Appointment of Lead Governor*	Decision	Corporate Secretary				
Holding the NEDs to account						
Audit Committee Chairs Assurance Report	Information	NED Chair	✓	✓	✓	✓
Business Performance Committee Chairs Assurance Report	Information	NED Chair	✓	✓	✓	✓
Quality Committee Chairs Assurance Report	Information	NED Chair	✓	✓	✓	✓
Research, Development and Innovation Committee Chairs Assurance Report	Information	NED Chair	✓	✓	✓	✓
Items to Note						
NHS Providers Governor Communications	Information	Corporate Secretary	✓	✓	✓	✓
Governors Calendar	Information	Corporate Secretary	✓	✓	✓	✓

Meetings 2021/22

Meeting Title	2021												2022		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Annual Members Meeting									7						
Council of Governors			9			8			7			9			8
Council of Governors - Chairs Briefings	13	10		14	tbc		tbc	tbc		tbc	tbc		tbc	tbc	
Council of Governors Membership and Engagement Group			16 tbc			22			16			7			15
Council of Governors Steering Group		2	tbc												

For Information 20/21 COG Meeting dates