NHS
The Walton Centre
NHS Foundation Trust

Council of Governors

Tuesday 14 June 2022

Agenda and Papers

Excellence in Neuroscience

MEETING OF COUNCIL OF GOVERNORS

AGENDA

Tuesday 14 June 2022
13:30 to 16:15

The Lecture Theatre – Sid Watkins Building

Ref	Time	Item	Owner	Purpose
STANDING ITEMS				
1	13:30	Welcome and Apologies (v)	Chair	N/A
2	13:35	Minutes of Council of Governors meetings held on 8 March 2022 (d)	Chair	Approve
3	13:40	Action Log (d)	Chair	Information
4	13:45	Declarations of Interest (v)	Chair	N/A
STRATEGIC CONTEXT				
5	13:50	Lead Governor's Report (d)	Lead Governor	Information
6	13:55	Chair's Report (v)	Chair	Information
7	14:00	Trust Strategy (v)	Medical Director	Information
8	14:15	Annual COG Effectiveness Review (d)	Corporate Secretary	Information
INTEGRATED PERFORMANCE REPORT				
9	14:30	Performance and Finance: Business and Performance Committee Chair's Assurance Report (d)	NED Committee Chair	Assurance
10	14.40	Quality: Quality Committee Chair's Assurance Report (d)	NED Committee Chair	Assurance
QUALITY				
11	14:50	Quality Committee Chair's Reports (d)	NED Committee Chair	Assurance
12	14:55	Draft Annual Quality Account (d)	Chief Nurse	Assurance
BREAK				
13	15:05	10 minute break	n/a	n/a
PERFORMANCE/ FINANCE/ WORKFORCE				
14	15:15	Audit Committee Chair's Report (d)	NED Committee Chair	Assurance
15	15:20	Business Performance Committee Chair's Reports (d)	NED Committee Chair	Assurance

v = verbal, d = document p = presentation

Ref	Time	Item	Owner	Purpose
16	15:25	Charity Committee Chair's Report (d)	NED Committee Chair	Assurance
17	15:30	RIME Committee Chair's Report (v)	NED Committee Chair	Assurance
PATIENT EXPERIENCE				
18	15:35	Patient Experience Strategy, Activity and Engagement Annual Report (d)	Head of Patient Experience	Information
GOVERNOR COMMITTEES				
19	15:50	COG Membership and Engagement Group 16 May 2022 • Chair's update (v) • Minutes (d) • Membership Strategy (d)	Governor Committee Chair	Assurance
20	16:00	COG Nominations Committee 11 May 2022 • Chair's update (v) • Minutes (d	Chair	Assurance
21	16:05	COG Advisory Committee 23 May 2022 • Chairs Update (v) • Minutes (d)	Lead Governor	Assurance
CLOSE OF MEETING				
22	16:10	Any Other Business (v)	Chair	N/A

Date of Next Meeting: Annual Members Meeting and Council of Governors meeting
Thursday 8 September 2022, 2pm
Lecture Hall, Sid Watkins Building, Walton Centre NHS Foundation Trust

v = verbal, d = document p = presentation

UNCONFIRMED

MINUTES
COUNCIL OF GOVERNORS PUBLIC MEETING
8 March 2022
MS Teams

Present:

Name	Role		Initials
Seth Crofts	Acting Chair		AC
Barbara Strong	Lead Governor	Merseyside	LG
Jonathan Desmond	Public Governor	Merseyside	Gov
William Givens	Public Governor	Merseyside	Gov
Robert Howe	Public Governor	Cheshire	Gov
John Kitchen	Public Governor	North Wales	Gov
John Lloyd-Jones	Public Governor	Merseyside	Gov
Nanette Mellor	Partnership Governor	The Brain Charity	Gov
Ella Pereira	Partnership Governor	Edge Hill University	Gov
Thomas Stretch	Public Governor	Cheshire	Gov
John Taylor	Public Governor	North Wales	Gov
Jan Vaughan	Partnership Governor	M'side & Cheshire Clin Network	Gov
Melanie Worthington	Partnership Governor	Cheshire & M'side Neuro Alliance	Gov

In attendance:

Karen Bentley	Non-Executive Director	NED
Su Rai	Senior Independent Director	SID
David Topliffe	Non-Executive Director	NED
Ray Walker	Non-Executive Director	NED
Mike Burns	Chief Financial Officer	CFO
Jan Ross	Chief Executive Officer	CEO
Katharine Dowson	Corporate Secretary	CS
Carol Miller	Meeting Administrator - Corp Gov & Membership	MA

Apologies:

Amanda Chesterton	Staff Governor	Clinical	Gov
Rhys Davies	Staff Governor	Medical	Gov
Louis Pate	Staff Governor	Nursing	Gov
Mike Gibney	Chief People Officer		CPO
Andy Nicolson	Medical Director and Deputy Chief Executive		MD
Lisa Salter	Chief Nurse		CN
Lindsey Vlasman	Acting Chief Operating Officer		ACOO

Observing:

Martin Bamber	Public Member Merseyside

1. Welcome and Apologies

1.1. Apologies were received and noted as above.

1.2. The meeting was quorate

1.3. The AC gave a eulogy for Janet Rosser, following the recent notice of her death. He acknowledged her passion and the contribution made to the Trust over 10 years as Trust Chair and Non-Executive Director.

2. Minutes of meetings

2.1. The minutes of the Council of Governors held on 9 December 2021 were agreed as a true and accurate record with the following amendment:

17. Lead Governor Appointment
Barbara Strong left the meeting for this agenda item only.

17.1. The CS updated Governors on the expressions of interest exercise which had taken place for the role of Lead Governor. As no responses had been received, the LG had agreed to undertake the role for a further 12 months in order to allow additional governors to become eligible for the role as outlined in the Trust Constitution. It was noted that the final year for the LG would end in September 2023 as they would have served three full terms of three years.

2.2. The minutes of the Extraordinary Council of Governors held on 14 February 2022 were agreed as a true and accurate record with the following amendment:

2.6 BS added that she had been on the final panel and was supportive of the decision which had to be about who was the right person to take the Trust forward and echoed the positive comments about Mr Crofts and how difficult the decision had been.

3. Action Log

3.1. The action log was updated as follows

09/12/21 8. Neurological Alliance National Survey Results Report will be published in summer 2022 and therefore will be tabled at either the June or September meeting

4. Declarations of Interest

4.1. None

5. Lead Governor's Report

5.1. LG presented the Lead Governor report and acknowledged that this would be the last CoG meeting for the AC and thanked him, on behalf of the governors, for his contribution over the nine years as NED and praised the work he had undertaken at short notice as Acting Chair.

5.2. The LG highlighted the pan-Liverpool Training and engagement events as an effective way to network with members and governors of local trusts and encouraged governors to attend.

The Council of Governors noted the Lead Governor's report

6. Acting Chairs Report

6.1. The AC thanked governors for their support during his time as a NED and commented that it had been a privilege to be a NED and to step into the role of Acting Chair of the Walton Centre which was "the NHS at its very best". The Board were in a strong position, with the skills of the new NEDs and Chair, to be effective in a challenging time of change for the NHS.

6.2. The CEO reiterated the thanks given and highlighted the effective role he had played as Acting Chair and the support he had given.

6.3. The CEO gave an update on the Cheshire and Merseyside ICS.

6.4. A substantive CEO had been appointed, interviews were underway for the role of Chair, other key posts had been advertised and key engagement meetings continued. The Provider Collaborative were discussing collaborative mechanisms for local Trusts, support services and local government with a focus on population health and the patient experience.

7. Covid update

7.1. The CEO provided an update on Covid highlighting:

- Vaccination as a condition of deployment (VCOD) had been revoked
- 90% of staff had been vaccinated and support was in place to encourage staff uptake of the vaccination offer
- Covid numbers were small within the Trust and were stagnant across the region
- Visiting at the Trust would be updated in line with regional guidelines
- Elective recovery remained a focus to clear backlogs of waiting lists for 52 week and the 104 week spinal patients transferred from Liverpool University Hospitals NHS Foundation Trust (LUFHT)
- All patients on waiting lists were clinically assessed and prioritised

The Council of Governors noted the Covid update

8. Integrated Performance Report Q3

8.1. The CFO and ACOO presented the Integrated Performance Report and highlighted the following:

Activity
- Plans were in place to increase activity
- Referrals had returned to expected rates
- Ongoing focus on clearing long waiters
- Infection prevention recovery plan had led to significant improvements

- Workforce
- Theatres activity affected by staff Covid related sickness and self-isolation due to family members isolating

- Finance
- Breakeven at Q3 £26k surplus against a plan of £120k
- Forecast to breakeven at end of Q4 2021/22
  In line with Cheshire and Merseyside finance regime commitment
- in 2022/23 moving back to normality with 12 month financial planning cycle and 3 to 5 year capital planning
- Reduction in capital for 2022/23, risk based approach to reprioritising and reviewing capital plans with operational teams

The Council of Governors noted the integrated performance Report

9. Annual Register of Interests 2021/22

9.1. The CS presented the governors annual register of Interests which was noted by the CoG.

9.2. Declarations for 2022/23 would be requested in the 1st quarter of 2022/23

9.3. The report was noted with the following amendment:

The Loyalty interest below had ended on 16 April 2021:

Jonathan Desmond
Walton Centre NHS Trust - sister Dr Helen Elizabeth Millward employed as a Registrar in Rehabilitation Unit (Sid Watkins).

The Council of Governors noted the report on the annual register of interests for governors

10. Governor Survey Results

10.1. The CS presented the results of the governor survey undertaken in January 2022.

10.2. Following comments received CS replied that it was hoped that the main CoG meeting would take place in person, with the option to attend virtually. COG Committees would mostly continue

to take place virtually. Further training for Governors would be put in place to use Virtual Boardroom.

10.3. Following comments from governors it was agreed that the possibility of issuing governors with nhs.net email accounts would be explored.

ACTION nhs.net email accounts for governors to be explored**.**

11. Governor Elections

11.1. The CS presented the plans for the governor elections in 2022:

- Elections would take place by post and online between June – August 2022 and run in accordance with the Trust Constitution Annex 4, Model Rules of Election
- 10 seats eligible for election in 2022 - 9 public and 1 staff
- Constituency data, previous election turnout and the election timetable were included in the report for information

The Council of Governors noted the Governor elections report

12. MIAA Insight – Results of Governor Survey

12.1. The SID presented the results of a national MIAA governor insight report following a survey which had been undertaken of all NHS Foundation Trusts. Five Walton Centre Governors had responded.

12.2. Following the presentation a discussion took place on the process for holding the NEDs to account and how central this was to CoG meetings, the CoG Cycle of Business and how public governors could represent members of their constituencies.

12.3. The LG, as Chair of the CoG Membership and Engagement Group explained that the group had the remit, in liaison with the CS, to monitor and put in place opportunities for member engagement and identifying what membership of the Trust represented.

12.4. The CS provided further clarification on the role of the public governor as a representative of the interests of their constituency members as a whole by offering views to the CoG from the perspective of that constituency. This did not mean Governors were expected to represent all views from their constituencies.

12.5. CS advised that the Trust was intending to introduce an annual governor self-assessment effectiveness survey would allow further analysis and the results would be bought back to the CoG in June 2022.

ACTION: Results of the CoG Effectiveness survey to be presented in June 2022

13. Council of Governors Cycle of Business

13.1. The CS presented the Annual Cycle of Business.

13.2. Following comments on the process and opportunity to hold the NEDs to account, it was agreed that further consideration was needed to consider how NEDs are held to account by governors with a number of options to be explored including Committee presentations and NED/Governor engagement opportunities.

ACTION: The Agenda of the CoG meeting to be revised in consideration of centralising the role of holding the NEDs to Account

14. Governor Committee minutes and Terms of Reference Annual Review

14.1. The LG presented the minutes and annual review of committee/group Terms of Reference (ToR)

14.2. The LG advised that the CoG Advisory Committee had vacant roles within the membership and governors were encouraged to become members or observe the committee. Following a request by the committee, a further opportunity for governors to comment on the Trust Strategy had been organised and all governors had been invited to attend.

14.3. The CoG Membership and Engagement Group had identified that age was an under-represented group within the Trust membership and had plans to develop mechanisms to enhance engagement to that group.

14.4. Governors were asked to approve the ToR for the CoG Advisory Committee and CoG Membership and Engagement Group.

The Council of Governors approved the ToR for the CoG Advisory Committee and the CoG Membership and Engagement Group

15. Key Issues Reports

15.1. The following key issue reports were noted by governors:

- Business Performance Committee
- Quality Committee
- Audit Committee
- Charity Committee

15.2. Following questions from governors the CFO and NEDs gave assurance to governors that the Audit Committee and MIAA had oversight of the Cyber Security key risk on the Trust Board Assurance Framework (BAF) and that weekly IT updates and patches were actioned, ongoing controls and awareness was measured and peer reviewed nationally. NEDs DT and SR confirmed that the BAF risk was also monitored at Audit Committee, Business Performance Committee and MIAA undertook IT security audits, reviews and checklists.

15.3. The CEO gave assurance that the national process on contract exit strategies for Russian companies and interests was being actioned by the Trust Procurement team.

The Council of Governors noted the key issue reports

16. Any Other Business

16.1. None

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
08/03/22	10	NHS.net emails for Governors to be explored and offered if possible	CS	Complete, 2 governors took this up	June 2022	
08/03/22	12	Results of the CoG Effectiveness survey to be presented in June 2022	CS	On agenda – item 8	June 2022	
08/03/22	13	Agenda to be reviewed to centralise the role of Governors holding Non-Executive Directors to account	CS	Agenda revised	June 2022	
09/12/21	8	**Integrated Performance Report** Neurological Alliance National Survey results to be circulated to Governors when complete	DCOO	Neurological Alliance National update - The results are now being analysed will be collected into a report which will form the basis of our campaigning for the next two years, the report will be published on our website in summer 2022.	June/Sept 2022	

The Walton Centre NHS Foundation Trust

Report to Council of Governors
14 June 2022

Report Title	Lead Governor's Report
Executive Lead	Max Steinberg, Chair
Author (s)	Barbara Strong, Lead Governor
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Update for Governors on key activity since the last meeting

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

N/A

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

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

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Lead Governor's Report

Executive Summary

1. This report updates the Council of Governors (CoG) with significant events or developments since the CoG meeting held on March 8 2022.

Committees and Groups

Committee meetings

- CoG Nominations Committee met on 11 May 2022
- The CoG Membership and Engagement Group met on 16 May 2022
- CoG Advisory Committee met on 23 May 2022

2. Minutes from these meetings will be shared at the June CoG as agenda items.

Trust Strategy Development

3. Following the update on the Trust Strategy at the meeting of the CoG Advisory Committee on 17 February, at the request of the committee, a further session was delivered on 17 March and all governors were invited to attend. This valuable session was led by the Trust Medical Director and the Deputy Director of Strategy, and governors were given the opportunity to ask questions and discuss specific areas of interest in the Strategy.

4. An engagement event for members was also held on 22 March 2022 and was attended by a small number of Governors and Members.

Governor Training/ Engagement

5. External – NHS Providers

    - **NHS Providers Governor Workshop** 11 April 2022

      This was attended by the lead governor. The main focus of the workshop was a NHS Policy update including the national staff survey and staffing issues in the care sector.

    - **Accountability and holding NEDs to Account** 5 May 2022

      The Lead Governor attended this on-line training day and slides were circulated to all Trust governors.

6. More NHS Providers training for governors is available and the timetable of training events has been circulated to governors by the Corporate Secretary.

7. Internal – Members Event

    Pain Management: This was an excellent on - line event. Attendance was high, with 29 participants, this included Walton Centre patients, members, staff, governors, representatives from partner organisations and members of the public.

8. Further quarterly events are planned as follows:

    - 21 June 2022 Understanding the role of the Governor and how you can stand for election
    - 18 July 2022 Radiology
    - 22 November 2022 Allied Health Professionals
    - 16 February 2023 Neurophysiology

9. In the first instance these are taking place online with the possibility of holding face to face meetings in the future.

Chair/ Governors Online Briefings

10. These briefings continue to be helpful, informative and appreciated by governors.

    - Chair's briefing to the governors was on 12 April 2022. The new Chair introduced himself and gave the governors a summary of his background, experience and skills. The Chair then invited those governors present to introduce themselves and do likewise.

    - The Chair is now rethinking how he will engage with governors, as these sessions were set up in response to Covid. He will be asking governors for their views over the summer with further detail to be confirmed.

Governor Involvement in Recruitment of Non-Executive Directors (NED)

11. Governors on the CoG Nominations Committee will be involved in the forthcoming recruitment process for a new NED on the following dates:

    - Wednesday 29 June Longlisting
    - Tuesday 12 July – Shortlisting
    - Monday 25 July – Focus groups and interviews

12. An extra ordinary Council of Governors will also be scheduled for Tuesday 26 July at 11am to consider the recommendation of the interview panel and approve an appointment.

Governor Elections

13. In order to replace public governors who have left and fill other existing governor vacancies the election process begins on June 6th when nominations open. Vacancies are as follows:

    - Five for Merseyside
    - One for Cheshire
    - One for North Wales
    - Two for the rest of England and Wales
    - One for trust medical staff

14. Nominations close on 11 July and voting starts on 28 July. It is anticipated that new Governors will start with us in September at the Annual Members Meeting which this year is scheduled for Thursday 8 September at 1pm in the Lecture Hall, Sid Watkins Building.

Recommendation

To note

Author: Barbara Strong
Date: 6 June 2022

The Walton Centre NHS Foundation Trust

Report to Council of Governors
14 June 2022

Report Title	**Council of Governors Annual Effectiveness Review 2022 and Action Plan**
Executive Lead	Max Steinberg, Chair
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Generally positive feedback, with most respondees agreeing with the statements
- Holding Non-Executive Directors to account is seen as a challenge
- Governors are looking forward to being able to engage with members and come into the Trust again

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

- Action plan to be implemented

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Leadership	Choose an item.	Choose an item.	Choose an item.

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

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
CoG Advisory Committee	23/05/22	Katharine Dowson Corporate Secretary	Noted

Council of Governors Annual Effectiveness Review

Executive Summary

1. The responses to the Council of Governors (CoG) effectiveness review indicate an overall positive outcome with 76.5% of responses to all questions being Strongly Agree or Agree; there were no Strongly Disagree responses to any question. All responses supported the effectiveness of the CoG Committees and the reporting structure up to the main CoG meeting, although responses indicate that the process and reporting of the Nominations Committee to the CoG could be strengthened.

2. There were a small percentage of negative responses (2%) who selected slightly disagree, disagree or unable to answer to some questions and these are possible areas for development although where there was no associated comments it is more challenging to address that area. These areas are covered in more detail in the report.

3. At the CoG meeting in March 2022, governors were presented with the results of the MIAA Governor Audit and where questions aligned benchmarking has taken place against the responses to the CoG Effectiveness review. In all questions the WCFT governors responses were in line or better with the NHS overall apart from holding the Non-Executive Directors (NEDs) to account which was also highlighted by the responses to the CoG effectiveness review as an area for development.

4. The full results are presented in Appendix 1

Background

5. The Trust Constitution Council of Governors' Standing Orders are to ensure that the highest standards of corporate governance and conduct are applied to all meetings of the Council of Governors and associated deliberations. Annex 7 paragraph 11 states that:

> **11 Council Performance**
>
> 11.1. The Chair shall, at least annually, lead a performance assessment process for the Council of Governors to enable the Council of Governors to review its roles, structure and composition, and procedures, taking into account emerging best practice.
> 11.2 The performance assessment process in 11.1 shall include a review of the input into the Council of Governors of each appointing organisation.

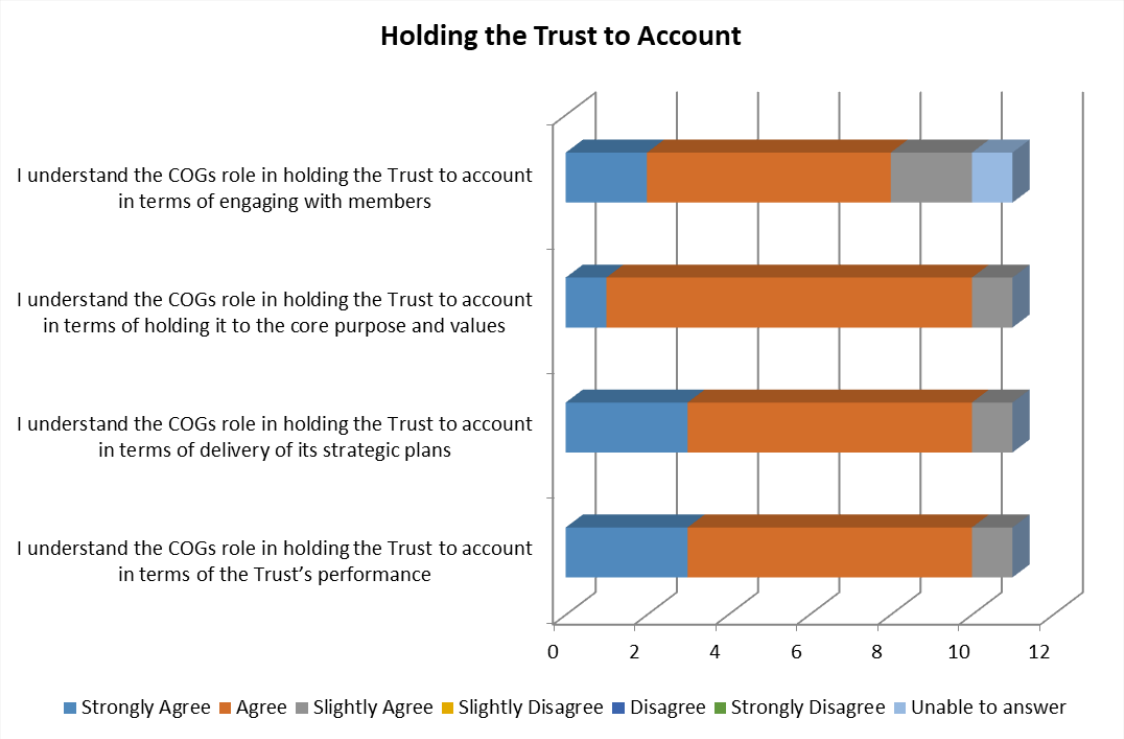
6. The effectiveness review was conducted through a link to an anonymous electronic questionnaire on MS Teams sent to all governors. The questionnaire was open for responses from 9 March 2022 to 8 April 2022.

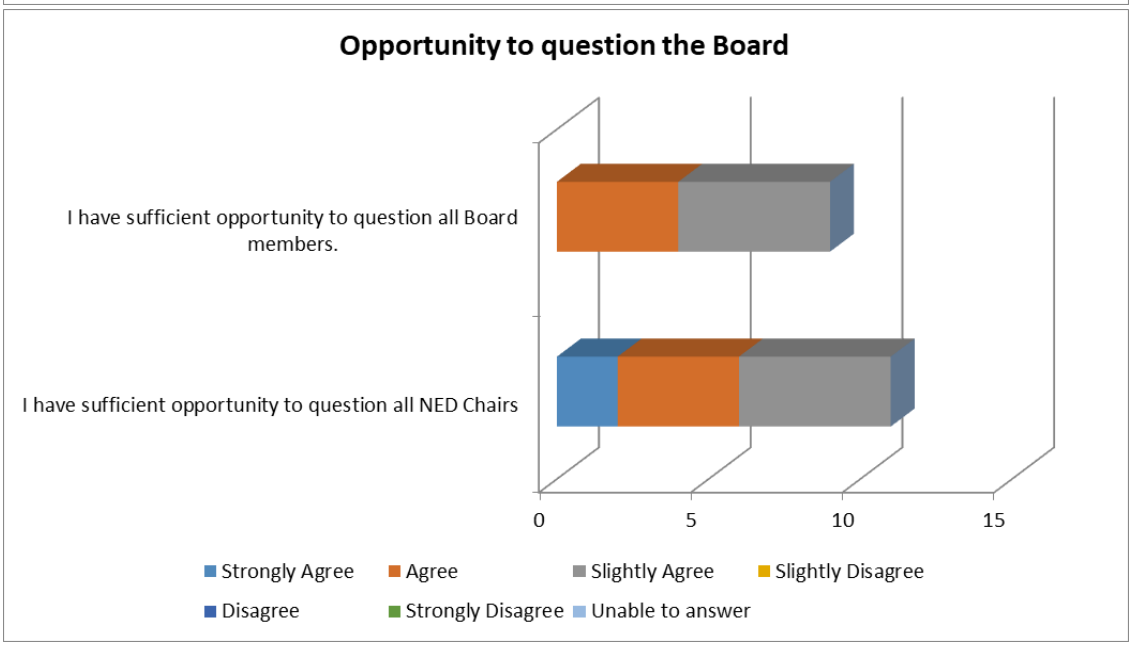
7. A total of 11 out of a possible 20 responses (55%) were received which was lower than the 2021 response rate of 63%, this is a difference of 2 fewer governors. There were a number of governor resignations in the period and therefore the number of Governors in post is lower. Governor meeting attendance in general has improved during the past year from 54.9% in 2020/21 to 58.2% in 2021/22.

Analysis

Holding the Trust to Account

8. The majority of governors responded positively. All governors answered that they had the opportunity to question the Board and NEDs but there were some governors who did not understand what that entailed or how to use the information provided to hold the NEDs to account.





9. Comments received:

"Needs to be made a slightly more prominent part of Council meetings."

"We can observe Board meetings, but I'm not sure how else we can judge the performance of the Board."

"Good understanding of the role in COG doing this. Pre-covid we had plenty of opportunities to meet them etc, although not as easy as when we had dedicated sessions with NEDS. I'd argue we don't need to go this far again, but improved communication channels would be ideal."

"There is an opportunity at CoG meetings, but it's a matter of having the right information to ask the right question."

"Governors are able to observe boards, and in my experience always been given opportunity to comment/question after the meeting has closed. Governors also get to attend online meetings that are at times attended by board members. When appropriate I've found board members to be approachable when information was needed about a specific issue."

"[…] I personally struggle with the concept of holding the NEDs to account for the performance of the Board, but I suspect I am not alone in this."

The Council of Governors agenda has been reviewed for the June meeting to increase the opportunities for NEDs to be held accountable by Governors and allow more time in the agenda for this to happen.

Influencing Strategy and forward plans

10. All responses were positive apart from two governors who were unable to answer the question on significant transactions. There is a strict criteria for what constitutes a significant transaction ie mergers and there had been none presented to the COG within the timescale covered by this review.

11. All responders agreed or strongly agreed that they had been given the opportunity to bring forward ideas on the Trust Strategy. There were conflicting comments on when governors felt that they had been involved. Strategy development updates were presented to the council in December 2021 and then at an extra session in February 2022 as well as to the Advisory Group in February.

12. Comments received:

"After the strategy has been decided! Again this may be face to face and Covid affected"

"As part of sub-groups"

"Governors are currently being involved in the development of the strategy."

13. **Membership Engagement**

14. The 2% negative response to membership engagement largely reflects the inability of Governors to visit the Trust due to ongoing Covid restrictions and this was echoed in the comments received.

15. The remaining engagement questions received positive responses to the questions "The Council ensures the needs, preferences and opinions of the Members are heard by the Trust" and "I am aware that the Council, through a committee, monitors public, patient and carer membership of constituent areas"

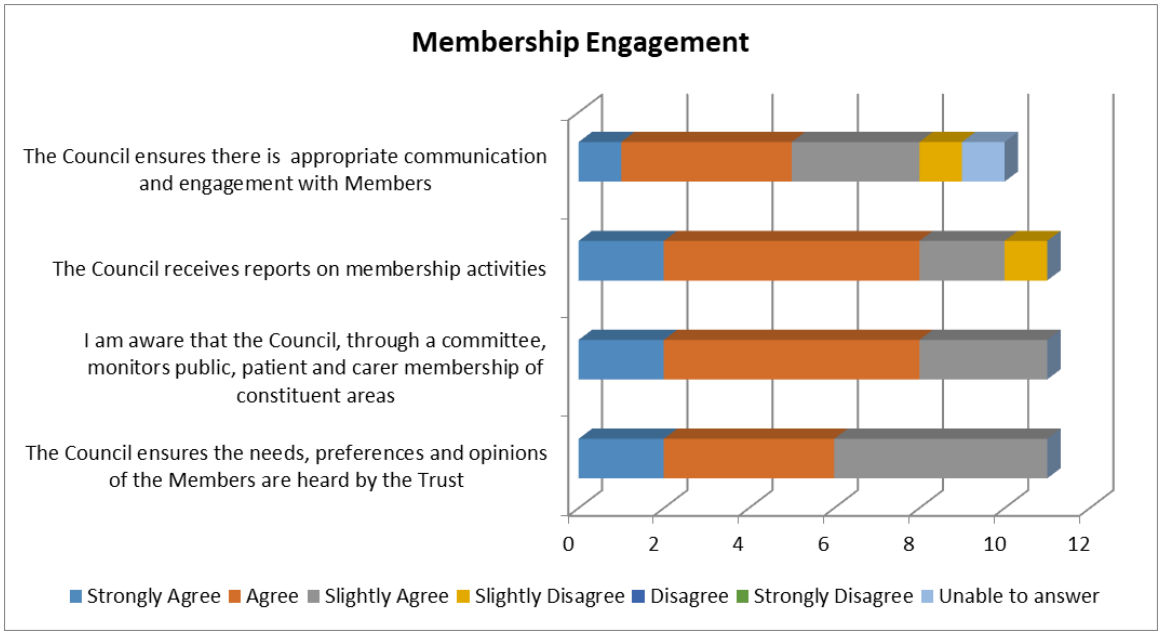
16. It was also noted in comments that Governors had differing levels of engagement and that membership engagement opportunities needed to be enhanced going forward. Increasing the reporting of the work of the Membership and Engagement Committee to the Council may also help with awareness of the planned work in this area.

17. Comments received:

"Appreciate covid issue, but this is an area where we need to make some improvements as we come out of the pandemic"

"There has certainly been no opportunity for this during the past two years."

"I think opportunity for this to happen is given, however constituency engagement is a challenge that has never really been met I think (but to my knowledge this is the case in a lot of Trusts)"



18. **Support and communications**

19. Whilst the majority of responses were positive and there were no negative responses, there were a significant number of Governors who were unsure or unable to answer the questions in this section, which suggests that additional work needs to be implemented in helping, particularly new governors, understand their role and the NHS on a practical level.

20. Comments received:

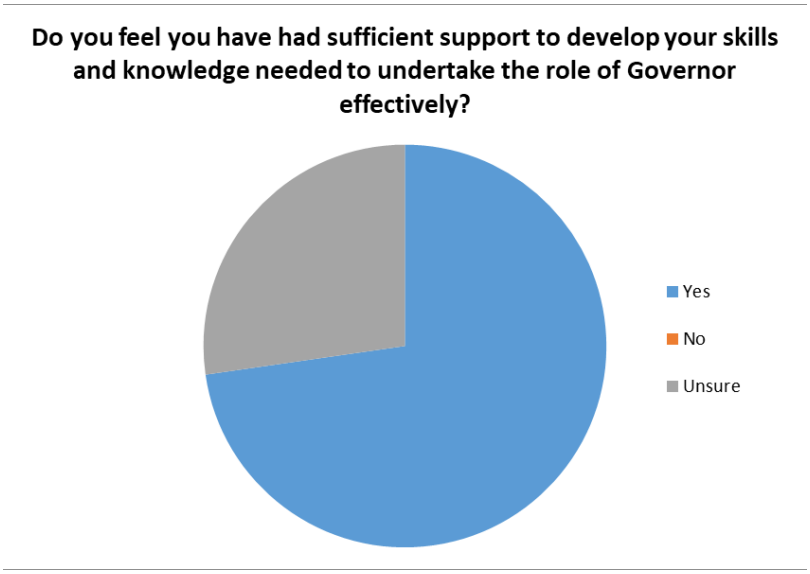
"it has been different in covid but efforts made to make sure regular meetings and updates to ensure we remain connected"

"Plenty of offers of good training via NHS providers."

"I do feel the role of Governor can be quite confusing to those outside of the NHS - getting to grips with new terminology, reports and systems which is something that may be beneficial to work on more - a 'back to basics of NHS Trust structure and terms' etc. I have done a lot of reading myself and googling."

"I have enough support because I came to the role with a certain skill set and knowledge of the NHS. I know this is not true of all governors. We want and need a diverse group of governors, and I think performing the role as best they can must be a significant challenge for governors who do not arrive with all the skills and knowledge they need. For example, training in chairing meetings and writing reports, and "asking the right questions" would be helpful for governors who don't already have skills or experience in these areas."

"I would say yes now I am an experienced Governor, but will say it was a challenge at first. Understanding what the role is (and crucially isn't) is easy to understand on paper although in practice it's not as always cut and dry. It felt for much of my first term it was a learning process on occasions."



Additional Comments received

21. Below are comments on the use of Virtual Boardroom (VBr) for meeting papers:

"Generally no problem. Prefer paper copy for personal reasons -eye strain. Several governors prefer paper copies mostly for sight strain but also making notes and pick up and put down, our effect on the planet, postal costs and delays are frequently used to reduce this. But VBr doesn't always open easily. Connectivity issues also occur."

"Using VBR is awkward in that all the papers open as a single pdf, meaning have to jump back and to the agenda during meetings."

22. Additional training could be offered to governors to address these issues as electronic papers will be the preferred distribution method in the long-term. The app does have a bookmark menu which allows you to return to the agenda or to a particular paper in one click.

Additional comments

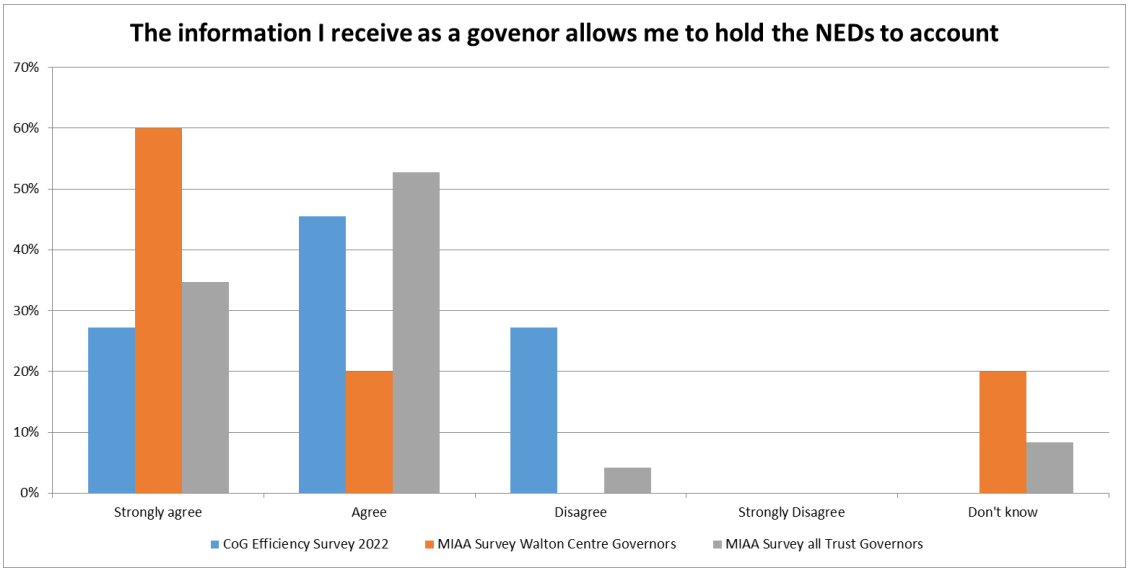
23. A level of frustration at holding virtual meetings and the impact this had on relationships with fellow governors and the Board was reflected in this comment:

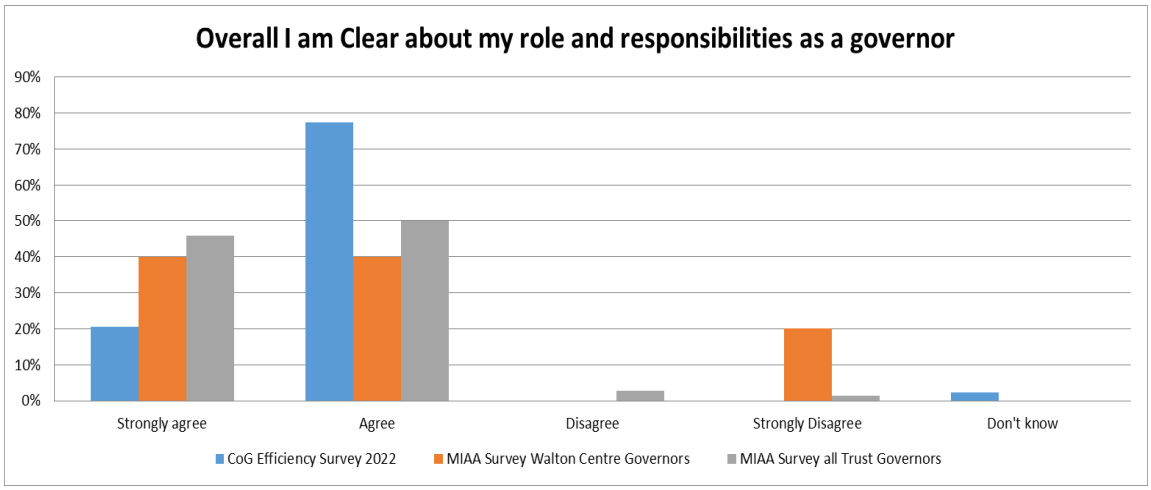
> *"I do not believe that the Trust always makes best use of individual's skills as governors. There is still a feeling that some directors and NEDs tolerate governors. This, under central command and control during the pandemic, has become more noticeable. Teams and Zoom meetings plus this attitude (maybe personal opinion) has resulted in lower Governor morale and involvement"*

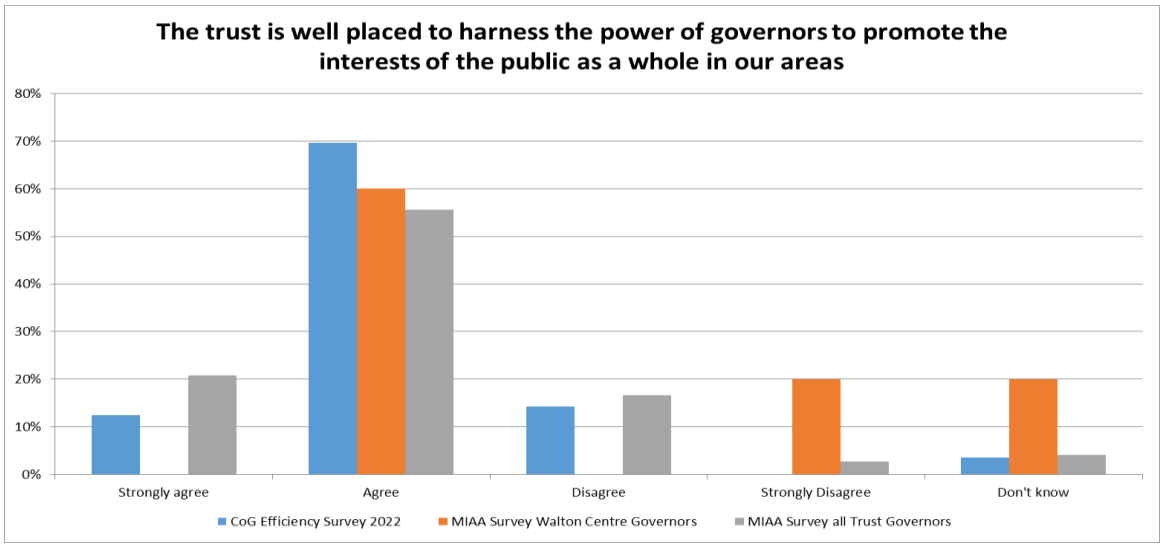
Benchmarking against MIAA Governor Audit

24. At the Council of Governors meeting in March 2022, governors were presented with the results of the MIAA Governor Audit. Where possible (four questions) the results have been benchmarked against responses from the CoG effectiveness review by Trust governors and by all governors who responded.

25. In all questions the WCFT governor's responses were in line or better with the NHS overall apart from 'The information I receive as a governor allows me to hold the NEDs to account.' This is an area which was also highlighted by the responses to the CoG effectiveness review as an area for development.







Action Plan

26. Areas for development had been highlighted in response to the effectiveness survey and are included within a draft action plan (Appendix 2).

27. Members are asked to identify any additional areas not already included in the draft action plan and to agree the areas identified, suggested actions and leads for each action in either the CoG Advisory Committee or the CoG Membership and Engagement Group.

Conclusion

28. The results of the Effectiveness Review will be presented to the next meeting of the CoG Advisory Committee who will draw up an action plan.

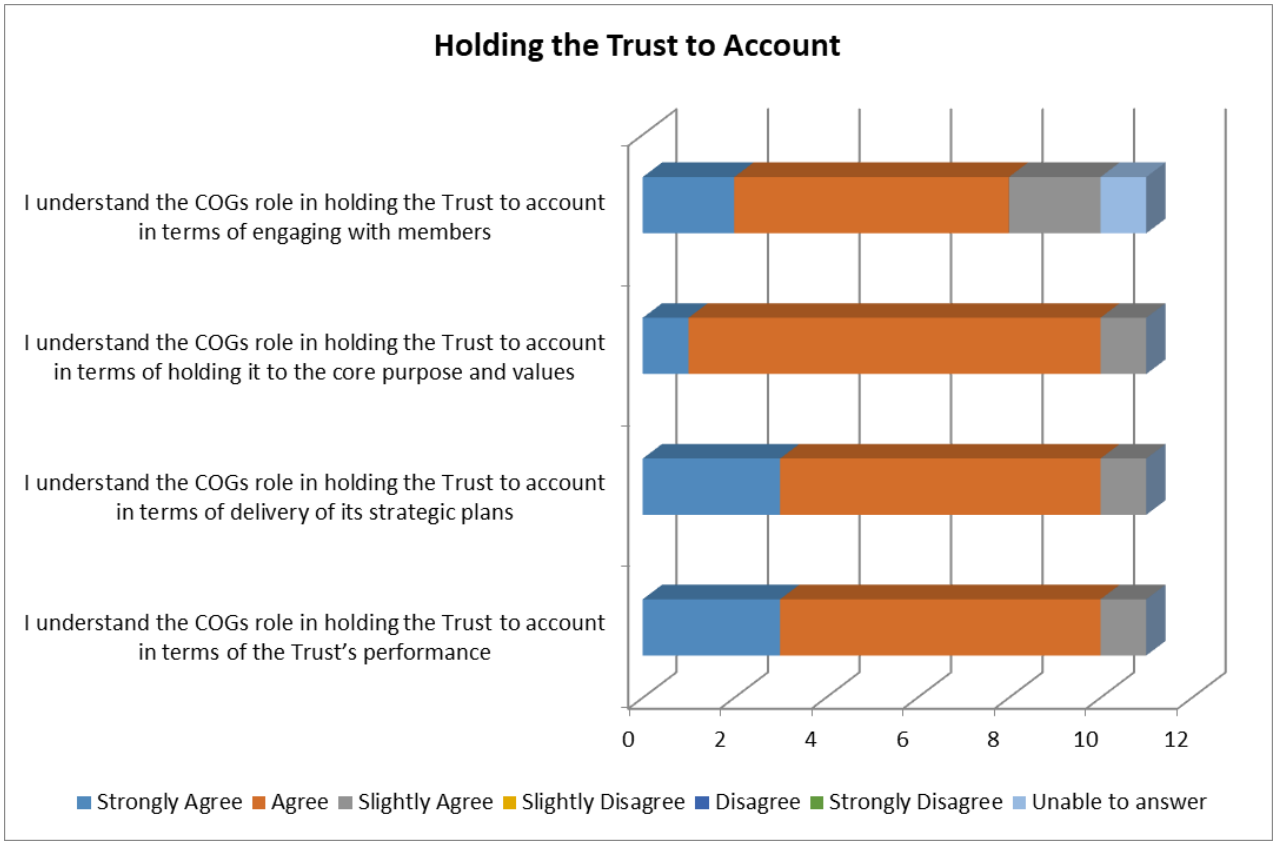
Recommendation

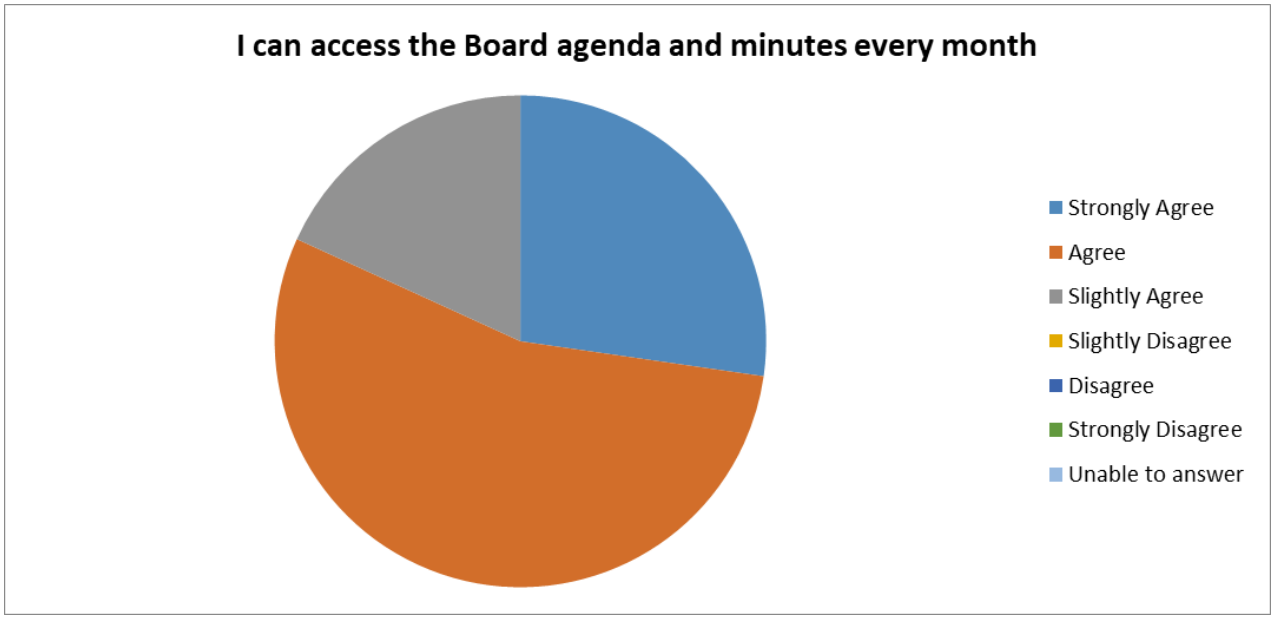
29. To note

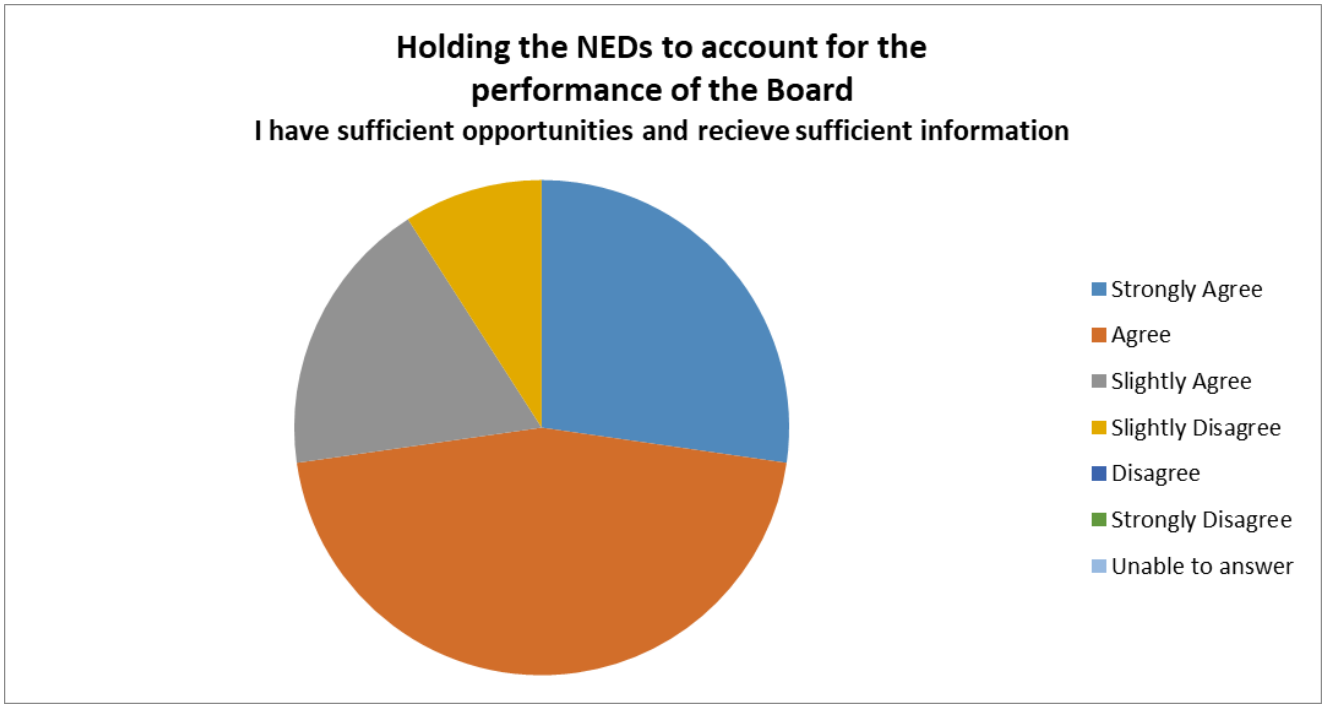
Author: Katharine Dowson, Corporate Secretary
Date: 21 April 2022

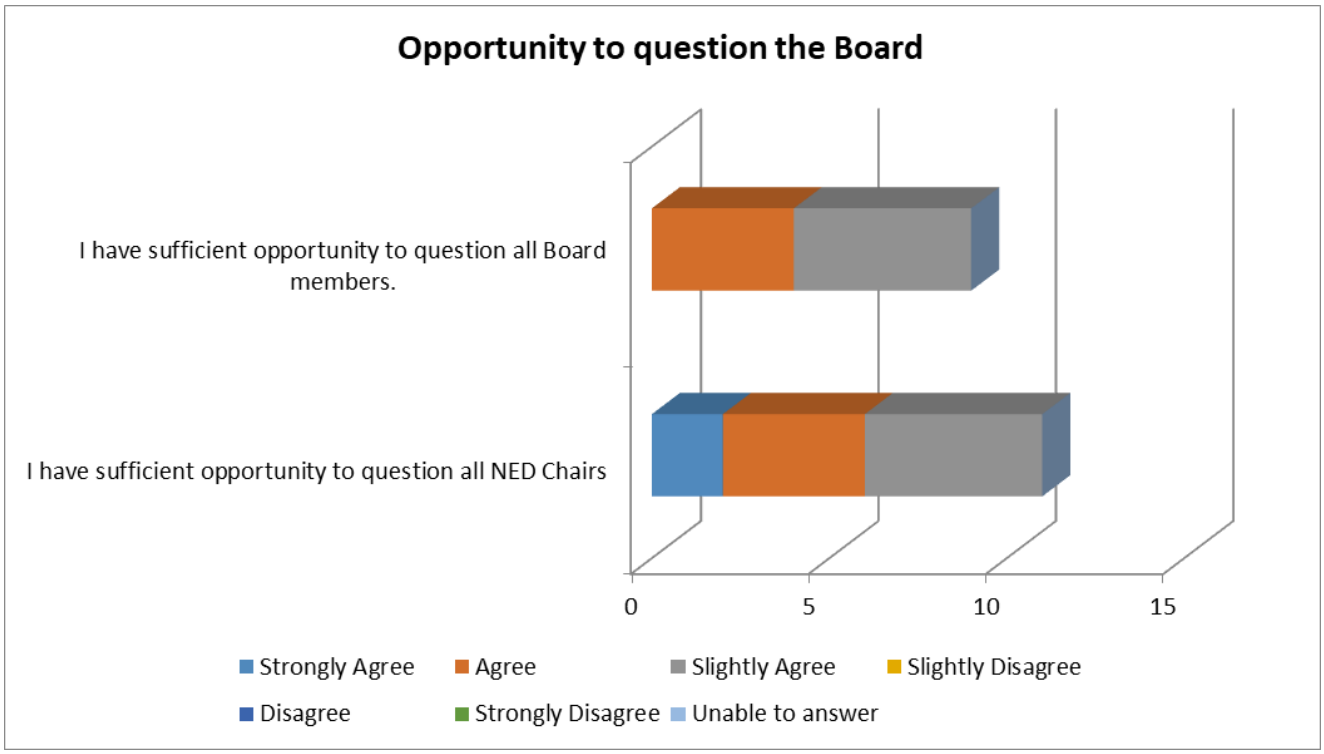
Appendix 1

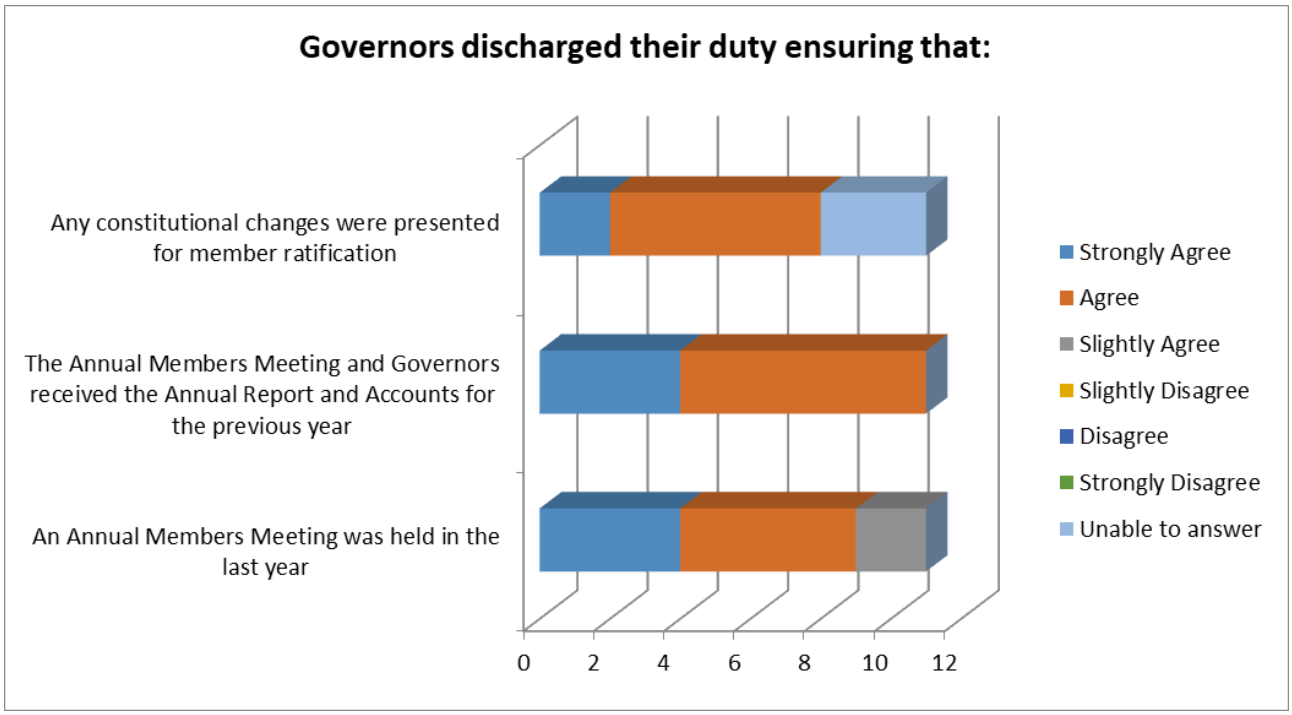
Full Results of the 2022 COG Effectiveness Review 2022

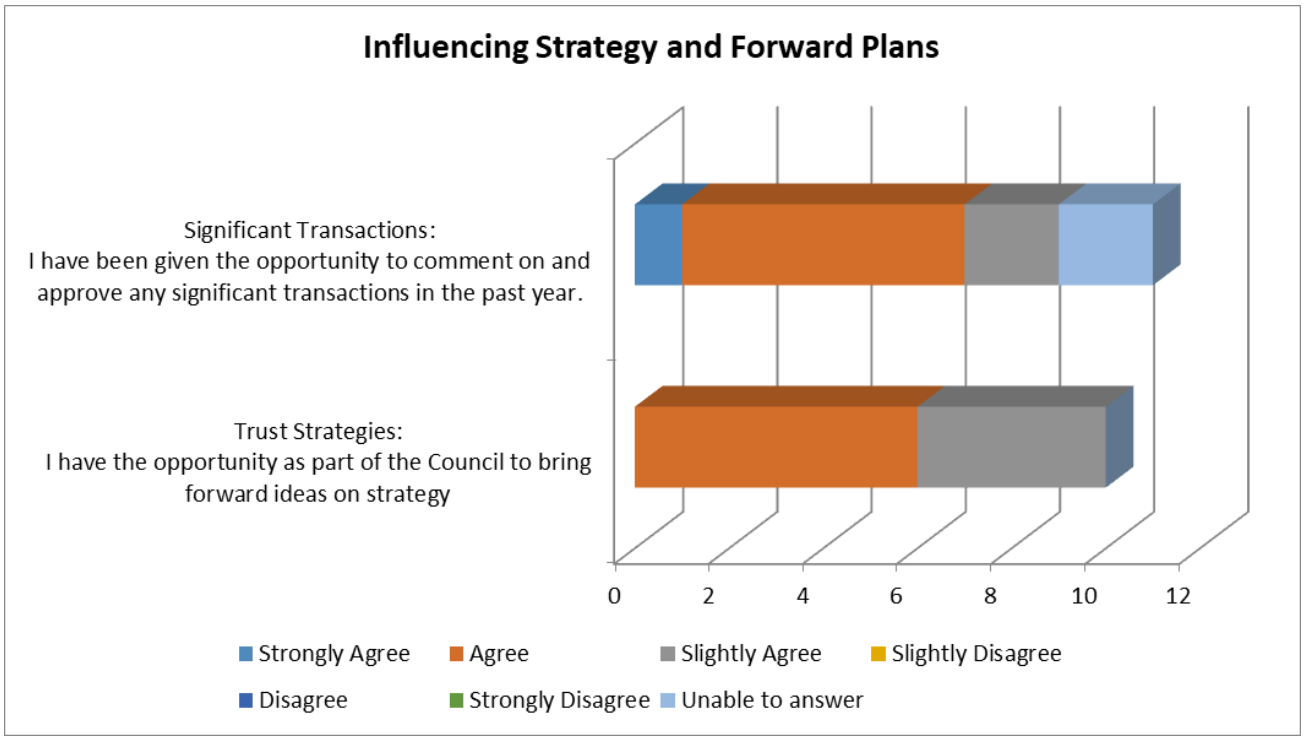


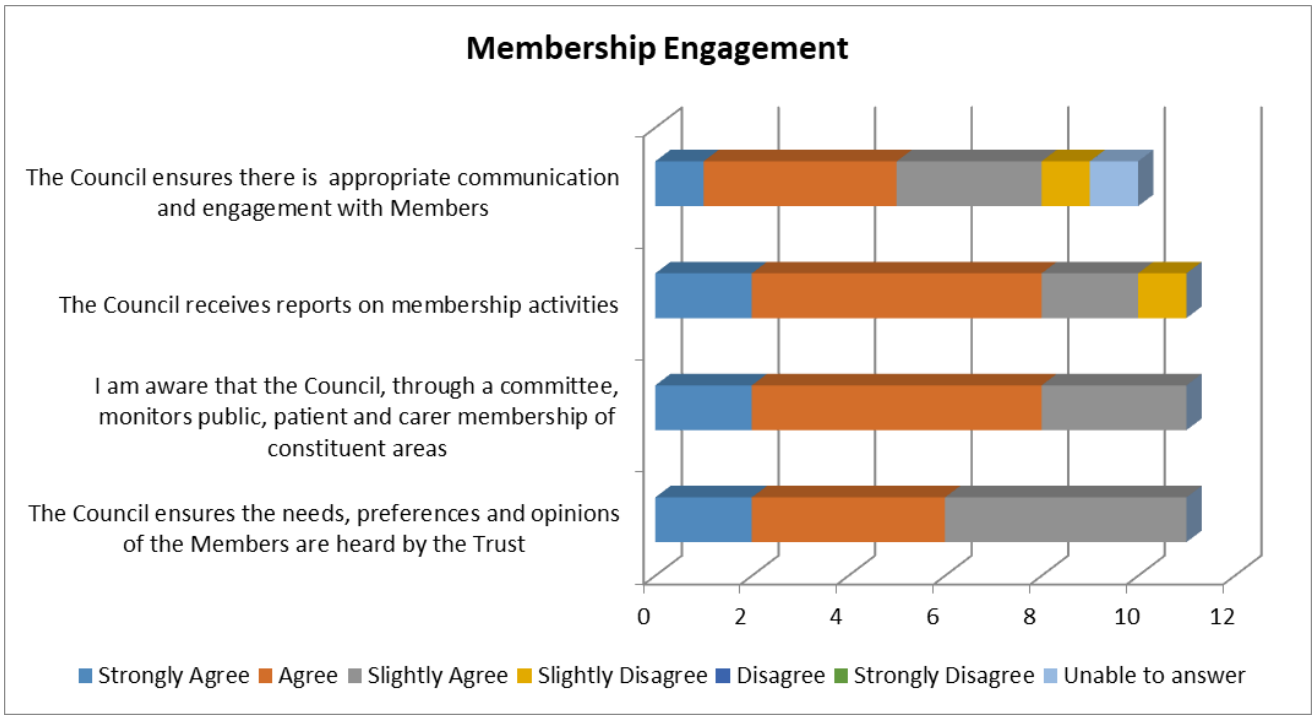


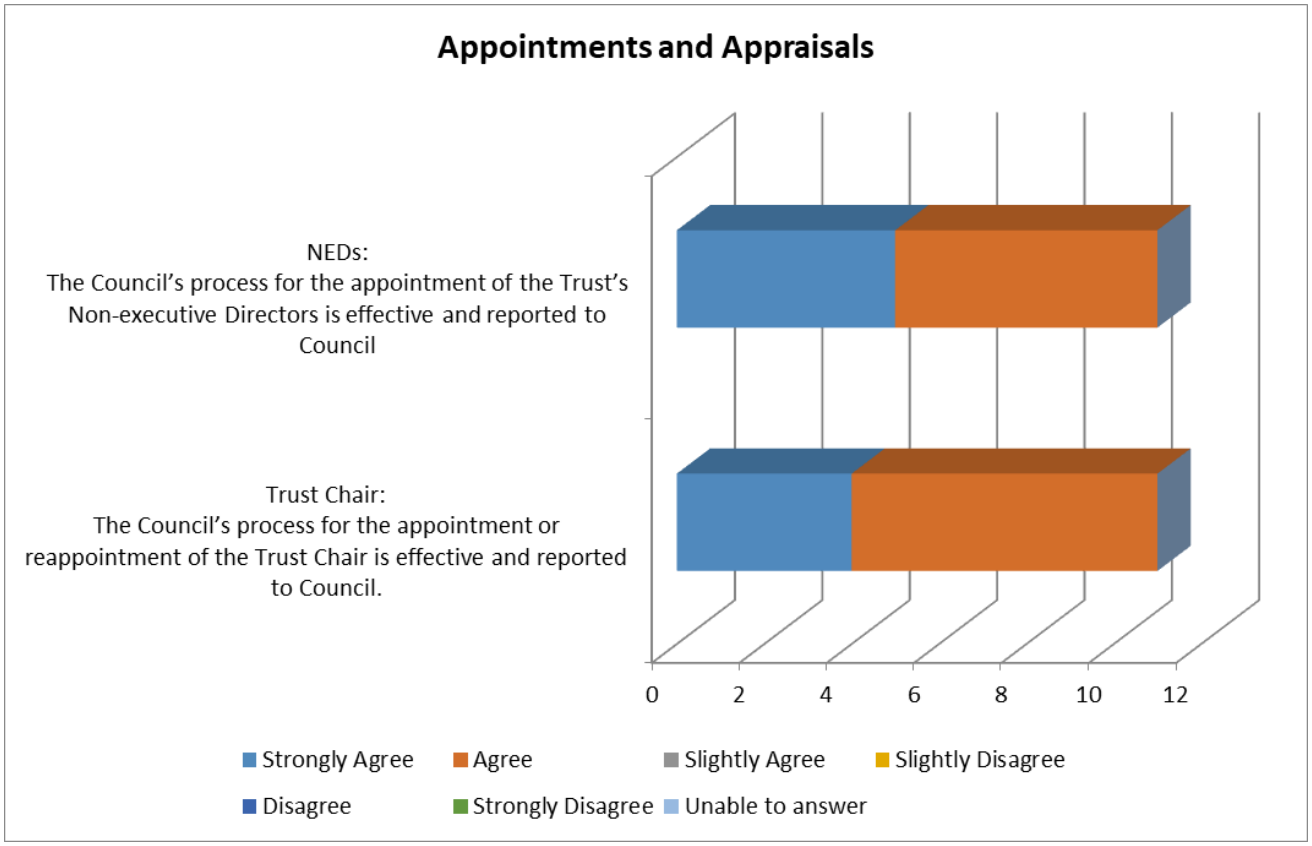

Holding the NEDs to account for the performance of the Board
I have sufficient opportunities and recieve sufficient information
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer

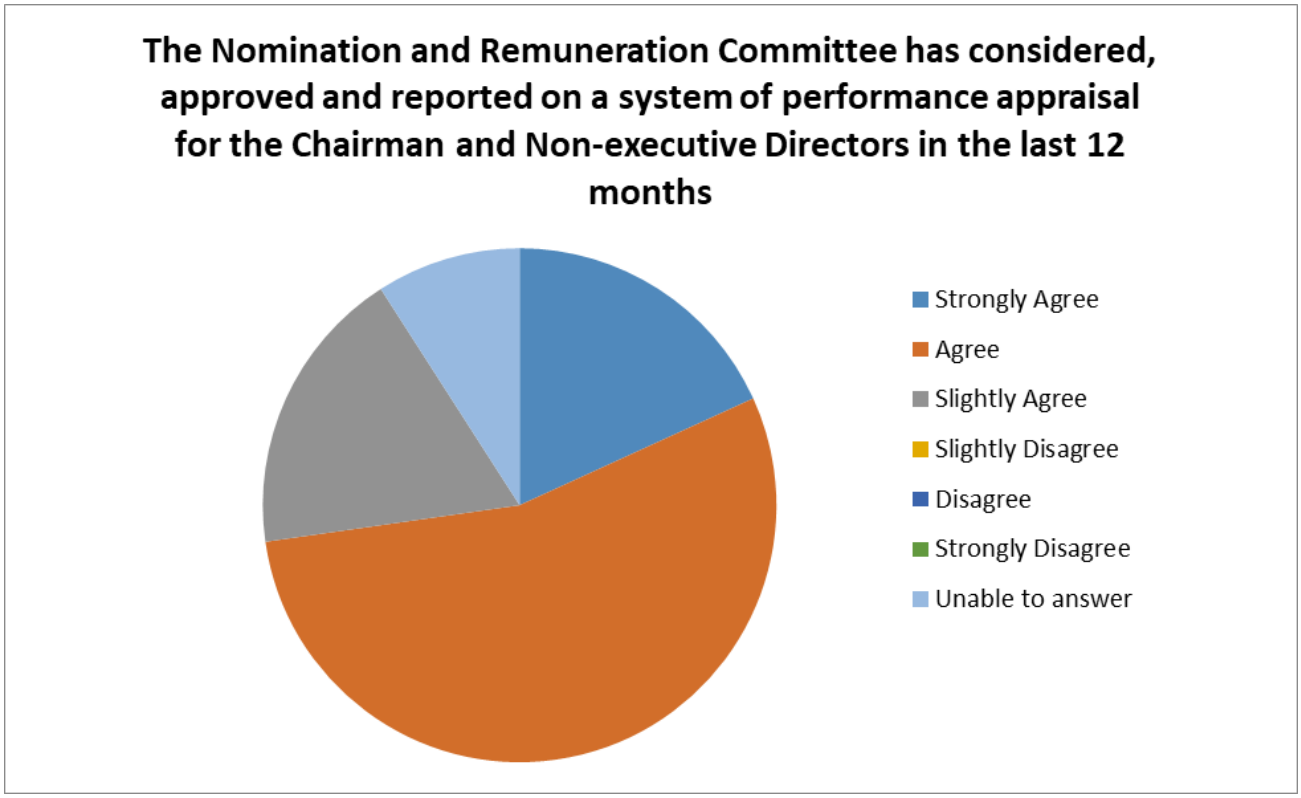

Opportunity to question the Board
I have sufficient opportunity to question all Board members.
I have sufficient opportunity to question all NED Chairs
0
5
10
15
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer

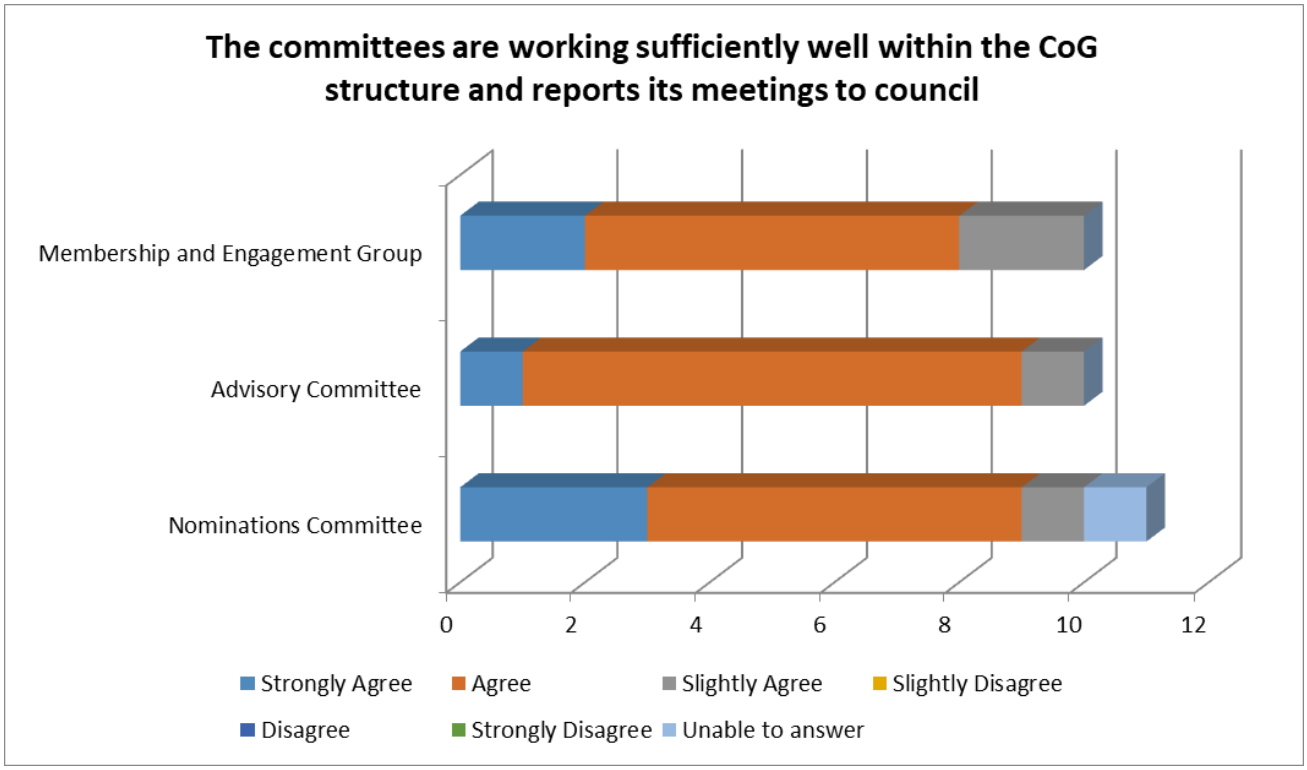

Governors discharged their duty ensuring that:
Any constitutional changes were presented for member ratification
The Annual Members Meeting and Governors received the Annual Report and Accounts for the previous year
An Annual Members Meeting was held in the last year
0
2
4
6
8
10
12
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer

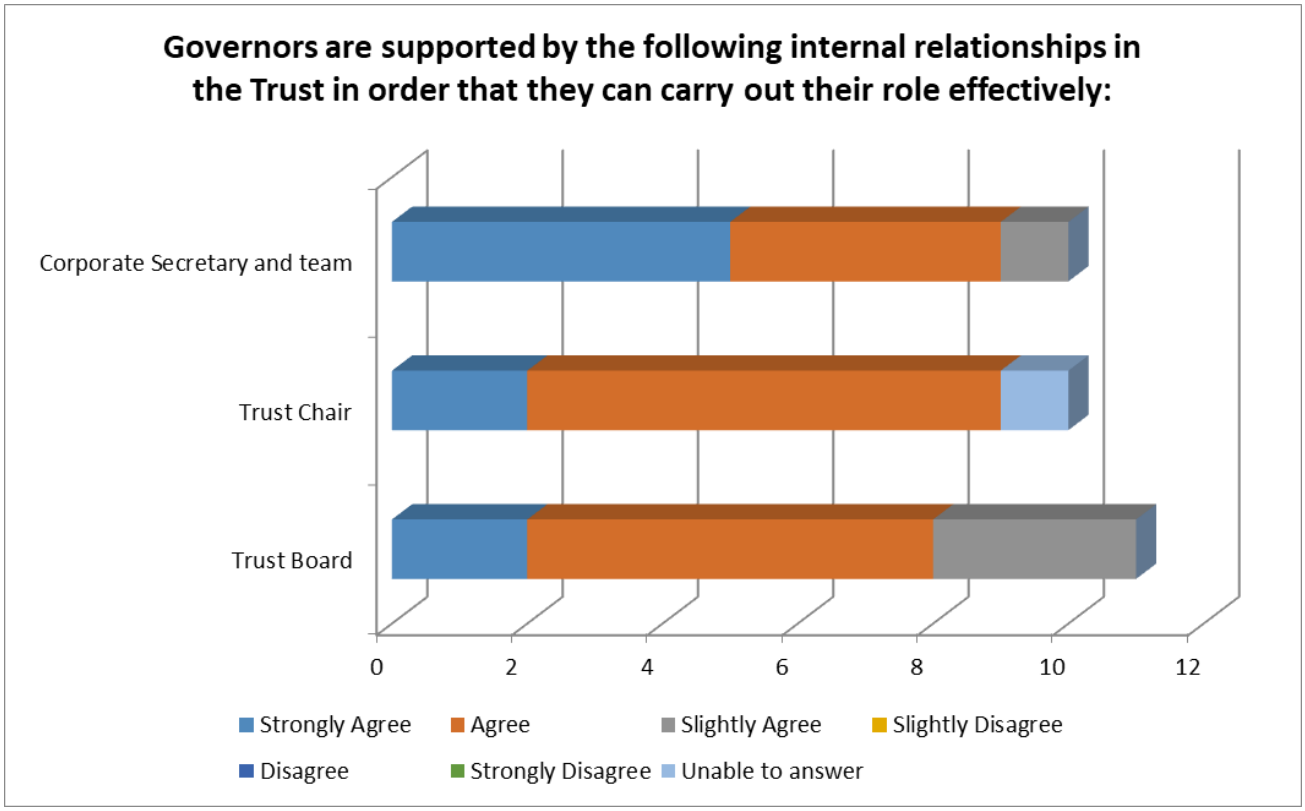

Influencing Strategy and Forward Plans
Significant Transactions:
I have been given the opportunity to comment on and approve any significant transactions in the past year.
Trust Strategies:
I have the opportunity as part of the Council to bring forward ideas on strategy
0
2
4
6
8
10
12
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer

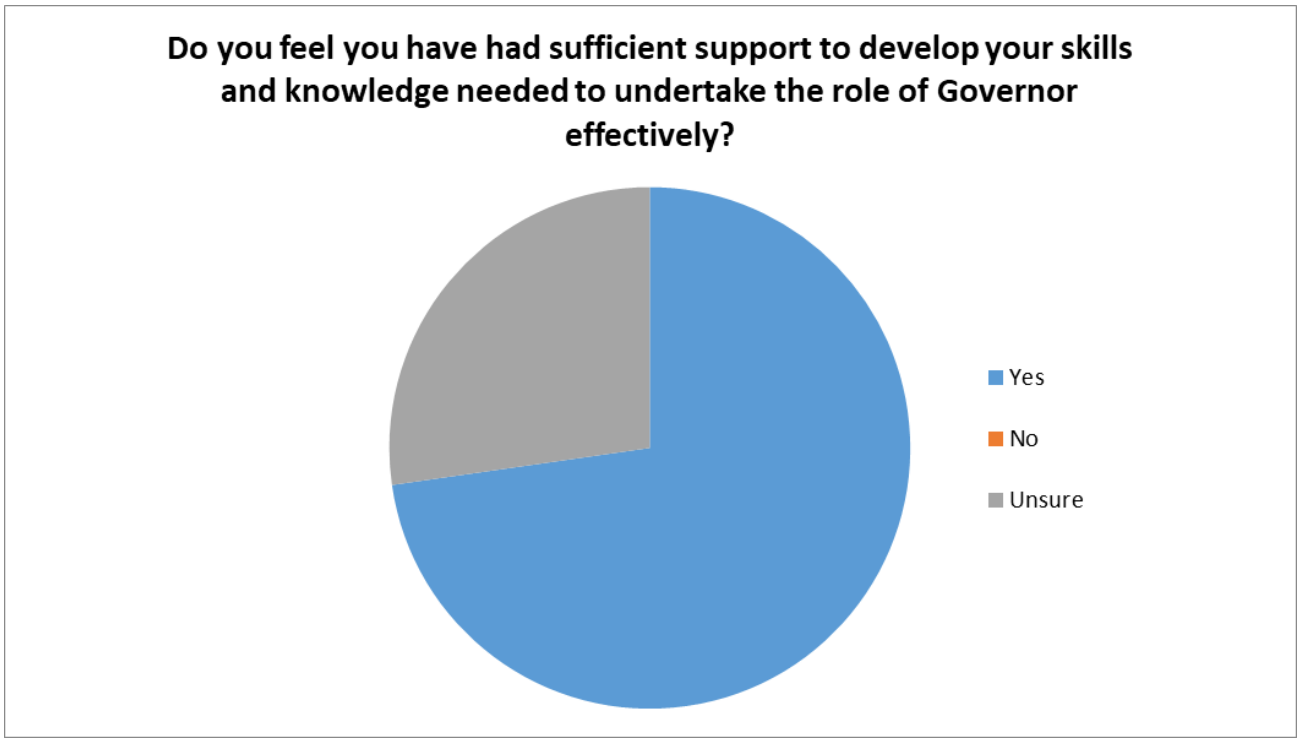

Membership Engagement
The Council ensures there is appropriate communication and engagement with Members
The Council receives reports on membership activities
I am aware that the Council, through a committee, monitors public, patient and carer membership of constituent areas
The Council ensures the needs, preferences and opinions of the Members are heard by the Trust
0
2
4
6
8
10
12
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer


Appointments and Appraisals
NEDs:
The Council's process for the appointment of the Trust's Non-executive Directors is effective and reported to Council
Trust Chair:
The Council's process for the appointment or reappointment of the Trust Chair is effective and reported to Council.
0
2
4
6
8
10
12
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer


The Nomination and Remuneration Committee has considered, approved and reported on a system of performance appraisal for the Chairman and Non-executive Directors in the last 12 months
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer


The committees are working sufficiently well within the CoG structure and reports its meetings to council
Membership and Engagement Group
Advisory Committee
Nominations Committee
0
2
4
6
8
10
12
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer


Governors are supported by the following internal relationships in the Trust in order that they can carry out their role effectively:
Corporate Secretary and team
Trust Chair
Trust Board
0
2
4
6
8
10
12
Strongly Agree
Agree
Slightly Agree
Slightly Disagree
Disagree
Strongly Disagree
Unable to answer


Do you feel you have had sufficient support to develop your skills and knowledge needed to undertake the role of Governor effectively?
Yes
No
Unsure

Appendix 2

DRAFT - Council of Governors Action Plan 2022/23

NO	EFFECTIVENESS QUESTIONs / TOPIC	RESPONSE/ACTION	LEAD	COMMENTS	STATUS
1	I understand the COGs role in holding the NEDs to account	• The Council of Governors agendas had been changed to increase NED accountability and involvement	COG AC		
		• All governors to be invited to annual Governor Induction training and PAN Liverpool membership and training opportunities	CGO	September to tie in with new Governor start dates	
		• The Chair is to review informal engagement opportunities for face to face informal meetings between NEDs and governors	CS		
2	The Council ensures there is appropriate communication and engagement with members	• Members receive Neuromatters - Ensure governor content is included • Virtual membership events organised for 2022/23 - Face to face engagement to be explored when appropriate - Increase governor social media content • Annual Members meeting - Possibility that 2022 meeting could be hybrid	COG M&EG	Neuromatters June 2022 will include information on governor elections	
3	The Council ensures the needs, preferences and opinions of the members are heard by the Trust			Confirmed date for AMM 8 September 2022	

4	The Council receives reports on membership engagement	• Information is Included within minutes of COG M&EG presented to COG - Increase awareness and highlight in Lead Governor report to COG	COG M&EG		
5	Do you feel that you have sufficient support to develop your skills and knowledge needed to undertake the role of Governor effectively	• NHS providers Training - One session per governor per year - Increase take up of offer	COG AC	Courses offered for May/June 2022 - Only four governors responded -	
6	Use of Virtual Boardroom for meeting papers	Virtual Boardroom training to be arranged and offered to Governors	CGO	Final date to be agreed with provider and CS	

	Complete & for removal
	In progress
	Overdue

The Walton Centre NHS Foundation Trust

Report to Council of Governors
14 June 2022

Report Title	Integrated Performance Report (IPR)
Executive Lead	Lindsey Vlasman – Chief Operating Officer
Author (s)	Mark Foy – Head of Information & Business Intelligence Matthew Crilly – Head of Finance – Neurosurgery
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- Performance measures have continued to recover following the Covid-19 pandemic

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

- Ongoing

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

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

004 Operational Performance	003 System Finance	004 Leadership Development

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

Strategy ☐	Policy ☐	Service Change ☐

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

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

Integrated Performance Report (IPR)

Executive Summary

1. The report attached at Appendix 1 provides a high-level summary of performance at the Trust. Comparison of performance indicators are provided quarter on quarter throughout the year. This is for the period ending March 2022.

2. Performance measures have continued to recover throughout the year.

Recommendation

To note

Author: Mark Foy – Head of Information & Business Intelligence
Date: 8 June 2022

Appendix 1

The Walton Centre NHS Foundation Trust

Integrated Performance Report
Council of Governors
Period Ending March 2022

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.

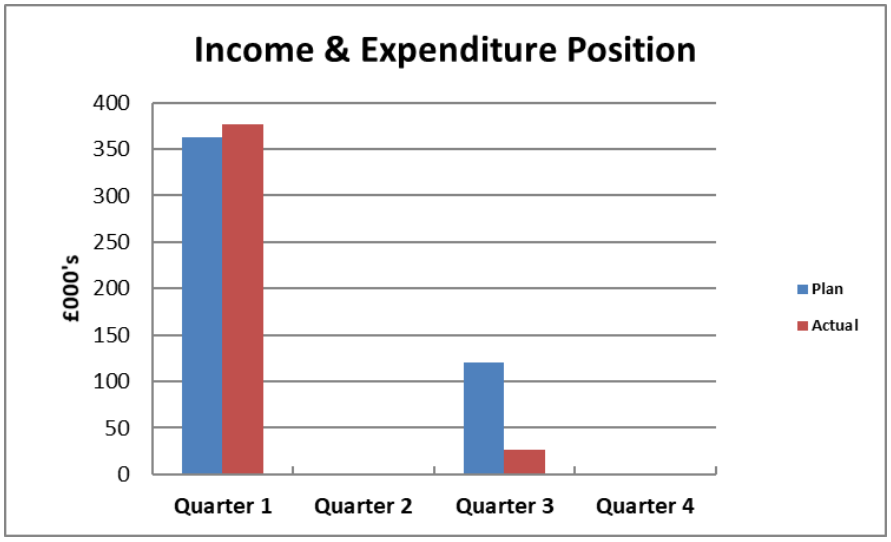
Finance

Due to COVID, the financial regime remains based on block funding for the full financial year and anticipated spend for the same period (based on average spend in Q3 of 2020/21). The plan for 2021/22 is break even position (submitted to HCP in November as part of the H2 planning process) in line with C&M requirements.
The current plan includes:

- Elective Recovery Fund (ERF) income and costs for the delivery of activity above the national trajectory targets
- 'Block' system funding received for Top-up, COVID related costs, growth and CNST
- Efficiency requirement to ensure a break-even position H1 and system efficiency of at least 2.5% in H2.

In month 12, the Trust reported a £134k deficit position. This is a £41k adverse variance against the planned in month position of £93k deficit. The deterioration in month is in the main due to higher depreciation costs relating to additional capital purchases. The increase in income received in month is mainly due to non-recurrent funding received in M12, which has been offset by an increased level of non-pay spend for purchases associated with this funding. There has been an additional adjustment between income and expenditure for the 6.3% pension top up, which is funded by the Department of Health.

The reported position for year end is breakeven (subject to audit), which is in line with plan. This position includes £2,813k elective recovery funding (£2,086k of which was achieved in H1) against a planned position of £2,998k, £185k below plan. The Trust has assumed £223k ERF income for activity in M12 (as per NHSE/I guidance)



COVID Expenditure

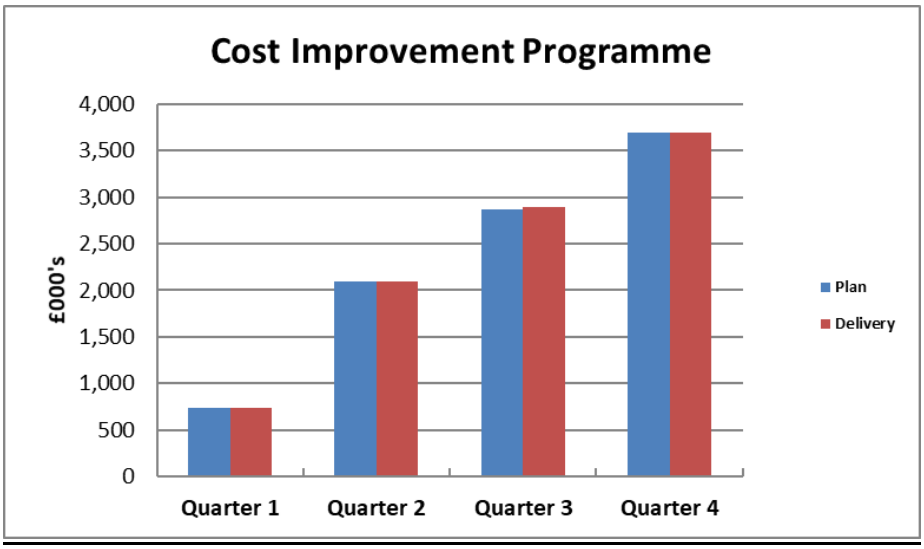
A summary of the Trust COVID-19 expenditure for Quarter 4 is below. At the end of the March, £1,009k had been incurred in response to COVID-19 for this financial year.

COVID -19 Expenditure	Apr-21 Actual £'000	May-21 Actual £'000	Jun-21 Actual £'000	Jul-21 Actual £'000	Aug-21 Actual £'000	Sep-21 Actual £'000	Oct-21 Actual £'000	Nov-21 Actual £'000	Dec-21 Actual £'000	Jan-22 Actual £'000	Feb-22 Actual £'000	Mar-22 Actual £'000	Year to Date Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	93	50	57	49	54	47	36	25	61	123	44	39	678
Decontamination	0	7	3	0	0	0	2	0	1	0	0	0	13
Agile working	0	12	1	0	0	0	0	0	0	0	0	0	13
Infection Control	0	0	0	0	22	4	14	3	0	(9)	0	0	34
Other	20	1	43	19	21	37	27	20	35	19	21	8	271
TOTAL	**113**	**70**	**104**	**68**	**97**	**88**	**79**	**48**	**97**	**133**	**65**	**47**	**1,009**

Other spend includes providing free car parking for staff, heavy duty mobile Sani-station units to be used across the trust and quarantine costs for overseas nurse recruitment.

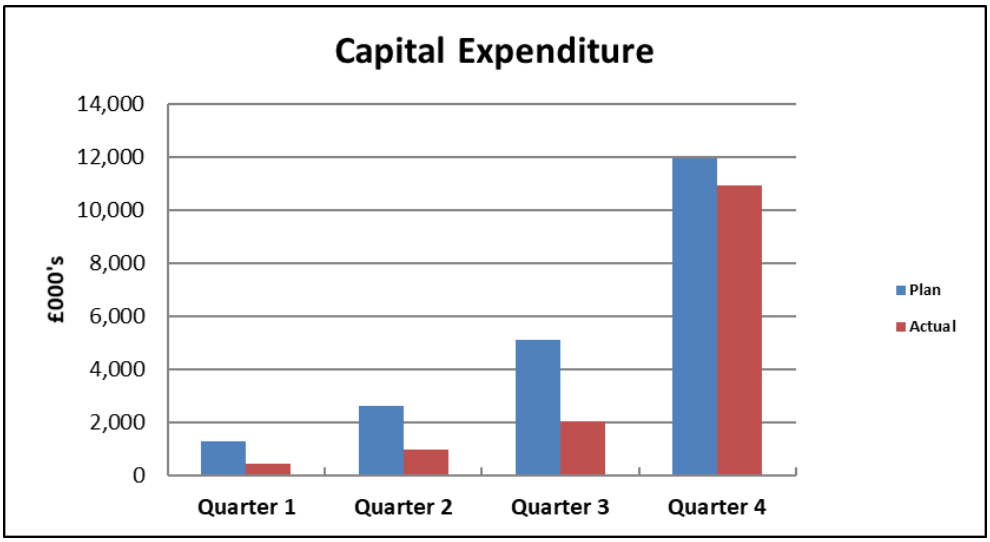
Efficiency Savings

In order to deliver the Trust's control total target By March we planned to achieve the QIP target of £3.698m. We have currently achieved £3.698m which was in line with plan.



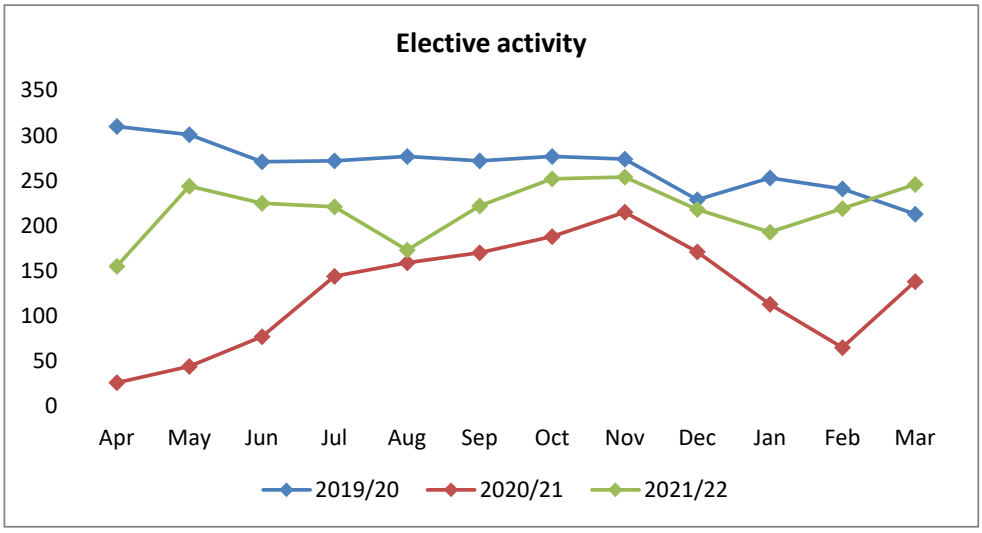
Capital

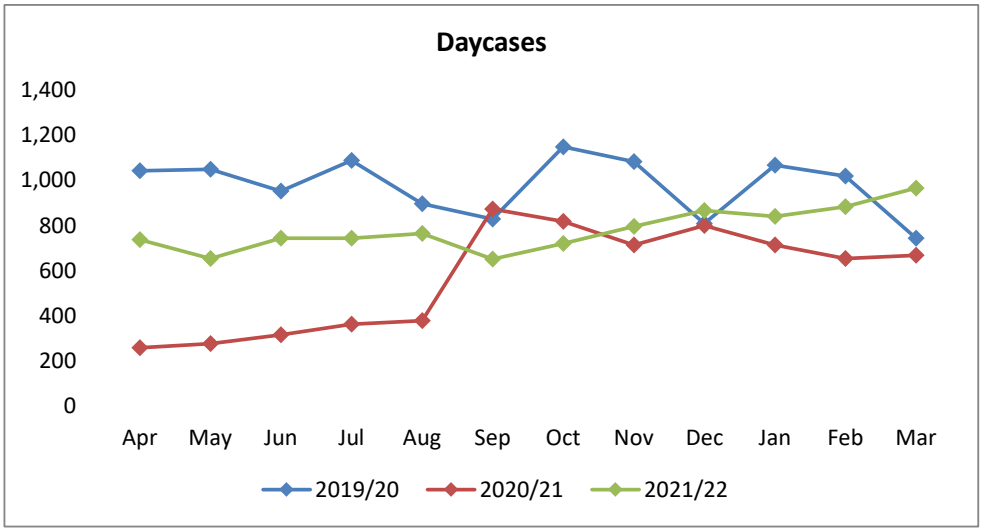
The Q4 capital expenditure is £10.941m, £1.007m below the total agreed funding allocation for the Q4 YTD of £11.948m. However this is primarily due to the deferral of £1m of Digital Aspirant funding into 22/23. When this is adjusted for, capital spend is £7k below plan.

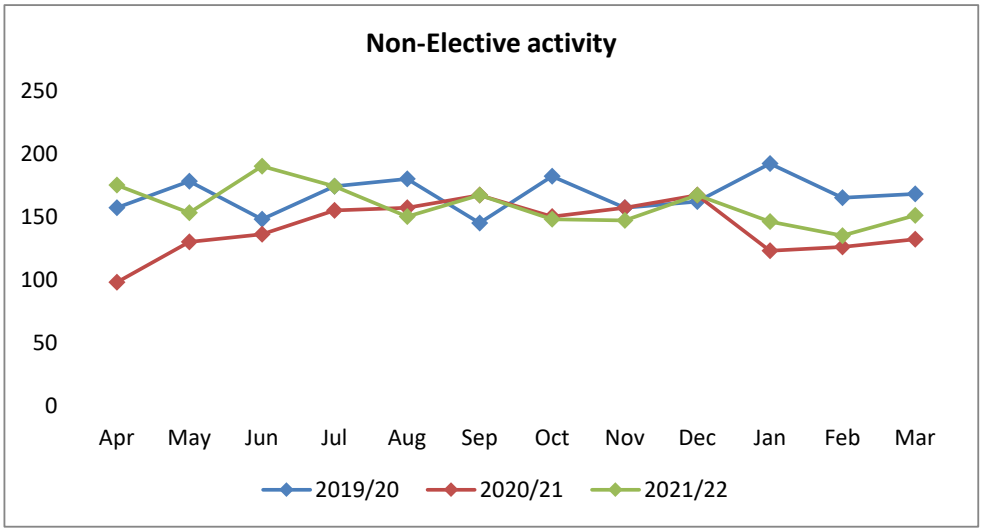


Activity

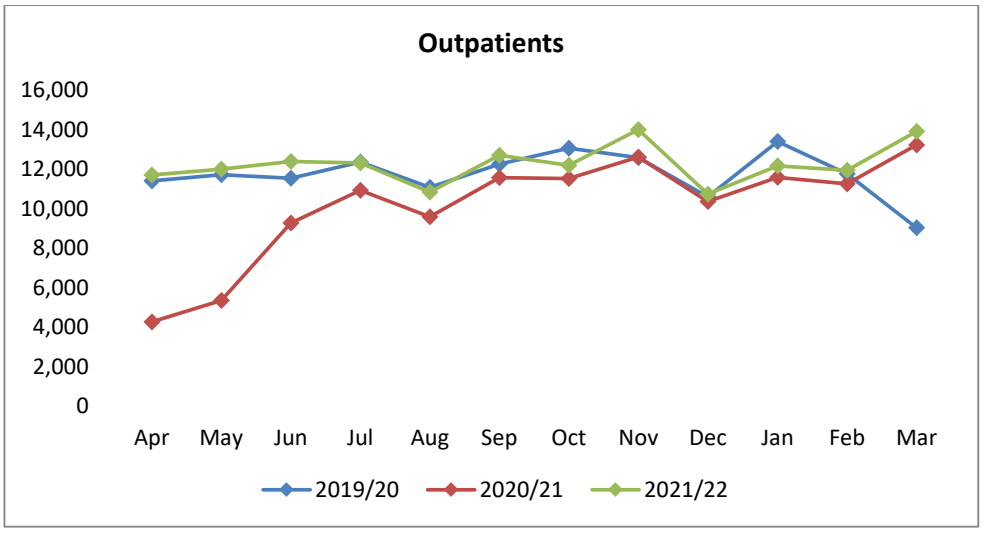
Inpatient & Day Case Activity: Inpatient activity remained at similar levels in Q4 2021/22 to Q3.







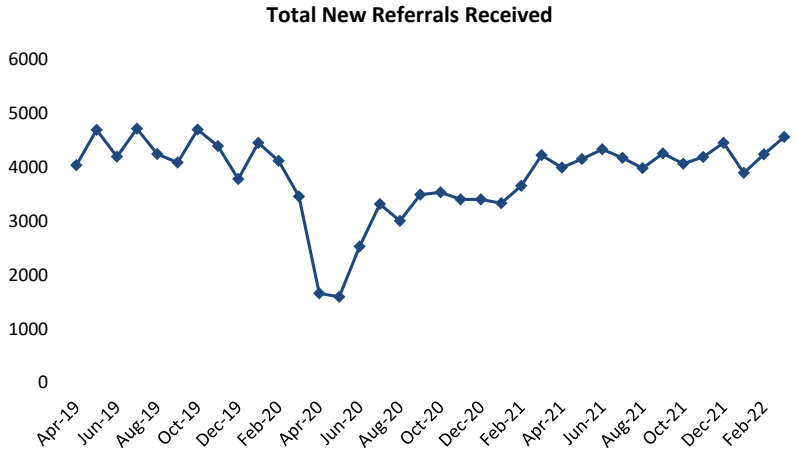
Outpatient Activity: Outpatient activity remained consistent in Q4 2021/22.



Referrals for outpatient appointments

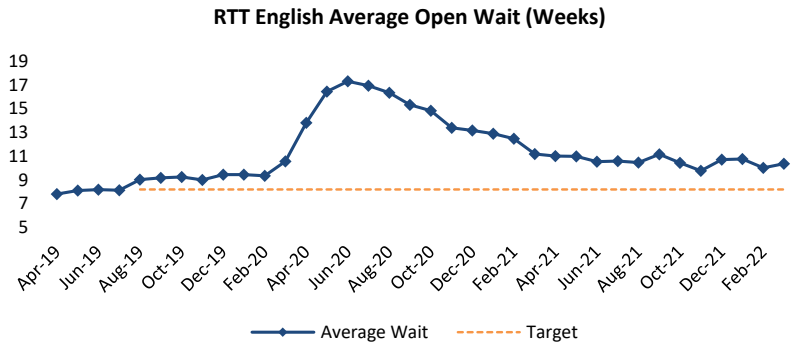
Clean referrals exclude referrals that are created by consultants retiring or transferring part of their practice to a colleague as part of service development or reorganisation and give a clearer indication of growth in demand for our services.

Referrals remained at normal levels in Q4 2021/22 following the drop due to Covid-19.

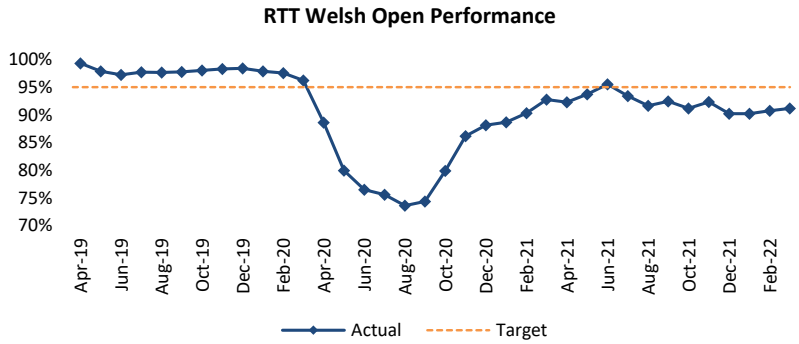


RTT (Referral to Treatment)

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 Q4 21/22 is 10.36 weeks. Performance has improved through the quarter following a deterioration of performance due to Covid-19

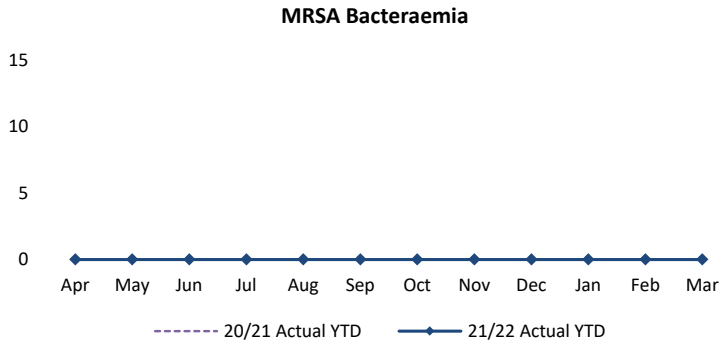


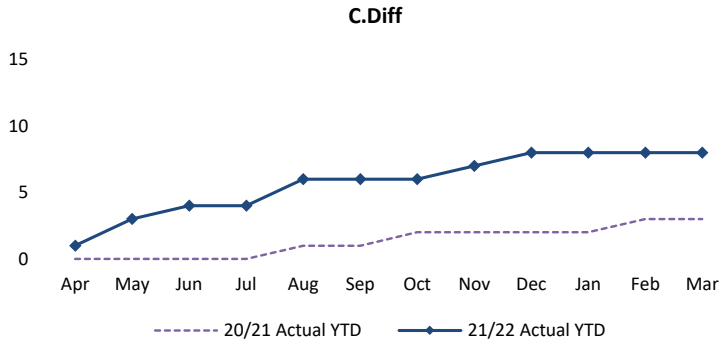
Welsh RTT performance continues to be monitored against the 95% standard, with performance below the standard at 91.15% in March 2022. Performance against the Welsh RTT target has stabilised throughout the Quarter following a drop in performance due to Covid-19.



Infection Rates

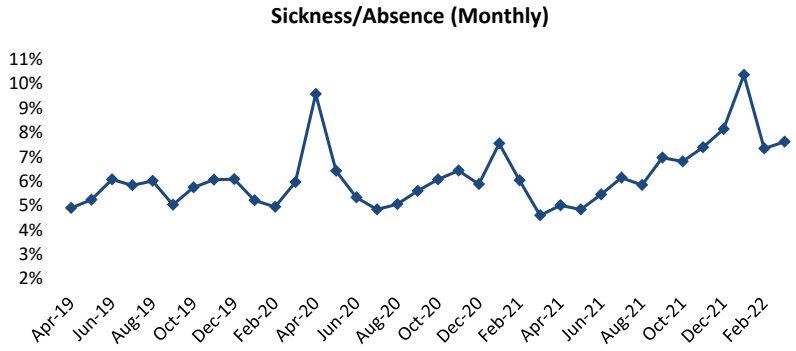
No cases of MRSA Bacteraemia were reported during 43 2021/22. The Trust has reported 8 cases of Clostridium Difficile against the PHE year-end threshold of 5 cases for 2021/22.

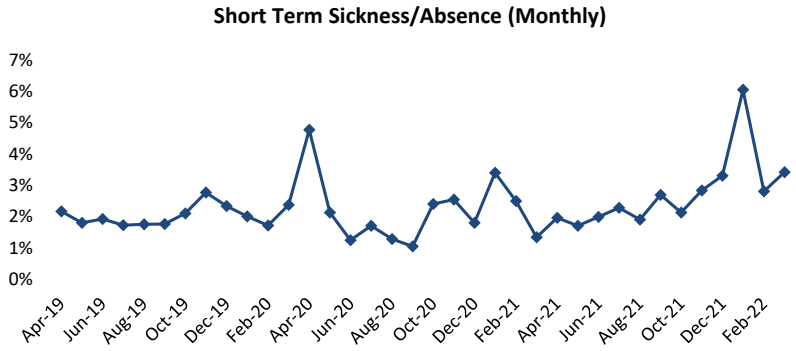


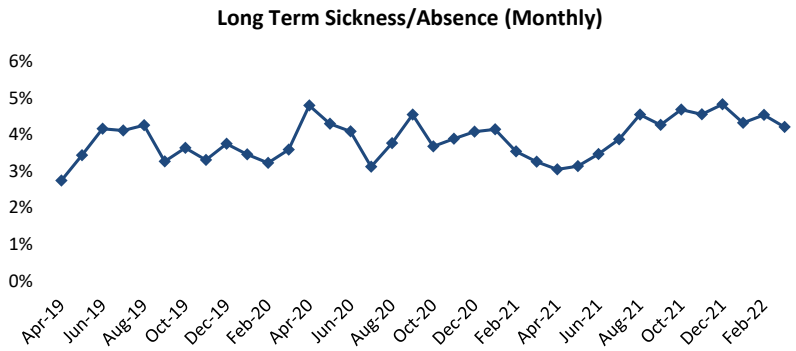


Workforce

Monthly sickness/absence rate is 7.63% which is above the target of 4.75%. The breakdown between long term and short term sickness as at March 2022 is as follows: 4.21% on long term sickness and 3.42% on short term.

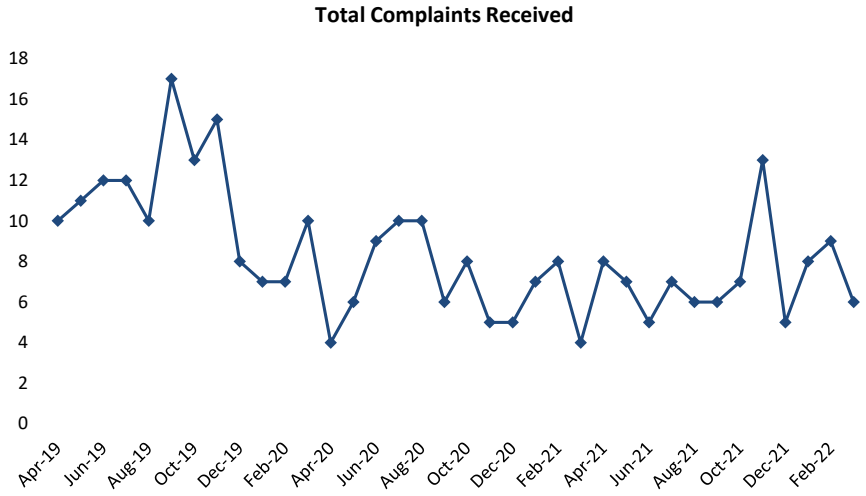


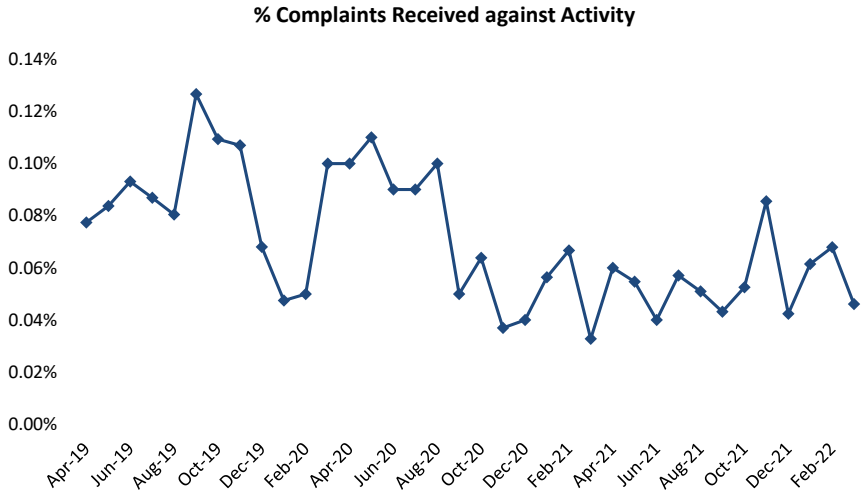




Complaints

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. Q4 2021/22 has seen 23 complaints reported.

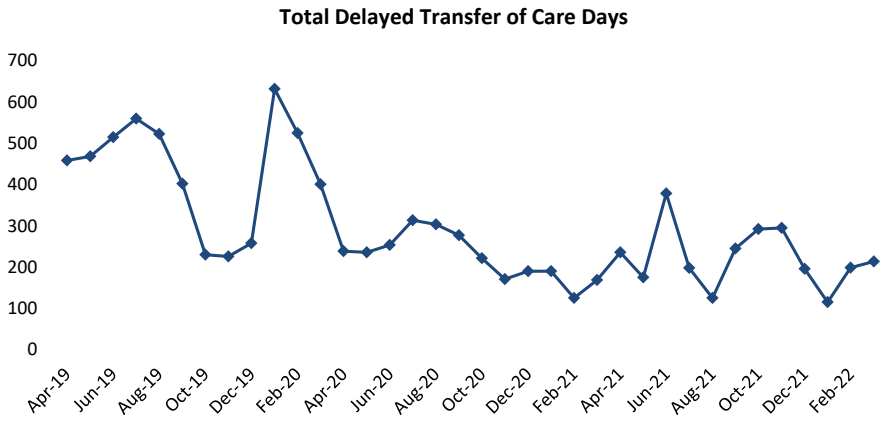




Efficiency Measures

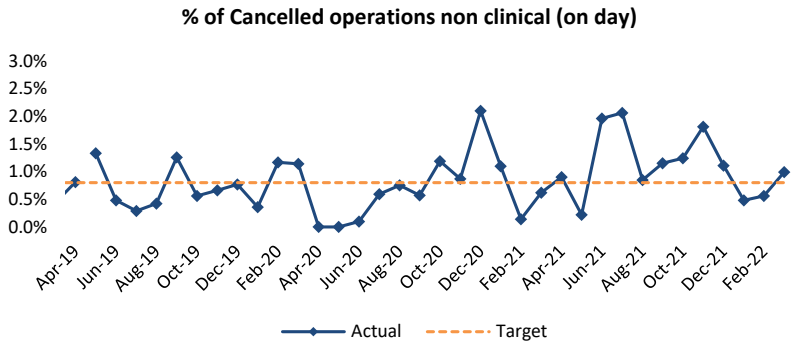
Delayed Discharges / Delayed Transfers of Care (DTOC):

The total Delayed Patient days has remained consistent during Q4 2021/22.



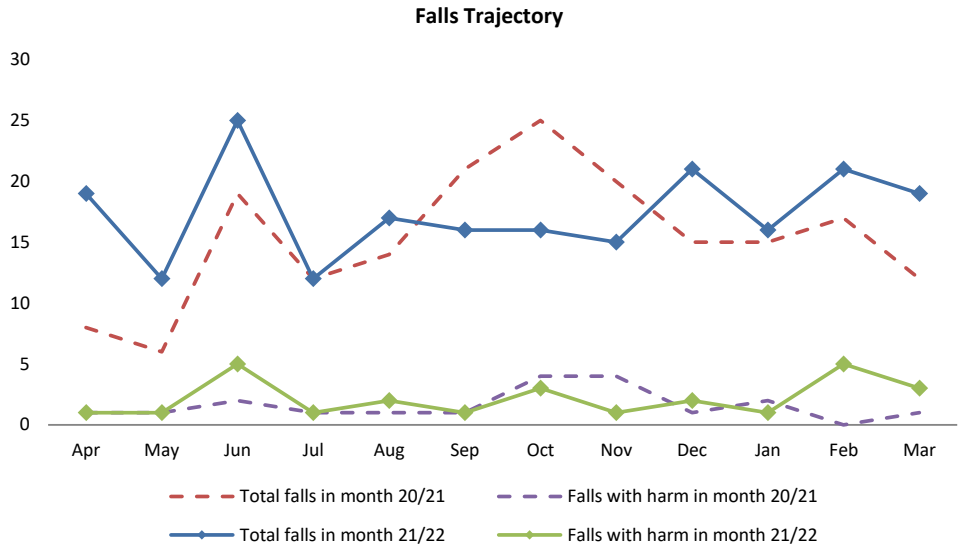
Cancelled Operations: The number of cancelled operations in Q4 2021/22 has reduced compared to Q3 in 2021/22.

	Number of non-clinical cancellations
Q3 2021/22	37
Q4 2021/22	20
Variance	-17



Safety Indicators

Patient Falls: Goal is to achieve a year on year improvement with the prevention of falls and falls with harm.

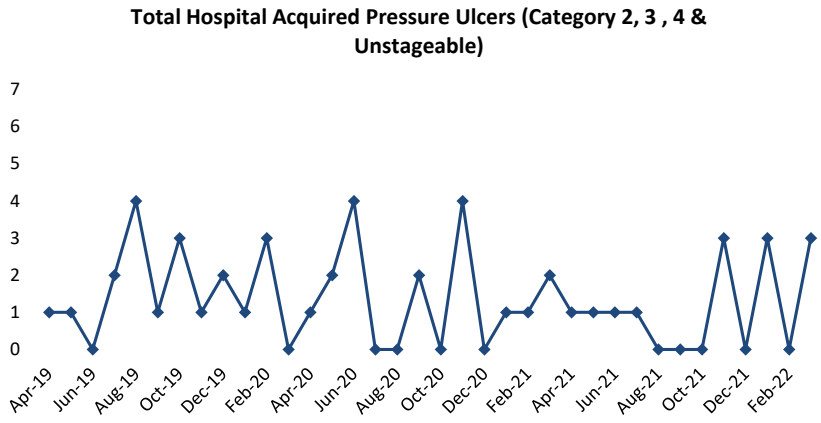


In 21/22 there has been 209 total falls of which 26 resulted in minor harm or above. This compares to 184 total falls at during 20/21.

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.

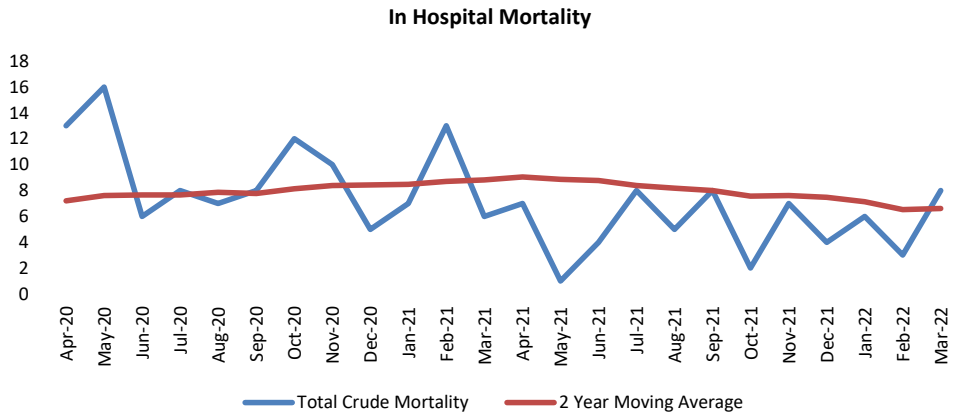
Pressure Ulcers

In Q4 2021/22 there were six Walton Centre acquired pressure ulcers.
Below is a graphic representation of the position to date



Mortality

Rolling crude mortality reduced in March 22. All cases are subject to detailed clinical review and discussion at Quality Committee and no cause for concern identified.



Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 27/4/2022		**Report of:** Business Performance Committee
Date of last meeting: 26/04/2022		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report March 2022 • Transformation and QIP Quarterly Report • Cost Improvement Programme 2022-23 • Analysis of Long Term Sickness Absence Report • Response to People Plan and Annual Trust Staff Survey 2021-22 • Health and Wellbeing Strategy 2022-23 • Digital Aspirant NHSX Monthly Update • Trustwide Risk Register for Neurology Risks • Cycle of business 2022-23 • Operation Plan (Final) 2022-23 • Commercial Contracts Strategy and Review (Procurement Department) • Orthotics Services Contract • Sub-committee Chair's Reports for 6 sub-committee meetings
2	**Alert**	• The 'final' finance plan for 2022/23 has been submitted and The Walton Centre plan is based on assumptions in the planning guidance, apart from utilities costs, given the specific pressure in this area. Achieving the Income & Expenditure plan will require stretching activity targets to be met, staff availability to be high and efficiency savings of 3% of turnover to be realised, amongst other risks. The capital allocated to the Trust is significantly less than the internal plan which has already been challenged down. • Sickness remains abnormally high with Covid related clusters continuing to disrupt the achievement of activity targets, notably in theatres. Activity targets are premised on Covid being effectively behind us, whereas in reality with regard to staff availability it is not.
3	**Assurance**	• Activity performance for cancer, diagnostics, activity restoration were all meeting plan in March. RTT stops missed target in the month but met target for the full half year. • The proportion of patients on PIFU (Patient-Initiated Follow-Up, part of outpatient transformation) increased to meet the year-end target, as it was extended to further services. • Theatre activity remains affected by staff sickness. Follow-up outpatients not attending appointments has increased, especially for virtual appointments, and is subject to a focused piece of work to improve. The number of long waiters >52 weeks has progressively increased over the last 3 months, although very long

		>104 week waiters has reduced to 3. • Sickness remains high at 8%, around 40% of which is short-term and around 60% are long-term cases. Of the latter, 85% are front-line clinical staff. Assurance was provided on how long-term sickness is managed. • Staff appraisal completion rates and mandatory training compliance both remain below minimum threshold targets. • Income & Expenditure outcome for the full year was at break-even position, in line with plan, achieving a key short-term priority. • A very significant capital spend of £5.3m in March ensured that the plan for the year was achieved. This is an important achievement given the much lower allocation currently for 2022/23. • On-time payment to creditors remains below target (Better Payments Practice Code), markedly so for payments within NHS. Action has now been requested by the regional NHS finance team. Issues centre particularly on disputed and late payments to/from Liverpool University Hospitals NHS Foundation Trust. An action plan is being compiled which will be shared with the Chair of Audit Committee. • The bed repurposing project centred on expanding the Rapid Access to Neurological Assessment (RANA) service is well advanced. There is line of sight of significant benefits including improved service and patient experience, reduced length of stay and other efficiency improvements, staff wellbeing benefits and reduced cost. It is planned to conduct a benefits realisation review after the changes have been fully implemented and consolidated. • Assurance was given on a project approach to steering how the Cost Improvement Plan (CIP) target challenge for 2022/23 is being addressed. There is line of sight on the majority of the target and ideas are continuing to be formulated. Procurement's contribution to this, as part of establishing economy of scale leverage across Health Procurement Liverpool (HPL), was explored with good oversight of Trust contracts and pro-active approach to future procurement processes demonstrated. • End-year progress against implementing the people plan was reviewed, providing assurance of good progress in most aspects. • Good progress in implementing the Digital Aspirant project continues.		
4.	**Advise**	• The proposed Health & Wellbeing strategy was considered and enthusiastically recommended for approval at Board as soon as the agenda can accommodate. • A business case to place the Orthotics service contract on a national NHS framework, pending a potential system collaborative contract tender, was approved. This will achieve a 10% saving on current costs.		
5.	**Risks Identified**	• Review of the neurology division risk register centred on the potential impact of consultant vacancies on the epilepsy service. A paper is to be presented to the Executive Team on 21 May 2022 with a plan to mitigate the risk around this issue. • In order to monitor progress on the increase in patients on the Follow Up Waiting List in Neurology (FOWL) the Committee requested a report be presented once full validation of all the entries had taken place. The appointment of a member of staff to the Neurology team solely assigned to this task would expedite matters and a report was expected in 3-6 months.		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 26/5/2022		**Report of:** Business Performance Committee
Date of last meeting: 24/5/2022		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report April 2022 • Capital Programme 2022-23 • Estates & Facilities Annual Report Follow-Up • People Pulse Survey Report • Digital Aspirant NHSX Monthly Update • Resilience Planning Group – Terms of Reference • Digital Aspirant Funding x 3 staffing resource business cases • Consent Agenda – Feedback from incident at LWH • Sub-committee Chair's Reports for 5 sub-committee meetings
2	**Alert**	None
3	**Assurance**	Integrated Performance Report • Activity performance for cancer, diagnostics and the trajectory for reducing long waits all met plan in April. • Activity restoration met target for day cases but was behind target for elective and new outpatients, largely caused by staff sickness. It is believed that most regional trusts struggled similarly. The Trust did not meet its Elective Recovery Fund financial target for M1 due to the weighting in the ERF calculation given to elective work which the Trust did not achieve. This was primarily due to Covid related staff sickness in theatres and the Trust has the opportunity to recover this by the end of Q1 and still achieve the ERF. • Sickness remained high at over 7% in April, although was starting to fall during May. • Staff appraisal recorded completion rate remains well below the minimum target; progress from the current leadership focus on this will be reviewed next month. • Nursing turnover has stabilised at around 14% (broadly the long-term average) but corporate / administrative turnover has continued to rise since last summer, now 18%. • I&E was in line with plan. Loss of income from ERF and under performance due to lower activity was mitigated through reduced costs from activity and planned phasing of costs. Income and expenditure were also both impacted by the delay of transferring some of the Health Procurement Liverpool staff and the transfer of the spinal activity from LUHFT.

		• On-time payment to creditors remains below the targets of the Better Payments Practice Code, but this has started to improve and there is an action plan in place.		
4.	**Advise**	• The content of April's quarterly People Pulse Survey was reviewed in depth and received enthusiastically. There were 236 participants which was still low, but more than double the previous highest response and enough to provide meaningful insights, together with some benchmarking comparisons, and some valuable narrative comments on feelings and feedback to leadership. The insights and issues highlighted will be explored further in forthcoming staff engagement sessions and taken into the People action plan. This promises to become a valuable 'low maintenance' quarterly feedback tool from which leading indicators can be derived and action taken much quicker than from the annual full People Survey. • The capital budget allocated by the ICS is currently £4.4m, versus an internal demand of £6.4m (which has already been reduced by challenge and rephasing). A bid has been made for a second tranche of budget allocation, the outcome of which is expected soon. • A review of how the Trust's estate compares against national assessment methodologies and benchmarks (integrating insights from the Premises Assurance Model, 6-Facet Survey, Estates Return Information Collection (ERIC) and Model Hospital) has been requested for a meeting in the autumn. • Three business cases to continue to resource the Digital Aspirant project implementation were approved. • Some learning from the incident at Liverpool Women's Hospital in November 2021 relating to improving resilience was noted.		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre
NHS Foundation Trust

Board of Directors' Key Issues Report

Report Date: 07/04/22		**Report of:** **Quality Committee**
Date of last meeting: 17/03/22		**Membership Numbers:** 15
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Medical Director's update • Integrated Performance Reports & KPI Reports • Quality Presentation by the MS ANP Lead • Quality & Clinical Strategy update • MiAA Recommendations for Annual Programme • Quality Impact Assessments • Quarterly Trust Risk Register • CQC Insight Report • Quarterly Pharmacy KPI Report • Pharmacy Review on Critical Care • In-Patient Survey Improvement Plan • Board Assurance Framework • Quality Committee Effectiveness Review & Terms of Reference • Quality Committee Cycle of Work • Health, Safety & Security Group Terms of Reference • Sub-Committee Chair's Reports
2.	**Alert**	• No alerts to report
	Assurance	• The Integrated Performance Report highlighted improvements in FFT feedback in both of the Neurology & Neurosurgery Divisions. The Neurology division has also seen improvements in tissue viability incidents. Focused work on patient falls, nutrition and hydration within both divisions is underway. There is also a continued focus on improving patient risk assessment scores. Neurosurgery teams noted the challenge of infection prevention with teams focussing on a return to the basics for infection control • Mortality figures on the RAMI have returned to the normal figures and remain low in comparison to other Trusts • Due to current over-establishment in medical training posts it has been easier for medics to attend training. It was noted that the medical turnover metric has limited value • The Advanced Nurse Practitioner Lead presented how the Multiple Sclerosis (MS) Team deliver a quality service across the six sites within the region. The

		Committee noted the positive impact the team and the services provided has on patients • BAF risks reviewed for end of year and recommended to Board for approval.		
	Advise	• The patient story highlighted the different expectations patients hold with regards to the service received. Expectations and perspectives with regards to a good quality service were discussed and it was noted that the further work in respect of "what good looks like" is underway by the Executive Team. • The Care Quality Commission (CQC) Insight Report was presented in a new format which was welcomed. The Central Alerting System (CAS) data is being verified and will be raised with CQC if it is not accurate. The Head of Risk advised that CAS alerts will now be monitored via the Clinical Services & Effectiveness Group and actions put in place to ensure alerts are closed within specified deadlines. • Pharmacy Review on Critical Care regular report update was provided, following past CQC input with regards to establishing a 7 day service. A recent Specification review on Critical Care recorded compliance with current provision. As different measures are being used, this issue is to be discussed further with the CQC and with the Critical Care Network. • The Quality Committee Effectiveness Review highlighted areas for improvement which included the quality of reports. A new board report template will be implemented on 01/04/22 to aid improvements in structure. A review of the QC cycle of business will ensure that sufficient external third party reviews are included. Committee membership to be reviewed in three months.		
2.	Risks Identified	None		
3.	Report Compiled by	Seth Crofts Acting Chair	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 05/05/22		**Report of: Quality Committee**
Date of last meeting: 21/04/22		**Membership Numbers:** 16
1.	**Agenda**	The considered an agenda which included the following: • Patient Story • Medical Director's Update • Integrated Performance Report & KPI Reports • Quality Presentation Neuropsychiatry Team • Quality Account Priorities Update • Tissue Viability Quarterly Report • Closure of CQC Action Plan • Pathology Quality Assurance Dashboard • External Visits with regards to Quality • Infection, Prevention & Control Terms of Reference • Subcommittees Chair's Reports
2.	**Alert**	**Medical Director's Update** • The first patient underwent MR Guided Ultrasound treatment led by Mr Farah. The procedure was successful. The patient was very pleased with the outcome **Integrated Performance Report** • Mortality rates noted an improvement. Compared to peers, WCFT has performed significantly better. RAMI data discussed further as to how assurance can be gathered so other Trusts can recognise how low rates are achieved at WCFT. • Neurology Division reported a moderate harm patient fall. The patient suffered a fracture of the L3 spine having lost their balance in during a physio session. The rapid review noted no lapses in care • Neurology Division received a complaint with regards to disclosure of sensitive information pertaining to gender. The complaint is under review and it was agreed that important lessons should be learnt from this and highlighted the need for future training. The ED,& I lead is aware of the complaint
	Assurance	**Integrated Performance Report** • Divisional Teams presented the IPR noting positive improvements with regards to increases in Friends & Family Test responses and compliance with risk assessments and NEWS scores. The 104 week waiting list has been reduced to 3 patients with the aim to be at zero by July 2022. The report highlighted on- going work in relation to bed repurposing and noted the priorities of falls prevention, nutrition & hydration and infection, prevention and control.

		• **Tissue Viability Report -** the Q4 report noted a slight increase for the number of verified pressure ulcers for 2021/22 of 19 compared to 18 the previous year. There were 2 unverified cases in 2021/22 compared to 5 cases in 2020/21.. This increase is most likely due to the deep dive undertaken by the TVN. The TVN has successfully engaged with ward staff achieving positive results on Lipton Ward. Similar work is to be undertaken on Chavasse Ward. Education for the year is planned, TV link nurses on the wards have been assigned and TVN is also planning to work with surgical teams. • **Quality Presentation - The Neuropsychiatry Team** provided a presentation with regards to the work of the Neuropsychiatry In-Patient Service. The service has expanded with activity in 2021 at 1751 in patients and 493 out patients. These figures are set to increase in 2022. The extended services means in-patients are seen quickly which can help to prevent violence and aggression incidents and provides welcome support for ward staff. It was noted that outcomes/benefits are hard to measure within certain fields which is an area for development • **Pathology Quality Assurance Report –** the report was discussed and noted • **Closure of CQC Action Plan -** the Committee received assurances that all of the actions from 2019 CQC action plan had either been closed or moved to usual business		
	Advise	• **The Patient Story** -advised the committee of a patient who was identified to attend face to face PMP service. Arising from a previous trauma, the patient was unable to wear a face mask or clear visor which breached the conditions of attendance. The patient was temporarily removed from the programme whilst Trust policies were investigated. The IPC Lead provided assurances that treatment within WCFT is not withheld if patients are exempt and unable to wear PPE. The story identified communication issues with clinical/divisional teams and the patient. The policy has been revised and shared with Trust staff and the patient will be re-invited to attend the PMP programme face to face. • **The Quality Account Priorities** for 2021/22 were accepted as closed. There are some outstanding actions which require further work. • **The Infection Prevention & Control (IPC) Terms of Reference** were presented. Following some minor amendments, the IPC ToR were approved • **Arising from IPCC Chair's Report** it was noted that the Draft IPC Strategy is being presented to various groups for comment and feedback. Further discussion ensued regarding MSSA rates at WCFT in comparison to other Trusts as WCFT is an outlier for MSSA. A breakdown of MSSA data into contaminants and MSSA cases to be included in IPR for QC next month • **Organ Donation Committee** now has a new Chair – NED – RW and new clinical lead – Jenny Burgess. • **There were no external visits** to the Trust this month		
2.	Risks Identified	• No new risks identified		
3.	Report by	Ray Walker	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 09/06/22		**Report of:** **Quality Committee**
Date of last meeting: 19/05/22		**Membership Numbers:15** **Quorate**
1.	**Agenda**	The Committee considered an agenda which included the following: • Patient Story • Quality or Risks for escalation to Quality Committee • Integrated Performance Report/Divisional KPI Reports • Governance, Risk and Patient Experience Annual Report • Mortality & Morbidity Q4 report • Safeguarding Annual Report • Quality Accounts – Full Final Draft • PLACE - Lite Report & Action Plan • Infection, Prevention & Control Q4 & Annual Report • External Visits Regarding Quality • CQC – Bi-Monthly Report • Quality Committee Cycle of Business • Sub-Committee Key Issues Reports to Quality Committee
2.	**Alert**	**Quality or Risks for Escalation to Quality** • There is a national shortage of Omnipaque Contrast and supplies are not expected until June. This is the only licensed drug and there is no alternative. The Divisional Team is conducting a risk analysis. Currently there is approximately 3 weeks supply in stock. Patients will not be advised until risk analysis has been completed. **Integrated Performance Report – Bed Repurposing** • It was noted that bed repurposing is going well with little or no disruption or disturbance to patients. However, patient capacity on Lipton Ward is currently 9 patients as opposed to 10 patients as work is on-going to make an area more functional for patients. The issue has been escalated to the Rehab Network. Should demand for the 10th bed be required, this can be accommodated Following the QC meeting it was confirmed that the ward now has returned to the full ten-bed capacity **CQC Insight Report** • Key message in the report indicated Safe performance as declining. This was attributed to two Never Events and outstanding CAS alerts (Central Alerting System) for which updates were provided to CQC at the last engagement meeting in April. Safe performance status is expected to improve in the next quarter

	Assurance	**Risk, Governance & Patient Experience Annual Report** • MiAA awarded highest assurance in relation to the Trust complaints process and 100% of Trust KPI for acknowledging and responding to complaints achieved in 2021/22 • Specialised Commissioners deemed the Botox incident to be a Never Event • Substantial progress has been made to reduce the number of outstanding incidents with all serious incidents and historical incidents being closed • Individual annual reports for Risk & Governance and for Patient Experience will be submitted for 2022-23 **Mortality & Morbidity Q4 Report** • The report noted a reduction in the number of deaths in the past 12 months • Mortality reporting progressing well with the new process. Delays are currently with the Coroner are from Oct due to Covid-19. However, contact with patients affected by such delays, is maintained by Patient Experience Team • Mortality Compliance stands at 90% with 7 outstanding for this quarter • Positive feedback has been received from families and staff via the Medical Examiner **Safeguarding Annual Report** • Partial Assurance was noted due to changes to the Inter-Collegiate document impacting negatively on Safeguarding Training KPI compliance. Increased training is now required. A training action plan has been implemented. The CCG are aware and are satisfied with work completed to date. • Liberty Protection Safeguards is expected to be implemented in April 2023 with consultation closing in July 2022 • Significant work has been undertaken with regards to Learning Disabilities and Autism • The Safeguarding Team has been asked to share learning arising from complex cases with wider external stakeholders. **Infection, Prevention & Control Q4 and Annual Report** • A 20% reduction in the number of MSSA incidents in comparison to the previous year. WCFT is no longer an outlier for MSSA & CDT within the region • There have been no incidents of MRSA since November 2017 • Flu Campaign for 2021-22 only reached 59% against 80% achieved in the previous year . Plans for a WCFT campaign for this year are underway • The IPC Strategy is under review following circulation for comments • Hand Hygiene remains a basic focus for all who work in the Trust		
	Advise	**Quality Accounts** • The final Quality Accounts were ratified by the Quality Committee with the recommendation for final approval by Trust Board • Updates for outstanding actions will be delivered quarterly at Quality Committee		
2.	Risks Identified	• See risk above in alert section (first bullet point)		
3.	Report Compiled by	Ray Walker	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Report to Council of Governors
14th June 2022

Report Title	Quality Account 2021/22
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Julie Kane, Quality Manager and Freedom to Speak Up Guardian
Action Required	To note

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

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

Key Messages *(2/3 headlines only)*

- The aim of the quality report is to improve public accountability for the quality of care. The report comprises the requirements for the quality account as required by the NHS Act 2009, in the terms set out in the NHS (Quality Accounts) Regulations 2010.
- The report provides updates relating to priorities set for 2021/22 and confirms what priorities have been agreed for 2022/23

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

- The final version of the Quality Account will be presented to the Trust Board on June 2022 and then published on the Trust website

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

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

001 Quality Patient Care	004 Operational Performance	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Audit Committee	17th May 2022	Julie Kane, Quality Manager and FTSUG	
Quality Committee	19th May 2022	Julie Kane, Quality Manager and FTSUG	
Patient Experience Group	19th May 2022	Julie Kane, Quality Manager and FTSUG	
Council of Governors Advisory Group	23rd May 2022	Julie Kane, Quality Manager and FTSUG	

Quality Account

Executive Summary

1. The Board undertook a full review of quality priorities used by the Trust for the previous financial year and agreed further improvement priorities.

2. Nine improvement priorities were agreed with various stakeholders for 2012/22 and have been focused upon throughout the year.

3. Each of the priorities fall into three domains including Patient Safety, Clinical Effectiveness and Patient Experience. Overall 5 of the priorities were achieved, 2 partially achieved and 2 not achieved.

4. The Trust participated in 100% of national clinical audits and 100% of national confidential which were eligible.

5. All Commissioning for Quality and Innovation (CQUIN) activity was suspended during COVID-19.

6. The CQC has not taken enforcement action against The Walton Centre during 2021/22.

7. Merseyside Internal Audit awarded the Trust 'High Assurance' following an external audit related to the complaints process stating there was a strong system of internal control which has been effectively designed to meet the system objective.

Background and Analysis

8. The aim of the quality report is to improve public accountability for the quality of care. The report comprises the requirements for the quality account as required by the NHS Act 2009, in the terms set out in the NHS (Quality Accounts).

9. The agreed quality improvement priorities contain specific indicators which have been monitored over the last twelve months to provide evidence of sustainable improvement.

10. Performance has been managed through Board Committees. Operational groups within the Trust have been responsible for the implementation of the quality priorities and reporting to Committees as required.

11. The External Auditors, Grant Thornton were not required to audit the priorities in the year due to the pandemic. Merseyside Internal Audit Agency (MIAA), the Trust's internal auditors, will re-engage with the Trust in 2022/23 to fulfil the requirements as set out by NHS England and NHS Improvement (NHSIE).

Conclusion

12. The Quality Account provides information and data on the Trusts performance and achievements during 2021/22.

13. Despite the pandemic The Walton Centre prioritised patient and staff safety however this meant that not all of the priorities were achieved.

14. Commissioners, local Healthwatch organisations and overview and scrutiny committees have been asked for commentaries on the 2021/22 Quality Accounts which will be included in the final version of the report. The Council of Governors Advisory Committee have also provided a summary on behalf of the Council of Governors

Recommendation

The Council are asked to note the report.

Author: **Julie Kane, Quality Manager and Freedom to Speak Up Guardian**
Date: **7th June 2022**

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Account

2021 – 2022

Part 1 Statement on Quality from the Chief Executive

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

Improvement Priorities

2.1 Update on Improvement Priorities for 2021–2022

2.1.1 Patient Safety
2.1.2 Clinical Effectiveness
2.1.3 Patient Experience

2.2 What are our priorities for 2022-23?

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 2021/22

Part 1 Statement on Quality from the Chief Executive

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

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

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

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

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

In addition, this year the Trust have achieved:

- NHSX Digital Aspirant funding will mean more integrated health care for patient of The Walton Centre
- MS Awareness Week – FACETS (Fatigue: Applying Cognitive Behavioural and Energy Effectiveness Techniques to LifeStyle) Programme
- New spinal clinic in North Wales bringing care closer to home
- Families continuing to save and improve lives through deceased organ donation
- Staff and supporters take a leap of faith for charity
- Making it to the Tokyo Olympic Games
- Patient drinks innovative 'pink drink' helping surgeon remove brain tumour
- International Nurses made The Walton Centre their home
- The Walton Centre awarded Tessa Jowell Centre of Excellence Status
- New neurology assessment eases bed pressures in Cheshire and Merseyside hospitals
- Enhanced Thrombectomy service
- The Walton Centre and UCLan leading pilot study into innovative digital stroke rehab tool

Quality initiatives are discussed and debated through various local meetings, reporting up to committees including the Audit Committee, Quality Committee and Business & Performance Committee in order to ensure that quality assurance is achieved. These Committees report to Trust Board to ensure that patient safety is a priority and is progressed in a timely way.

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

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

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

Jan Ross, Chief Executive

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

Towards the end of each financial year, the Trust worked closely with various stakeholders to identify areas of focus for improvement for the forthcoming year. At this time it also allowed the Trust to reflect on the year's previous performance against the identified quality improvement priorities. The NHS has seen a very different year in 2021/22 due to the pandemic however in spite of this; the hospital remained focussed on delivering outstanding care and supporting patients from other organisations during the difficult times.

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

All of the priorities were identified following a review by Trust Board on the domains of quality reported in 2020/21. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focussing our priorities for 2021/22.

The Trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care. The following section includes a report on progress against the three improvement priority areas for 2021/22.

2.1 Update on Improvement Priorities for 2021–2022

In December 2021 the Council of Governors and in February 2022 the Board of Directors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each priority was on target. At this review, quality priorities were identified and agreed for 2022/23. The improvement priorities all contained specific indicators which have been monitored over the last twelve months to provide evidence of sustainable improvement.

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

2.1.1 Patient Safety

Priority: Reduce pressure ulcers

Reason for Prioritising:
Pressure ulcers are preventable and there is a need to ensure patient harm is reduced and nursing standards of care are improved. During 2020/21 there were a total of 18 hospital acquired pressure ulcers. To have an overall 10% reduction in the number of hospital acquired pressure ulcers compared with the 2020/21 year end position and to have maintained zero tolerance of category 4 pressure ulcers across the Trust.

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

Priority: Redevelop Pain Management Programme (PMP)

Reason for Prioritising:
Due to the Covid-19 pandemic and the need to work differently and restart services, an online PMP programme was designed. To support the delivery of the Pain Management Programme in the current climate, the programme will be reviewed and re-developed and provide video conferencing and an interactive online group course.

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

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

Priority: Improve Patient Flow Across the Trust

Reason for Prioritising:
Optimisation of the patient's journey to remove any unnecessary steps from the pathway will allow us to deliver care in the right place, at the right time and enable patients to return to their usual place of care in a timely manner. Explore different ways to improve patient flow across the Trust. Streamline how bed and staff meetings are held and allow proactive management of any delays or issues.

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

2.1.2 Clinical Effectiveness

Priority: Introduce Patient Initiated Follow Up (PIFU)

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

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

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

Priority: **Increase Outpatient Appointment Slot Utilisation**

Reason for Prioritising:
This will help ensure effective use of resources, by increasing slot utilisation. This will increase the number of patient appointments for both new and follow up slots and ensure the most appropriate use of clinicians time. Increase outpatient slot utilisation by 5% during 2021/22. This will improve efficiency and aid the reduction in waiting times.

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

Priority: **Implement Inventory Management System**

Reason for Prioritising:
To provide Trusts with improved patient level costing information. eDC Gold enables products to be tracked to the patient and also provides greater operational inventory visibility on stock holding and expiry for Trusts. Implement the Electronic Demand Capture (EDC) and EDC Gold inventory management system. EDC - primary means of demand capture and order creation and is typically used for low value, high volume products (standard ward/ theatre consumables). EDC Gold - module within EDC providing inventory management visibility and control and is used for high value, low volume products. The outcome of effectively using the system will include improved patient safety and provide detailed patient costings. Standardised approach across NHS organisation - eDC is used in 90% of NHS trusts and eDC Gold is live in 30 NHS trusts.

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

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

2.1.3 Patient Experience

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

Reason for Prioritising:
Workforce Race Equality Standards data shows that Black and Asian Minority Ethnic staff experience higher rates of discrimination, harassment and bullying. National data on health inequalities relating to race consistently shows poorer outcomes for many Black, Asian and Minority Ethnic communities and patients.

Trust patient monitoring indicates that fewer Black and Asian Minority Ethnic patients are referred to the Trust than we would expect given the racial demographics of North West England. In light of the disproportionate effect that Covid-19 has had on Black, Asian and Minority Ethnic communities, patients and staff, the Trust will prioritise the wellbeing of Black, Asian and Minority Ethnic patients and staff in relation to its Covid-19 response and post Covid-19 systems recovery. Review progress/ set stretch ambitions to improve wellbeing and equality of BAME staff and patients. Set measurable ambitions and monitor progress at the Strategic BAME Advisory Committee which has recently been launched. Demonstrate that there is no significant difference in the reported wellbeing of staff and patients in relation to Covid-19 and race and ethnicity. The Trust should also be able to demonstrate an increase in the percentage or Black, Asian and minority ethnic patients attending the hospital to a figure closer to the percentage for the Black, Asian and minority ethnic population in Cheshire and Merseyside which stand at 4.5%

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

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

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

Priority: Provide Mental Health First Aid (MHFA) Training

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

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

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

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

Reason for Prioritising:
To ensure we maximise the utilisation of our theatres and expertise of the staff who work there, which in turn will allow them to deliver outstanding patient treatment and care in an efficient and effective way. Conduct a review of the Team Brief process to ensure theatre lists start on time. Review the recovery process and time spent in recovery. Review how the Trust can set up a designated area for same day discharges.

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

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

2.2 What are our priorities for 2022 – 2023?

In December 2021, the Council of Governors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each indicator was successfully implemented and monitored. After this review, quality priorities were identified and agreed for 2022/23 with the Quality Committee, Health watch and Specialist Commissioners identifying the final priorities from those initially identified by the Council of Governors.

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

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

How progress to achieve these priorities will be reported:

Committees have been reinstated at The Walton Centre (following the pandemic) and updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Quarterly quality meetings are held with the commissioners (via MS Teams) to review quality assurance and provide external scrutiny and performance management. Due to Covid-19, Merseyside Internal Audit Agency (MIAA) did not undertake audits or provide assurance on the Quality Account via the Audit Committee.

2.2.1 Patient Safety

Priority: 98% completion of MUST within 12hrs of ward admission and compliance with weekly MUST re-assessment

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

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

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

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

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

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

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

Priority: Introduce Same Day Admission/ Discharge (surgery)

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

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

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

2.2.2 Clinical Effectiveness

Priority: Introduce Nutrition Champion Training Programme

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

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

Each area to have a nutritional champion lead

Priority: Implement Virtual Reality (VR) Simulator

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

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

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

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

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

2.2.3 Patient Experience

Priority: Develop Training Programme Cheshire and Mersey Rehabilitation Network

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

This will improve the experience of patients and service delivery.

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

Priority: Introduce Staff Training to Support People with Communication Difficulties

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

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

Priority: Reduce the Number of Complaints

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

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

2.3 Statements of Assurance from the Board

During 2021/22, The Walton Centre provided and/or sub-contracted four relevant health services:

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation

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

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

2.3.1 Data Quality

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

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

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

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

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

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

2.3.2 Participation in Clinical Audit and National Confidential

During 2021/22, 8 national clinical audits and 1 national confidential enquiry covered relevant health services that The Walton Centre provides.

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

The national clinical audits and national confidential enquiries that The Walton Centre was eligible to participate in during 2021/2022 are as follows:

2.3.3 National Audits

- Adult Critical Care (ICNARC / case mix programme)
- Severe Trauma – Trauma Audit & Research Network (TARN)
- National Emergency Laparotomy Audit (NELA)
- The Sentinel Stroke National Audit Programme (SSNAP)
- National Audit of Care at the End of Life (NACEL)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- National Comparative Audit of Blood Transfusion (NCABT)
- National Neurosurgery Audit Programme (NNAP)

2.3.4 National Confidential Enquiries

- Epilepsy

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2021/2022 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit	Participation	% Cases submitted
Acute care		
Adult Critical Care (ICNARC / Case Mix Programme)	Yes	100%
Severe Trauma (Trauma Audit & Research Network)	Yes	100%
National Emergency Laparotomy audit (NELA)	Yes	0% (1 eligible case)
The Sentinel Stroke National Audit Programme	Yes	93%
National Audit of Care at the End of Life (NACEL)	N/A	100%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
National Comparative of Blood Transfusion (NCABT) – 2021 Audit of patient blood management and NICE guidelines	N/A	N/A
Older people		
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	N/A	N/A – No WCFT cases met the inclusion criteria which are those over 60 years of age and have fallen and fractured their hip
National Confidential Enquiry into Patient Outcome and Death		
Epilepsy	Yes	100%

The reports of 3 national clinical audits were reviewed by the provider in 2021/22 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

National Audit	Actions
Adult Critical Care (ICNARC / Case Mix Programme)	• Findings are discussed quarterly • The Trust will continue participating in the ICNARC/Case Mix Programme by submitting data for all patients admitted to Critical Care

Severe Trauma - Trauma Audit & Research Network (TARN)	• The Trust will continue to submit data to TARN and will review individual cases as appropriate
The Sentinel Stroke National Audit programme (SSNAP)	• All WCFT thrombectomy cases are reviewed at the Regional Thrombectomy MDT group. • The regional MDT group identify and discuss potential areas for improvement across the patient pathway

2.3.5 Participation in Local Clinical Audits

The reports of 90 local clinical audits were reviewed by the Trust in 2021/22 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:-

Neurology Clinical Audits & Service Evaluations

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

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

ward (N 344)	nutrition champions are assigned
Review of bowel management in Neurorehabilitation (N 296)	• Present audit findings to nursing and medical teams, to generate discussion • Share findings with dietetic team to allow consideration of similar project in acute teams. • Update stool chart and present to team for consideration
Review of Anthropometric measures in Horsley ICU (N 329)	• Immobile patients not weighed on admission to ICU • Weight obtained – to be documented on daily monitoring form • Patients requiring weekly weights highlighted at weekly MDT • Dietitians provided training to ICU staff on transfer weighing scale for immobile patients • Presented to ICU Operational Group • Audit undertaken – all actions complete
Evaluation of medical interruptions to rehabilitation within CMRN that exceeded 14 days (N 318)	• Collecting more data on those patients discharged during their interruptions - The CMG continue to review all interruptions at the monthly meetings and report any issues or recommendations to our strategic board
Audit of MRI examinations confirming radiographer administration of contrast agent (N 336)	• Staff reminded to detail contrast agent information on radiology computer system
Exploring the prognostic value of electroencephalogram for patients with Hypoxic ischaemic encephalopathy out of hospital cardiac arrest (N 339)	• No actions necessary
Gastrostomy placement: are we meeting NICE guidelines? (N 315)	• Benchmark against referral times/processes in similar settings • Develop flow-chart to inform gastrostomy referral discussions/referrals • Gain consensus on pathway from wider clinical team • Implement flow chart/pathway at WCNN • Present this audit to wider clinical teams • Deliver training at Therapies CPD session • Discuss at CMRN Hub Op meeting • Discuss at SLT/Dietitian team meetings
Audit of acknowledgement of urgent reports (N 353)	• Email team responsible for signing the unsigned report • Audit results to be discussed at next audit meeting with the issue highlighted to clinical leads. Clinical leads to disseminate across their divisions. • Ensure signing off reports promptly is covered during junior doctor's induction either as part of radiology or other (e.g. IT/ep2) presentation.
Evaluating the management team of psychosis and cognitive decline in Parkinson's disease patients (N 249)	• No actions identified

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

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

Neurosurgery Clinical Audits & Service Evaluations

Audit title	Actions
Compliance of trust guidelines regarding transfusion related investigations for non-Instrumented lumbar spine surgery (NS 120)	Establish local guidelines with respect to pre-operative need for group and save/crossmatch in patients undergoing single level decompressive surgery Create awareness and educate ward staff and doctors about above agreed guidelines Re-audit to confirm compliance
Oral ketamine to support outpatient and inpatient opioid weaning (NSRP 5)	Patient information leaflet developed and completed Prospective data collection in addition to prescribing database Key points for data collection on EP2 to be agreed. LFT and ketamine level on TD web Present to the headache group
GlobalSurg/Covid-19 Surg Week (NS 306)	Where possible, surgery should be delayed for at least 7 weeks following SARS-CoV-2 infection. Patients with ongoing symptoms ≥ 7 weeks from diagnosis may benefit from further delay. No Actions to arise

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

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

Audit of tracheal tube length om ventilated patients on ITU (NS 205)	Discussed at ITU op group, felt the best way of implementing change would be to change the wording on the ITU chart where this daily check is documented to include “measured at teeth” where before it read “measured at” leaving this open to interpretation. Once the charts are in circulation. I will send an email to all on Horsley and the ACCP team will inform staff on the daily rounds
Outcomes of surgical management of glioblastomas and cerebral metastases in patients over 75 years old (NS 245)	No actions necessary
Laterality of ACDF (NS 297)	No change of practice is needed as results very much reflect findings in the literature – nil actions
Re-audit of spinal deformity practice (NS 301)	No actions necessary
Immunology vertical audit 2020 - Anti-AChR (NSRP 18)	Technidata to update collating order on worksheet. Review stock levels over periods of absence such as public holidays. Raised as a staff suggestion ES92.To be considered on the next update of the intranet and internet departmental web page.
Seizure Kits audit (NS 313)	Produce a list of emergency kits available in the Trust, their contents, location where they are stored and how they should be refilled/replaced if the seal is broken or the expiry date has passed. The list should be available on the intranet. Explore the possibility of Pharmacy Department replacing used or expired Seizure Kits – update pharmacy will take over supplying seizure kits Re-instate the SMART lead audit of emergency trollies. Information provided to new staff on induction. Cascade of information to existing staff via Ward Managers.
Local Audit of Care at the End of Life (LACEL) (NS 368)	Limited information on previous National Audit of Care at the End of Life, therefore not able to make full direct comparisons to note improvement or areas for development with all aspects of end of life care. To complete in National Audit of End of Life Care Round 3
Managing Perioperative Normothermia (NS 352)	Audit temperature of fluid warming cabinets. Discussion to be had with procurement regarding obtaining surgical access blankets therefore preventing the need for them to be cut.
IMMU/72 How often is a well characterised paraneoplastic anti-neuronal antibody identified in a regional neurological centre (NS 272)	No actions necessary
Clinical Management:	The Environmental temperature of Recovery is not

Perioperative patient care, Post-anaesthetic Care 2020 (NS 351)	always between 19-22 degrees for adequate ventilation – heating systems now upgraded by estates, additional heaters can also be provided No universal Padded cot sides available. Blankets to be used instead to pad cot sides
Development of a prognostic score to reduce avoidable referrals for mild Traumatic Brain Injury (TBI) (NS 246)	Submit ethical approval/audit approval for prospective testing of the score Notify audit department when accepted paper has been published Begin plans to develop long-term prospective study of the scoring system
HTA 63 Traceability Audit 2019 (NS 288)	All Neuropathology staff reminded of importance to complete tracers and place in the file. All Neuropathology staff reminded to check each individual slide number and not presume all slides in a slide tray are from the same case. Slide file will not be so tightly filled and file drawers to be labelled annually when the majority of slides have been filed. Process of refiling slides for National External Quality Assurance Scheme (NEQAS) back with the original case rather than in a separate EQA file reinforced with staff. Monitor return of slides from Haematological Oncology Diagnostic Service (HODS) in next audit following the service move earlier this year. Neuropathology staff to add haematoxylin and eosin (H&E) to the Laboratory Information Management System (LIMS) if required as part of a molecular test. Test panels will be created for molecular tests where required to ensure number of slides match.
Coroner's and Hospital Post Mortems Horizontal Audit 2020 (NSRP16**)**	Staff were reminded of the 30 days disposal period. If the disposal is rescheduled due to any reason a note should be left on the NA sheet and order entry notes on LIMS stating the reasons. The three senior members of staff are now on a monthly rota to ensure respectful disposals are arranged promptly. A database is currently being updated to record when wet tissue has been retained – this database is still not active currently, work is on-going to implement a database to incorporate retention/disposal and return of post mortem material.
HTA 71 Research Ethics Committee (REC) & Regional	No actions necessary

Governance Committee (RGC) Approvals Audit 2020 (NSRP 15)	
HTA 72 Research Request Forms R2 & R3 Horizontal Audit 2020 (NSRP 13)	No actions necessary
Management of specimens in theatre audit (NS 350)	For all Theatre Staff to be aware of importance confirming patient details are correct on specimen container The Labels should be affixed properly before placing specimen in container
Outcome of patients with lung cancer and brain mets (NS 360)	Tell people about the problem – Presentations Conventional cytotoxic chemotherapy (CCC) complete, also WCFT, and CCC Scottish Referral Guidelines (SRG), and British Neuro Oncology Society (BNOS) proposed as well as a publication Consider new pathway - New pathway agreement which can go through the CQG. Assessment of compliance - Reaudit after pathway running for > 1 yr
Specimen Acceptance Policy Horizontal Audit 2021 (NSRP 6)	Essential information not complete in 69% of Neuropathology request forms. On-going Trust wide actions to implement an electronic order communications requesting system.
Imaging timing after surgery for glioblastoma- an evaluation of practice in Great Britain (INTERVAL-GB)- Liverpool pilot study (NS 370)	Low compliance to 72hr MRI scan after surgery - Inform surgeons of the need to scan patients, and re-audit in 3-6 months, additional slot capacity in radiology made.
HIST 313 Surgical Vertical Audit 2019 (NSRP 1)	Information on request form not completed by clinicians, Tracey Rowan to email theatre staff to ensure all forms are properly completed
HIST 332 Surgical Vertical Audit 2020 (NSRP 1)	No action necessary
LNBW11 Research Consent forms Audit 2020 (NSRP 14)	Incomplete consent forms – contact specialist nurses and retrospectively complete consent forms The correct colour (white forms) of completed Walton Research Tissue Bank consent forms are not being sent to the labs – contact theatre staff and give reminder that white copy of completed consent forms is for Liverpool Neuroscience Biobank, blue for patient notes and pink for the patients as mentioned in the protocol, as a refresher
28 Day Faster Diagnosis Patient Pathway (NS 175)	2 week wait referrals are not current triaged, leading to inappropriate referrals being tracked on a cancer pathway, increasing the risk of breach to Faster Diagnosis Standards (FDS) & other relevant cancer pathways - Discuss with consultant about the need for

	clinical triage of 2 week wait referrals The audit highlighted that in the majority of records, it was not clearly documented that these patients were referred via a 2 week wait pathway - Meet with records and PAC to discuss a mode for easy identification of referral status For some tumour diagnoses (meningioma, low grade glioma), it was not clear what the patient had been informed i.e. cancer or not cancer - Discuss in cancer services with Neuro-oncology Surgeons Clarity of clinical documentation in clinic letters - To be discussed in Neurology Consultants meeting and cancer services
Initiation of anti-epileptic (AED) therapy post head injury (NS 209)	Develop guidance in conjunction with Consultants – action developed into a clinical trial, MAST, to randomise patients after head injury to certain anti-epileptic treatment Dissemination of audit to relevant team
rTMS for neuropathic pain: Patient Reported Outcomes about, Pain, Function and Quality of Life. (NS 218)	Review non-responders and responders in more detail. Brain connectome analysis in process as part of MRes project Meeting with psychiatry and alder hey neurosurgeons to finalise potential SLA to make transcranial magnetic stimulation (TMS) financially viable
Long Term Survivors of Glioblastoma (NS 224)	Under documentation of performance status, to add a field for performance status in a pre-existent electronic form for GBM patients Under documentation of radiological parameters – discuss at MDT AGM how to take forward To incorporate all outcome forms into EP2 and add in variable
Clinical Management: Perioperative patient care, Post-anaesthetic Care 2018 (NS 227)	Recovery temperature – estates and heating system upgrade completed and additional heaters provided if needed Look to purchase padded cot sides – unable to purchase as no universal cot sides available
Anaesthesia in theatre (NS 231)	There is no explicit local guidance that supports anaesthetic practitioners to prepare emergency/exceptional circumstances - Discuss with LODP team leader and LODP for Education.
Omission and delay of critical medicines in neurocritical care (NS 304)	Raise awareness of critical medicines – list of critical medicines to be incorporated into each patient's bedside folder Raise awareness of issues leading to inappropriate omission/delay of critical medicines – pharmacy bulletin to be emailed to ITU staff in Horsley internal newsletter

	summarising audit findings and outcomes Re-audit 6 monthly
Outcomes of patients with GBM treated at WCFT in 2019 (NS 317)	Increase use of 5 ALA – continue to support and suggest 5 ALA use in Neuro-oncology MDT Improve outcomes for tumour patients – discuss treatments in MDT and increase enrolment into clinical trials
Use of Handling of surgical instruments (NS 349)	To ensure all new staff have completed the educational packs and competencies
Comparison of Clinical Outcomes For The Online Pain Management Programme (PMP) Compared To Previous Face to Face Outcomes (NS 394)	Lack of existing published data on online pain management programmes – write up audit for publication Lack of 6 month follow up data - Examine outcomes of follow up data and compare with face to face Develop assessment guidance document to improve assessment decision making when deciding treatment planning
Traceability Audit 2020 (NSRP 19)	Slide unaccounted for. Differing uses of fail and repeat code. - Clarification of fail and repeat process as not currently defined Additional slides not recorded on LIMS. Referral stains not recorded in LIMS - Clarification of process for recording stains performed elsewhere as not currently defined. Tracers not included in file - Staff reminded to include tracers in file
Review of overall activity regarding shunt admissions and procedure at WCNN during 01.04.2019 – 31.03.2020 (re-audit) (NS 322)	N/A - shunt procedures completed from 2020 onwards will have been prospectively added onto the UKSR as outlined in the SOP; which will further increase compliance with reporting into the future
Accountable Items, Swabs Instruments and needle count (NS 355)	Discuss with Staff the importance of the Theatre Team engaging when counts are being performed. Discuss with Scrub Staff the importance of informing the Surgeon that count is correct before closure of a cavity To note, swab count compliance is documented on the local risk register and highlighted as part of WHO checklist
Antimicrobial Stewardship (NS 364)	Disseminate audit findings and recommendations to ITU/Microbiology MDT Stop / duration / review dates omitted in 50% of prescriptions. Indication documented in 89% - reminders to ITU prescribers to document a duration / review / stop date /indication on prescription kardex.

	Limited utilisation of Micro Tracker form to document – encourage use of micro tracker form on ward round Set re-audit review date
Audit of quality of reporting peripheral nerve biopsies at The Walton Centre. (NS 385)	Assessment of endoneurial inflammatory reaction, particularly in relation to vasculature. While describing endoneurial cellular infiltrates specific comments to be added as to their relation with the endoneurial vasculature or not. Information of material available for electron microscopy. Nerve report template to incorporate this information under macroscopy. Existing nerve panel - This requires changing in line with that suggested by RCPath.
Central line insertion documentation audit / Re-audit of CVC LocSIPPs' documentation adherence (NS 390)	Continue to adhere to the CVC LOCCSSIP forms when performing CVC insertion, reminders to all appropriate staff to fill in the during procedure section, presentation and discussion has been made during the audit meeting Re-audit to check compliance
The Use of Electrosurgery (NS 353)	Presently no smoke evacuators in Theatre when using monopolar diathermy - theatres have acquired filters that project the suction equipment. Conventional suction still used to clear smoke, ideally the device is attached to the diathermy – options being trialled at the moment, surgeons are finding "bulky". To note, the danger of surgical smoke is also due in parliament in due course

Trust wide Clinical Audits & Service Evaluations

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

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

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

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

2.3.6 Participation in Clinical Research and Development

The number of patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority was 489. Due to the impact of Covid-19 no yearly target was set for this financial year, however an approach was developed to manage our research delivery portfolio during the pandemic. This has enabled us achieve our high level objective of determining a plan of upcoming research studies and closing smaller studies, allowing us to shape a financial plan and taken on the decision of which research projects to implement.

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

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

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

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

During 2021/22 the Trust has worked collaboratively with the following networks and organisations to attract NIHR funding to deliver and disseminate clinical research and innovation to inform service transformation and improvement:

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

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

2.3.7 CQUIN Framework & Performance

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

2.3.8 Care Quality Commission (CQC) Registration

The Walton Centre is required to register with the Care Quality Commission and its current registration status is registered without conditions. The CQC completed a review of the mental health services across the Trust in November / December 2020. The CQC were satisfied that no further monitoring was required and recommendations have been completed. The CQC has not taken enforcement action against The Walton Centre during 2021/22. The CQC undertook an inspection, including well led, during March and April 2019, which resulted in an Outstanding status for the second time.

Ratings for The Walton Centre

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

2.3.9 Trust Data Quality

The Walton Centre submitted records during 2021/22 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

The percentage of records in the published data (January 2022) which included the patient's valid NHS Number was:

99.9% for admitted patient care

99.9% for outpatient care

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

99.9% for outpatient care

100% for admitted patient care

This year is the fourth year of the new Data Security and Protection Toolkit. The Toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health Policy. Within the Toolkit there are 38 assertions and 110 mandatory evidence items.

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

The Trust is on target to meet all assertions and mandatory evidence items for the Data Security and Protection Toolkit, which is due to be submitted to NHS Digital on 30th June 2022. This deadline was extended in line with Covid-19 and will now remain as the new submission date for future years.

The Trust has implemented action plans to aim to achieve another high score on the new Data Security and Protection Toolkit and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessments undertaken as part of the mandated 21-22 DS&P audit requirements is currently ongoing throughout March and April 2022 and the Trust will then receive the outcome of this review in May 2022.

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

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

The Walton Centre Internal Clinical Coding Audit 2021/2022

Coding Field	2020/21	2021/22	Difference	Mandatory	Advisory
Primary diagnosis	91.00%	96.70%	+5.70%	90%	95%
Secondary diagnosis	86.00%	94.14%	+8.14%	80%	90%
Primary procedure	97.00%	99.40%	+2.40%	90%	95%
Secondary procedure	98.00%	93.87%	-4.13%	80%	90%

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

2.3.10 Learning from Deaths

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

2.3.10.1 During 2021/22, 64 of The Walton Centre patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

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

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

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

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

2.3.10.2 0 representing 100 % of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:

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

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

0 case record reviews and 0 investigations completed after 31.03.21 which related to deaths which took place before the start of the reporting period

0 representing 100% 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 100% of the patient deaths during 2021/22 are judged to be more likely than not to have been due to problems in the care provided to the patient (6 cases awaiting review).

2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services

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

The Trust continues to make progress with CS2. In the 7 day service audits from 2016-2019 the overall rate of compliance improved from 50% to 79%. The compliance rate at the weekends in the audits have consistently been high, demonstrating a Consultant presence for review throughout 7 days. As a specialist Trust there has been discussion with the 7 day services team regarding difficulties that arise for us with this standard. All patients who are transferred to The Walton Centre will have been seen and assessed in their local hospital, usually will have had investigations such as scans, and in neurosurgery admissions (which are the vast majority) the diagnosis will usually be clear. All admissions are discussed with a Consultant prior to transfer and a management plan is formulated. There is a two tier middle grade on-call system in neurosurgery so there is always a senior trainee on-call. In some cases there is a clear plan for the patient on arrival and assessment by a senior trainee is considered clinically appropriate. Also, all patients admitted as an emergency will be initially assessed by a member of our MDT SMART (Surgical and Medical Acute Response Team) team, which consists of medical staff and outreach /critical care trained nursing staff. Therefore, the differences in the service will reflect some difficulty with compliance with this standard in all patients, but there remains the aim to reach the target of 90%. This has not been re-audited since 2019 due to the impact of the Covid-19 pandemic, but there are plans to re-audit this during 2022.

The mortality report continues to be reviewed quarterly at Quality Committee and Trust Board. This has not shown any trends in deaths by day of the week and day of admission.

In summary, the Trust continues to show an improvement in compliance with CS2 but due to being a tertiary centre, some patients may appropriately be treated on arrival by a senior trainee but are reviewed in a timely manner following this by a Consultant. In addition, there are the other clinical standards which the Trust continues to progress well with.

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

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

Shift handovers - each morning at 8am there is a neurosurgical handover meeting led by the Consultant on-call - all patients referred overnight (whether transferred or not) are discussed and scans reviewed. This is an MDT meeting involving medical, AP staff, SMART team coordinator and bed management team. There is a formal handover meeting at 8pm each weekday, coordinated by the SMART coordinator and involving junior medical staff.

There are well defined procedures for medical handover following each shift. At weekends at 8.30am there is a handover meeting attended by the Consultant neurosurgeon on-call, the trainee medical staff and SMART coordinator. In neurology there is a daily board round, including weekends. The role of SMART coordinator in safe handover is documented in the Trust policy 'Operational Guidelines for the Surgical and Medical Acute Response Team (SMART)'.

Transfer to community, primary and social care – There are daily Consultant reviews to support discharge. There is a complex discharge coordinator working during the week but not at weekends. This service is covered by the bed management team or bleep holder at weekends. Ward based pharmacists support the ward rounds and medications to take out (TTO) are completed by the pharmacist or AP. There are referral pathways for community settings and access and referral systems in place for all providers, social care and continuing health care. There is pharmacy support for TTO at weekends.

There is a process in place for repatriation to other Trusts, but since the onset of the Covid-19 pandemic there has at times been a need to intentionally relax these criteria as part of mutual aid to the acute Trusts in our region. There is a weekly delayed discharge meeting to discuss any patients with a long length of stay and these are escalated as appropriate.

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

2.3.12 Speaking Up

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

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

Part 3 Trust Overview of Quality 2021/22

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

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

Patient Safety Indicators

Trust Acquired	2019/20	2020/21	2021/22
C Difficile	5	3	8
MRSA Bacteraemia	0	0	0
Ecoli	13	7	11
Minor and Moderate Falls	37	19	30
Never Events	1	0	2

Clinical Effectiveness Indicators

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

Patient Experience Indicators

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

3.1 Complaints

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

We recognise that attending hospital can be a difficult and frightening experience for all and this was particularly tough during a pandemic when visiting restrictions continued. The Patient & Family Experience Team (PET) provides a confidential support and advice service to patients, their families and carers, as well as helping to resolve enquiries and concerns and complaints on their behalf. This can be prior to, during or after their visit to the Trust and they can be contacted in various ways including telephone, email, in writing, book an appointment or in person whilst in the Trust.

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

Throughout the past year, the Patient Experience Team has:

- continued to listen to and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided support to families unable to visit their loved-ones during Covid-19 and for the families of the bereaved
- provided support to families who struggled with visiting arrangements and escalated concerns on their behalf
- continued to support and engage with volunteers and safely re-introduce them into roles into the trust in line with infection prevention guidance and precautions
- ensuring all volunteers receive adequate training and support before resuming in roles
- reviewed and enhanced the complaints management process including implementing a local resolution pro-forma and responded to all concerns and complaints within the Trusts KPIs
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meeting prior to discharge
- continued with supporting virtual visiting with large activity screens and Letters to Loved Ones which enabled families to stay in touch with their loved ones during the visiting restrictions.
- provide bi-monthly assurance to Trust Board by presenting complaints data/trends and analysis
- Introduced new initiatives including: Birthday Gifts/cards/visits for inpatients, so no patient is forgotten on their birthday, Sleep Well packs for inpatients all initiatives supported by The Walton Charity and Connecting hearts for memory boxes
- applied for external funding from NHSI for a 12 month project and developed 7 day role for Patient Support Assistants to provide support for patients/families and bridge the gap between ward and Patient Experience Team. The aim of this service is to support new and existing volunteers returning to clinical areas and improve communication between patients and families
- facilitated external engagement events in partnership with Healthwatch to gain and act on feedback provided from patients and groups who represented them
- developed the process for an improved death certification/coronial/Medical Examiner referral pathway in partnership with LUHFT. The aim of this service is to improve communication and prevent delays to bereaved families. This will also support ward staff in addition to offering assurance to the Board that the Trust adhere to national standards identified in the Learning from Deaths Guidance.
- as part of the Mortality Governance Lead role/PET developed a pathway to proactively provide family support following a death

- developed a process in collaboration with the Communications Team for the Trust Board to receive a patient story either video formal or live via MS Teams from each of the different service lines at each Board meeting.
- Continued education and support provided to junior drs and consultants in relation to good practice/documentation and when required to provide input into coronial enquiries-inquests and claims
- High level learning from complaints/claims/coronial inquests and enquires share in quarterly governance bulletin

3.1.2 Complaints Management and Lessons Learnt

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

Every enquiry, informal concern and formal complaint is given careful triage and consideration. Each concern and complaint receives an appropriate investigation and complainants receive their response in their preferred format. This can be in a telephone call to give them an opportunity for further discussion, or response from the Patient Experience team via email or letter. All formal complaints are responded to by the Chief Executive and/or complainants may be offered a meeting with the senior staff from the respective division, supported by the Patient Experience Team.

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

The last 12 months have demonstrated that the complaints process is robustly embedded to ensure that complaints are addressed in a timely manner and that meaningful apologies are provided. All concerns and complaints are discussed by the Patient Experience Team and the Divisional Management Teams at a weekly joint divisional meeting. This process ensures that all complaints are being carefully considered and appropriate investigations are in progress and to ensure timeframes are met. Every effort is made to ensure that responses are comprehensive and that any lessons are learnt are outlines within the response. Outstanding actions from complaints are discussed weekly and shared at relevant divisional governance meetings until the Divisional Directors are assured that actions are fully implemented and closed.

Outcomes from complaints are reported monthly to the respective risk and governance committees and meetings within the Trust. Trends, themes and lessons learnt are discussed in detail in the Governance, Risk and Patient Experience Quarterly report which is presented to Quality Committee. This report is also presented externally at our Specialist Commissioners meeting. Any trends in subject, operator or area of concern identified from complaints/concerns are escalated in real time to the Executive team.

Complaints are reported and discussed with the Executive Team bi-monthly to offer assurance that the management process is robust and actions managed in a timely way.

Complainants are kept informed and updated during the process by regular contact from the team and feedback from those who have used the complaints process is used to help us improve and shape the service we provide. Compliments received following a concern or complaint are recorded on Datix as the team often receive feedback regarding the level of support they have received from the team during the process.

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

3.1.3 Complaints Activity

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

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

Complaints received 01 April 2021 – 31 March 2022

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

The slight increase in complaints is not surprising and in keeping with the current pressures on the NHS, as trends included appointment arrangements, waiting times and communication. It is reassuring to note that 100% of complaints were responded to within the Trust's KPI timeframe and there was a noted improvement in average response times. A key element of the person and family centred care approach is focusing on the individual outcomes patients and families are seeking when they raise concerns. The Patient Experience Team acknowledges all complaints and agrees the best way of addressing their concerns, in line with managing expectations. The Trust work in partnership to investigate any joint complaints with all other NHS organisations whereby care received within The Walton Centre is highlighted as a concern as part of any complaint they receive.

3.1.4 Duty of Candour

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

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

3.2 Local Engagement – Quality Account

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

3.3 Quality Governance

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

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

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

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

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

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

NHSX announced The Walton Centre NHSFT will be included in the second wave of the Digital Aspirant programme – a project which helps trusts across the country digitise and progress towards paper-free patient record keeping.
The country's only specialist neurosciences trust is one of seven organisations to receive up to six million pounds each over the next three years to help deliver digital ambitions.

3.5 MS Awareness Week - FACETS programme

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

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

The Walton Centre has extended satellite spinal clinics in North Wales for the first time. The Trust is working alongside the Robert Jones and Agnes Hunt NHS Foundation Trust to bring care for spinal patients closer to home. As part of the Trusts Care Close to Home Initiative, bringing clinics to some of the more remote regions the hospital serves, means less travel and more meeting with clinicians, which is often a stressful occurrence, in a familiar setting.

3.7 Families continue save and improve lives through deceased organ donation

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

3.8 Staff and supporters take a leap of faith for charity

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

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

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

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

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

3.11 International Nurses make The Walton Centre their home

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

3.12 The Walton Centre awarded Tessa Jowell Centre of Excellence Status

The Walton Centre NHS Foundation Trust, alongside the Clatterbridge Cancer Centre NHS Foundation Trust and the North Wales Cancer Treatment Centre, has been awarded Centre of Excellence status after rigorous assessments led by experts from the Tessa Jowell Brain Cancer Mission (TJBCM). The entire team works extremely hard to deliver the best possible wrap-around care for all the 500 brain tumour patients and their families treated at The Walton Centre each year.

3.13 New neurology assessment eases bed pressures in Cheshire and Merseyside

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

3.14 Enhanced Thrombectomy service

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

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

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

3.16 Overview of Performance in 2021/22 against National Priorities from the Department of Health's Operating Framework

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

Performance Indicator	2021/22 Performance	2021/22 Target	2020/21 Performance
Incidence of MRSA	0	0	0
Screening all in-patients for MRSA	97.94%	95%	96.55%
Incidence of Clostridium difficile	8	5	7
All Cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery	100%	94%	100%
All Cancers: 62 days wait for 1st treatment from urgent GP referral to treatment	100%	85%	100%
All Cancers: Max waiting time of 31 days from diagnosis to first treatment	100%	96%	100%
All Cancers : 2 week wait from referral date to date first seen	100%	93%	98.9%
All Cancers: 28 Day Faster Diagnosis	98.75%	75%	N/A

Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	N/A	N/A	N/A
Maximum 6 week wait for diagnostic procedures	0.30%	1%	19.33%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Fully Compliant		

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

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

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

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

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

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

During 2021/22 The Walton Centre provided and/or sub-contracted four relevant health services. These were neurology, neurosurgery, pain management and rehabilitation.

3.18 Indicators

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

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

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

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

Rationale: The Trust does not provide mental health services

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

Rationale: The Trust is not an ambulance trust

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

Rationale: The Trust is not an ambulance trust

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

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

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

Rationale: The Trust does not perform these procedures

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

Response:

	No. of readmissions	% of Inpatient Discharges Readmitted
2020/21	139	4.25%
2021/22	201	4.56%
Change	N/A	0.31%

Calculation of readmission rates is based on the national standard as defined within the Compendium of clinical and Health Indicators. (https://indicators.ic.nhs.uk/webview/).

The rates are for patients 16 years and over as The Walton Centre does not treat patients under the age of 16.

Actions to be taken

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

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

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

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

Response:

- The Trust is required to participate in the CQC National Inpatient Survey annually to allow benchmarking of the patients' experience with other NHS providers. The survey is recognised as being a key indicator of overall care for the organisation and regulators, including the CQC and commissioners. Picker Institute was commissioned by The Walton Centre together with 75 other NHS organisations to collate and present the organisation's results for each Trust.

- The Walton Centre has been identified as performing 'Better Than Expected' because our patients answered positively about their care across the entire survey and this was significantly above all other Trust averages. The results highlight a 56% response rate (previously 50%, with an average response rate of 45% for other organisations and the Trust scored much better, better or somewhat better for 9 out of 10 sections of the survey. This is remarkably positive and especially as this was during the Covid-19 pandemic.

- The Trust was rated 8th out of 75 Trusts of those using Picker for overall positive score, which is an improvement in rank from last year (9th). 78 of respondents said they had a long term condition.

National Inpatient Survey Question	2017 Result	2018 National Comparison	2019 Result	2020 Result	2021 Result
1. Were you involved as much as you wanted to be in decisions about your care?	7.8	About the same	About the same	89% Better	Due Sept/Oct 22
2. Did you find a member of hospital staff to talk to about your worries or fears?	6.0	About the same	About the same	93% Better	Due Sept/ Oct 22
3. Were you given enough privacy when discussing your condition or treatment?	8.6	About the same	Slightly worse	84% Better	Due Sept/ Oct 22
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.1	About the same	Better	92% Much better	Due Sept/ Oct 22
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.7	Better	Better	91% Much Better	Due Sept/ Oct 22

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

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

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

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

Patient Experience Initiatives

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

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

Response:

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

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

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

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

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

Ranked People Promises

NHS People Promise:
This is a national promise all staff make across the NHS to each other – to work together to improve the experience of working in the NHS for everyone. The themes and words that make up the People Promise have come from those who work in the NHS in the form of the above seven promises.

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

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

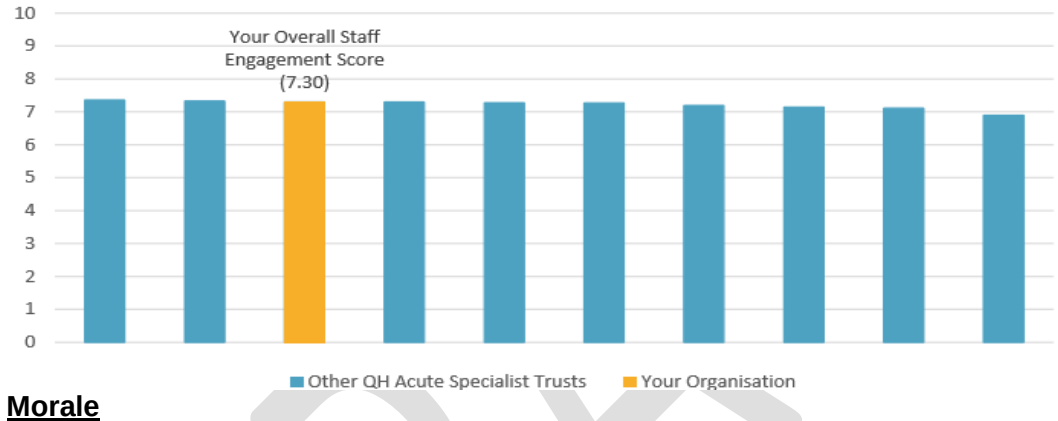
Staff Engagement

Staff Engagement is measured across three sub scores:

- Motivation,
- Involvement
- Advocacy

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

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



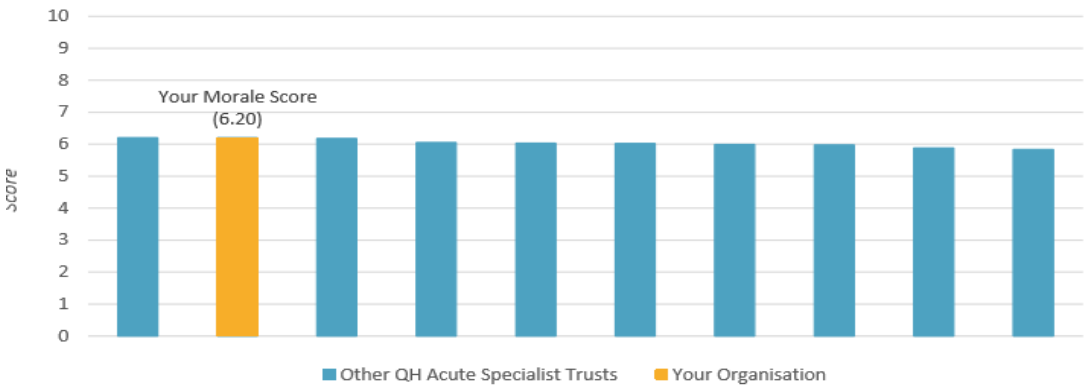
Morale

Morale is measured across three sub-scores:

- Thinking about leaving
- Work pressure
- Stressors

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

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



Top and Bottom Question Scores

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

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

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

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

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

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

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

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

WRES/WDES

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

WDES Headlines The Walton Centre

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

The Trust intends to continue to work with staff side and staff through various engagement sessions to increase the response rates and percentage scores for the 2022 survey. A Trust action plan and Divisional action plans will be formulated and approved by Board

<u>Volunteers</u>

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

- Regular welfare calls and virtual meetings
- Virtual Coffee Mornings and quizzes
- Newsletters

- Socially distanced safe park walks
- Engagement and staff/volunteer support with local foodbanks
- Picnic in the park to celebrate National Volunteer Week

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

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

In summary, although it continued to be a very challenging year for the Trust and NHS, despite working very differently we have overall successfully achieved positive patient and family experience outcomes and we aim to build on this further in 2022/23.

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

Rationale: The Trust does not provide community mental health services

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

Response:

YEAR		Q1	Q2	Q3	Q4
2017/18	The Walton Centre	99.09%	99.69%	98.34%	97.17%
	National Average	95.20%	95.25%	95.36%	95.21%
2018/19	The Walton Centre	98.52%	99.00%	98.86%	96.78%
	National Average	95.63%	95.49%	95.65%	95.74%
2019/20	The Walton Centre	98.79%	98.97%	98.85%	98.58%
	National Average	95.63%	95.47%	95.33%	Suspended due to Covid
2020/21	The Walton Centre	95.35%	98.17%	98.08%	97.94%
	National Average	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid
2021/22	The Walton Centre	99.03%	98.7%	98.44%	98.6%
	National Average	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid	Suspended due to Covid

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

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

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

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

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

Response:

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

WCFT Clostridium difficile infections per 100,000 bed days:

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

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

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

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

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

13. Rate of patient safety incidents per 1000 bed days

Response:

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

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

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

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

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

The Trust will continue to:

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

Annex 1

NHS South Sefton Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

NHS Liverpool Clinical Commissioning Group

Insert Commissioning Group Feedback

Insert Healthwatch Statements for 2021-22

Glossary of Terms

ACCP	Advanced Critical Care Practitioner
BAME	Black and Asian Minority Ethnic
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
EDC	Electronic Demand Capture
EP2	Electronic Patient Record System
FACETS	Fatigue Applying Cognitive Behavioural & Energy Effectiveness Techniques
FFFAP	Falls and Fragility Fractures Audit Programme
FTSUG	Freedom to Speak Up Guardian
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit & Research Centre
KPI	Key Performance Indicator
MDT	Multidisciplinary Team
MHFA	Mental Health First Aid
MIAA	Mersey Internal Audit Agency
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool
NCABT	National Comparative Audit of Blood Transfusion
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Clinical Excellence
NIHR	National Institute of Health Research
NNAP	National Neurosurgery Audit Programme
NQB	National Quality Board
PET	Patient Experience Team
PIFU	Patient Initiated Follow Up
RCA	Root Cause Analysis
SJR	Structured Judgement Review
SMART	Surgical and Medical Acute Response Team
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TARN	Trauma Audit & Research Network
VTE	Venous Thromboembolism
WCFT	Walton Centre Foundation Trust

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 17/05/22		**Report of:** Audit Committee
Date of last meeting: 17/05/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Draft Financial Accounts 2021/22 • Draft Annual Report 2021/22 • Draft Quality Account • Principle Risks 2022/23 • Clinical Audit Annual Report 2021/22 • Annual Cycle of Business 2022/23 • Board Register of Interests • Fit and Proper Persons Report • Non-Executive Director Independence • Informing the Audit Risk Assessment 2021/22
2.	**Alert**	• The Committee noted that the annual report was on track to be signed off on 20th June however recognised that the completion of the value of money audit was likely to be delayed to the end of June 2022.
3.	**Assurance**	• Draft financial accounts were presented and it was noted that these were in the process of being audited. Comments were welcomed and following consideration of comments received and completion of the audit the accounts would be submitted to the extraordinary Audit Committee meeting on 20th June for approval. • The draft annual report was presented and this was currently in the process of being audited. Following receipt of any comments from the auditors the report would be updated to address any comments raised and then forwarded to the communications team to improve the formatting. The annual report would then be submitted to the extraordinary Audit Committee meeting on 20th June for approval. • The draft quality account was presented and it was noted that two quality priorities had not been achieved and one quality priority had been partially achieved. These priorities would be rolled over to 2022/23 and continue to be monitored at Quality Committee. The quality account would be presented to Quality Committee on 19th May for discussion and stakeholder presentations would be held via Microsoft Teams on 10th June. Following this the quality account would be finalised and published at the end of June.

		• The approach to clinical audit was discussed and it was recognised that improvements in clinical audit had been made following a challenging two year period. Processes were being reviewed to ensure that they were fit for purpose and links with Divisional Risk and Governance meetings were also under review. An overview of work completed to ensure audits were closed down was provided and robust processes were being rolled out to ensure that all audits undertaken were a priority area for the Trust. The cycle of business would be updated to clarify reporting processes for clinical audit into the Audit Committee. • The Board register of interests was reviewed and this would be updated to ensure all declarations were included. • The fit and proper persons report was presented and all self-declarations had been completed with one outstanding due to maternity leave. • The Non-Executive Directors independence report was presented and it was confirmed that none of the declarations made were considered a conflict of independence.		
4.	**Advise**	• There were no areas to advise the Board of.		
5.	Risks Identified	• None		
6.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

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4.	**Advise**	• There were no areas to advise the Board of.		
5.	Risks Identified	• None		
6.	Report Compiled by	Su Rai, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 27/4/2022		**Report of:** Business Performance Committee
Date of last meeting: 26/04/2022		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report March 2022 • Transformation and QIP Quarterly Report • Cost Improvement Programme 2022-23 • Analysis of Long Term Sickness Absence Report • Response to People Plan and Annual Trust Staff Survey 2021-22 • Health and Wellbeing Strategy 2022-23 • Digital Aspirant NHSX Monthly Update • Trustwide Risk Register for Neurology Risks • Cycle of business 2022-23 • Operation Plan (Final) 2022-23 • Commercial Contracts Strategy and Review (Procurement Department) • Orthotics Services Contract • Sub-committee Chair's Reports for 6 sub-committee meetings
2	**Alert**	• The 'final' finance plan for 2022/23 has been submitted and The Walton Centre plan is based on assumptions in the planning guidance, apart from utilities costs, given the specific pressure in this area. Achieving the Income & Expenditure plan will require stretching activity targets to be met, staff availability to be high and efficiency savings of 3% of turnover to be realised, amongst other risks. The capital allocated to the Trust is significantly less than the internal plan which has already been challenged down. • Sickness remains abnormally high with Covid related clusters continuing to disrupt the achievement of activity targets, notably in theatres. Activity targets are premised on Covid being effectively behind us, whereas in reality with regard to staff availability it is not.
3	**Assurance**	• Activity performance for cancer, diagnostics, activity restoration were all meeting plan in March. RTT stops missed target in the month but met target for the full half year. • The proportion of patients on PIFU (Patient-Initiated Follow-Up, part of outpatient transformation) increased to meet the year-end target, as it was extended to further services. • Theatre activity remains affected by staff sickness. Follow-up outpatients not attending appointments has increased, especially for virtual appointments, and is subject to a focused piece of work to improve. The number of long waiters >52 weeks has progressively increased over the last 3 months, although very long

		>104 week waiters has reduced to 3. • Sickness remains high at 8%, around 40% of which is short-term and around 60% are long-term cases. Of the latter, 85% are front-line clinical staff. Assurance was provided on how long-term sickness is managed. • Staff appraisal completion rates and mandatory training compliance both remain below minimum threshold targets. • Income & Expenditure outcome for the full year was at break-even position, in line with plan, achieving a key short-term priority. • A very significant capital spend of £5.3m in March ensured that the plan for the year was achieved. This is an important achievement given the much lower allocation currently for 2022/23. • On-time payment to creditors remains below target (Better Payments Practice Code), markedly so for payments within NHS. Action has now been requested by the regional NHS finance team. Issues centre particularly on disputed and late payments to/from Liverpool University Hospitals NHS Foundation Trust. An action plan is being compiled which will be shared with the Chair of Audit Committee. • The bed repurposing project centred on expanding the Rapid Access to Neurological Assessment (RANA) service is well advanced. There is line of sight of significant benefits including improved service and patient experience, reduced length of stay and other efficiency improvements, staff wellbeing benefits and reduced cost. It is planned to conduct a benefits realisation review after the changes have been fully implemented and consolidated. • Assurance was given on a project approach to steering how the Cost Improvement Plan (CIP) target challenge for 2022/23 is being addressed. There is line of sight on the majority of the target and ideas are continuing to be formulated. Procurement's contribution to this, as part of establishing economy of scale leverage across Health Procurement Liverpool (HPL), was explored with good oversight of Trust contracts and pro-active approach to future procurement processes demonstrated. • End-year progress against implementing the people plan was reviewed, providing assurance of good progress in most aspects. • Good progress in implementing the Digital Aspirant project continues.		
4.	**Advise**	• The proposed Health & Wellbeing strategy was considered and enthusiastically recommended for approval at Board as soon as the agenda can accommodate. • A business case to place the Orthotics service contract on a national NHS framework, pending a potential system collaborative contract tender, was approved. This will achieve a 10% saving on current costs.		
5.	**Risks Identified**	• Review of the neurology division risk register centred on the potential impact of consultant vacancies on the epilepsy service. A paper is to be presented to the Executive Team on 21 May 2022 with a plan to mitigate the risk around this issue. • In order to monitor progress on the increase in patients on the Follow Up Waiting List in Neurology (FOWL) the Committee requested a report be presented once full validation of all the entries had taken place. The appointment of a member of staff to the Neurology team solely assigned to this task would expedite matters and a report was expected in 3-6 months.		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 26/5/2022		**Report of:** Business Performance Committee
Date of last meeting: 24/5/2022		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Integrated Performance Report April 2022 • Capital Programme 2022-23 • Estates & Facilities Annual Report Follow-Up • People Pulse Survey Report • Digital Aspirant NHSX Monthly Update • Resilience Planning Group – Terms of Reference • Digital Aspirant Funding x 3 staffing resource business cases • Consent Agenda – Feedback from incident at LWH • Sub-committee Chair's Reports for 5 sub-committee meetings
2	**Alert**	None
3	**Assurance**	Integrated Performance Report • Activity performance for cancer, diagnostics and the trajectory for reducing long waits all met plan in April. • Activity restoration met target for day cases but was behind target for elective and new outpatients, largely caused by staff sickness. It is believed that most regional trusts struggled similarly. The Trust did not meet its Elective Recovery Fund financial target for M1 due to the weighting in the ERF calculation given to elective work which the Trust did not achieve. This was primarily due to Covid related staff sickness in theatres and the Trust has the opportunity to recover this by the end of Q1 and still achieve the ERF. • Sickness remained high at over 7% in April, although was starting to fall during May. • Staff appraisal recorded completion rate remains well below the minimum target; progress from the current leadership focus on this will be reviewed next month. • Nursing turnover has stabilised at around 14% (broadly the long-term average) but corporate / administrative turnover has continued to rise since last summer, now 18%. • I&E was in line with plan. Loss of income from ERF and under performance due to lower activity was mitigated through reduced costs from activity and planned phasing of costs. Income and expenditure were also both impacted by the delay of transferring some of the Health Procurement Liverpool staff and the transfer of the spinal activity from LUHFT.

		• On-time payment to creditors remains below the targets of the Better Payments Practice Code, but this has started to improve and there is an action plan in place.		
4.	**Advise**	• The content of April's quarterly People Pulse Survey was reviewed in depth and received enthusiastically. There were 236 participants which was still low, but more than double the previous highest response and enough to provide meaningful insights, together with some benchmarking comparisons, and some valuable narrative comments on feelings and feedback to leadership. The insights and issues highlighted will be explored further in forthcoming staff engagement sessions and taken into the People action plan. This promises to become a valuable 'low maintenance' quarterly feedback tool from which leading indicators can be derived and action taken much quicker than from the annual full People Survey. • The capital budget allocated by the ICS is currently £4.4m, versus an internal demand of £6.4m (which has already been reduced by challenge and rephasing). A bid has been made for a second tranche of budget allocation, the outcome of which is expected soon. • A review of how the Trust's estate compares against national assessment methodologies and benchmarks (integrating insights from the Premises Assurance Model, 6-Facet Survey, Estates Return Information Collection (ERIC) and Model Hospital) has been requested for a meeting in the autumn. • Three business cases to continue to resource the Digital Aspirant project implementation were approved. • Some learning from the incident at Liverpool Women's Hospital in November 2021 relating to improving resilience was noted.		
5.	**Risks Identified**	• None		
6.	**Report Compiled**	David Topliffe, Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 27/1/22		**Report of:** The Walton Centre Charity Committee Meeting
Date of last meeting: 22/1/22		**Membership Numbers:** Quorate
1	**Agenda**	The Committee considered an agenda which included the following: • Update on Violence and Aggression App • Finance Report – including investment reports • Fundraising Activity update • Charity Risk Register • T&D Funding Applications (4 applications) • Formal approval of 2 applications • Impact presentations on Virtual Engagement Rehabilitation Assistant (VERA) and Junior Doctors Mess refurbishment • Outline of Fundraising Strategy 2022-25 • Reserves Policy • Draft Grant Making Policy • Annual Investment Report • Cycle of Business
2	**Alert**	• The charity currently splits funds of £1.2m between 2 investment managers Ruffer and CCLA. From the investment reports provided by both companies it was evident that events in Ukraine were having the same effect as the Covid pandemic on the markets and real growth in portfolios would be hard to deliver. As the funds were invested in low risk stock with immediate access at no, or very little, cost it was agreed to continue with the investments. The Committee decided to give further thought as to where the cash reserves would be placed and would seek the advice of Jaeger and Associates (independent advisors) on this issue. • It was noted that the Home from Home fund that covers the cost of family accommodation in Sid Watkins Building was in deficit after commitments. The major source of income for this fund, Hope Mountain Hike, would no longer be taking place and although a new fundraising initiative had been put in place (Walk for Walton) it would not provide the same amount of funding this year. This fund requires around £50k per year to cover costs and this had always been met pre-Covid.
3	**Assurance**	• The Committee were asked to approve an increase in reserves from £60k to £296k for a 12 month period. Details on how this figure had been calculated

		were detailed in the policy. The Committee approved the Reserves Policy and agreed to review the reserves figure on an annual basis. • Good progress continued to be made on the Charity Risk Register. The next report would provide a summary and the top 5 risks would be the focus. New board members would be made aware of their responsibilities as Corporate Trustees of the Charity at a future Board away day session. • The draft Grant Making policy was approved. This would lead to a comprehensive policy being developed as part of the overall fundraising strategy.
4	**Advise**	• The Committee received the Finance Report which showed that fund balances had reduced from £1,693k to by £1,438k as at 31 March 2022. The charity had continued to be affected by the pandemic with the fund balance reducing by £255k in 2021/22. The Committee were appreciative of how the report was now presented containing more narrative and graphs. The charity plan for 2022/23 was noted. • The various funds were discussed and plans outlined on how to encourage movement in stagnant funds and the requirement for fund managers to share plans for expenditure. • The fundraising activity report provided an update on the neuro VR simulator appeal which was successfully completed and the training tool had now been delivered. Work was underway to deliver 2 events in May the annual golf day and 'Walk for Walton'. The Jan Fairclough Ball would take place on 25 November 2022. • The fundraising manager provided an overview of the changing remit of NHS Charities Together from a membership association to a co-active fundraising organisation. In some areas, particularly on national levels, this would make it a direct competitor to many NHS charities. • The Committee received an update on the progress of the Violence & Aggression App following a recent application for funding. The Charity Committee had supported the initiative but noted that process had not been followed and it was presented to the Executive Team who supported the idea but decided it was not the right time to agree to funding. The application would be removed from the Charity commitments. • Impact presentations on Virtual Engagement Rehabilitation Assistant (VERA) and the junior doctors mess refurbishment were received. Both initiatives had succeeded in having a positive impact on patients and staff and the presentations were very well received. It was noted that the majority of funding for the junior doctors mess was received through NHS Charities Together grant. • 4 applications from the Training & Development Department for part funding towards staff professional development were approved. • Formal approval was given to the following applications: o Uniforms for volunteers £2,587 + VAT (previously approved via email). This was under the threshold of £5k for applications requiring Charity Committee approval but was acknowledged it would be an ongoing request as and when required. o Application on behalf of Neuroscience Research Centre £30k. It was agreed at the Charity Committee meeting in January 2018 that £30k should be allocated to the NRC on an annual basis to support excess treatment costs (at the time) and smaller capability studies to help enable and develop research at the Trust. RIME Committee would

		assess and approve requests for funding of smaller studies using these funds and the Committee would expect an annual report on the activity carried out. • The Head of Fundraising presented a paper outlining the Charity's proposed direction of travel for the next 3 years, with a comprehensive strategy being developed once the Trust Strategy had been finalised. A particular area of focus was the need to keep up to speed with the latest trends in digital technology and to ensure the charity had the right skills and expertise in digital fundraising and marketing. Following a lengthy discussion the Committee endorsed the investment requirements to appoint a digital fundraising manager and the Head of Fundraising would now move forward with the next stage in the process to achieve this aim. It was noted that this appointment may also have an impact on the Trust and this needed to be reviewed in light of the new post for the Charity. • The Committee is to receive a report from the Charity Executive Lead on fundraising cost and performance benchmarking for the Walton Centre charity • The Committee approved a £30k fund allocation to RIME for additional patient treatment costs • The Charity and Committee will continue to focus on raising the Charity profile		
5	Risks Identified	• None		
6	Report Compiled by	Su Rai Non-Executive Director	Minutes available from:	Corporate Secretary

Board of Directors' Key Issues Report

The Walton Centre NHS Foundation Trust

Report Date: 11/05/22		**Report of:** Research, Innovation and Medical Education Committee
Date of last meeting: 04/05/22		**Membership Numbers:** Quorate
1.	**Agenda**	The Committee considered an agenda which included the following: • Committee Effectiveness Review 2021/22 and Terms of Reference Report • Board Assurance Framework – Q4 2021/22 • Good Clinical Practice Training Progress Update • UK Clinical Guidelines for the Diagnosis of Fibromyalgia Syndrome • Strategic Partnerships Update • Medical Education Strategy and Implementation Plan Update • Outcomes from R&D Workshop on 18/03/22 • Research and Development Finance and Performance Report • Review of SPARK Funding Applications • Sub-committee Chair's Reports for 2 sub-committee meetings
2.	**Alert**	**Committee Effectiveness Review 2021/22 and Terms of Reference Report** • Further to feedback received from members in the 2021/22 Committee Effectiveness Review, it was proposed for a working group to be convened to review the Committee's function, responsibilities and engagement encompassing terms of reference, membership and work plan and those of its sub-committees. There was agreement that the day and time of the Committee meetings should also be reviewed as are currently scheduled to be held the evening prior Trust Board which was thought to be detrimental to its effectiveness. **Outcomes from R&D Workshop on 18/03/22** • Outcomes from the NRC workshops held in March and April 2022 - Clarity on the improvements required with an emphasis that now was the time for reinvestment into research and that if this did not take place within the next 3 months, there would be critical failures for the Trust in terms of reputation, staff retention and patient outcomes. An action plan for the next 3-18 months had been developed with the key priorities identified as: o Staffing – appointment of a senior NRC manager within the next 3 months and research nursing resource o Governance and quality assurance o Communication. Recruitment to a senior manager position (Band 8a) for the NRC was approved at Executive Team Meeting on 04/05/22.

		Review of SPARK Funding Applications • An update on Liverpool Health Partners SPARK grant applications where the Trust was either the study sponsor or lead site was presented. Out of 28 applications made; 17 had been unsuccessful, 1 had been successful and 10 were outstanding. Further work was being undertaken by the NRC to identify the reasons why applications had been unsuccessful to enable lessons to be learnt. Although some of the projects had been a success in terms of creating collaborations/networks there was acknowledgement that there was a need to turn activity into successful outcomes.
3.	**Assurance**	**Good Clinical Practice Training Progress Update** • A comprehensive review of GCP training compliance had been undertaken by the NRC which showed that out of 207 research active members of staff as of the 25 March 2022: 105 GCP certifications were in date, 53 GCP certifications required renewal, 49 had either not completed their GCP training or there was no record. Committee was assured that there were no non-compliant members of staff contributing to clinical trial/investigatory work and that the risks were being appropriately managed. Follow ups were being made with those staff identified as requiring GCP certification renewal or completion of their GCP training. Risk of future reoccurrence would be managed via recent increase in the administrative capacity within the NRC which would support a more robust governance process moving forward and also strengthening alignment with the Principal Investigators Forum.
4.	**Advise**	**UK Clinical Guidelines for the Diagnosis of Fibromyalgia Syndrome** • Dr Andreas Goebel was one of the lead authors for the new UK Clinical Guidelines for the diagnosis of Fibromyalgia Syndrome along with a Primary Care colleague from the Liverpool City region, Dr Chris Barker. The guidelines were launched at the Royal College of Physicians in Liverpool on the 26 April 2022: https://www.rcplondon.ac.uk/news/rcp-publishes-new-guidance-diagnosis-fibromyalgia . These were the first UK guidelines for the condition and would have a significant contribution to the patient group. Since their launch, the guidelines had received 4,000 downloads by service providers nationally and were an excellent example of cross-sector collaboration work across primary and tertiary care. Dr Goebel had also been involved in an auto-immune basis for Fibromyalgia study in conjunction with Kings College London which was nominated in December 2021 by the Guardian as one of the top 10 science stories of the year: https://www.theguardian.com/science/2021/dec/19/the-years-top-10-science-stories-chosen-by-scientists. As a result of the study, there had already been a £10 million investment generated in the North West primarily in Liverpool, from private companies. **Medical Education Strategy and Implementation Plan Update** • As a Trust, we are continuing to grow our medical education faculty and have recently appointed a Trainee Health and Wellbeing Lead, Miss Maggie Lee, Neurosurgical Consultant. This was a one-year funded post through Health Education England as part of the national COVID Recovery training programme to provide additional support to clinical and educational leads with regards to junior doctor pastoral and professional needs. Dr Antonella Macerollo had also been appointed as Undergraduate Research Co-ordinator for the Trust.

		The Trust was also looking to appoint to an Educational Appraisal Lead role and an expression of interest had been received in response to this. Financial approval had been received for a further year's funding for the Education Fellow posts.		
5.	**Risks Identified**	• No new risks identified		
6.	**Report Compiled by**	Professor Paul May, Non-Executive Director	Minutes available from:	Corporate Secretary

The Walton Centre NHS Foundation Trust

Council of Governors
14 June 2022

Report Title	Patient Experience Activity Annual Report
Executive Lead	Lisa Salter, Chief Nurse
Author (s)	Lisa Judge Head of Patient & Family Experience
Action Required	To note

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

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

Key Messages

- 100% of Trust KPIs achieved for acknowledging and responding to complaints in 2021/22
- Average response time of 23 working days against a target of 25 working days for Level 1 complaints
- June 2021 - Mersey Internal Audit Agency (MIAA) conducted an audit in relation to the Trust's complaints procedure and process. This resulted in the Trust being awarded High Assurance
- Complaints is noted to be High Performing on Trust's Integrated Performance Report (IPR)

Next Step

- Continue to monitor the identified themes and trends from concerns and complaints and embed actions and learning.

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

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

Not Applicable	Choose an item.	Choose an item.

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Quality Committee	19 May 2022	Lisa Judge, Head of Patient Experience	Annual report 2020-21 reviewed

Patient Experience Activity Annual Report

Executive Summary

1. All complaints and concerns are managed in line with the NHS Complaints Procedure via the Trust's Complaints Policy

2. The Trust have a statutory duty to acknowledge complaints within 3 working days and respond to complaints in line with their policy.

3. 100% of Trust KPIs for acknowledging and responding to complaints in 2021/22

4. June 2021 - Mersey Internal Audit Agency (MIAA) carried out an audit in relation to the Trust's complaints procedure and process. This resulted in the Trust being awarded High Assurance.

5. The full report of activity for 2021/22 is included as Appendix 1.

Background and Analysis

6. This report provides a summary of the Patient Experience teams' activity, outcomes and actions across the Trust for 2021/22. Providing the Council of Governors (COG) with assurance that themes and trends identified from complaints, concerns and claims are being managed appropriately.

7. Themes, trends and lessons learned identified are reviewed quarterly by the Thematic Review Group. The group includes representation from Nursing, Human Resources, Quality and Divisional Management teams.

8. Lessons learned are shared via the divisional governance meetings on a monthly basis and quarterly through the Quality Committee. Any trends from incidents, complaints, concerns managed via the Governance Assurance Framework (GAF) and the entries will be presented to the relevant divisional governance meetings information, monitoring and assurance purposes.

Conclusion

9. The Patient Experience Team will continue to monitor complaints management and the identified themes via the Quality Committee work plan.

Recommendation

i. To note report
ii. To take assurance that the Trust recognises the importance of lessons learned

Authors: Lisa Judge
Date: 23 May 2022

Appendix 1

Patient Experience Report Annual Report

1. Introduction

The purpose of the report is to:

- Provide an annual summary of Governance activity, outcomes, and actions across the Trust for 2021/22.
- Provide assurance to the Council of Governors those concerns, and complaints are being managed affectively, robust actions are taken to mitigate trends and we learn lessons are learnt.
- Provide assurance that we aim to provide the best possible patient and family experience.

2. Throughout 2021/22, the Patient Experience have:

- proactively listened to patients, carers and families thereby effectively resolving enquiries and concerns before they escalate to formal complaints
- provided additional support to families unable to visit their loved-ones due to visiting restrictions
- safely reintroduced the volunteer service on site
- continued to strive to improve the complaints management process in line with Trust targets
- proactively engaged with families/clinical staff by being involved at the earliest opportunity at best interest and multi-disciplinary meetings prior to discharge
- delivered bespoke training sessions and awareness sessions to teams and Council of Governors
- developed and implemented a new project to focus on a 7-day service of Patient Support Assistant role across wards, to bridge the gap between the ward and Patient Experience Team providing support to patients and families during visiting restrictions
- improved the delivery and compliance of Friends & Family Test (FFT) including introducing a digital platform and QR codes
- provided patients with access to a mobile phone to liaise with family members and undertake digital FFT feedback
- reviewed the mortality process and learning from deaths process in line with the introduction of the Medical Examiner
- implemented a new electronic referral system to the Medical Examiner/ Coroner
- introduced a new digital feedback form on website for patients and families to submit an enquiry, raise a concern or complaint or share a compliment
- developed new initiatives on wards with Sleep Well Packs for patients which include sleep masks and earplugs to aid patients to have a restful sleep supported by the Walton Charity
- introduced Birthday cards/gifts for all inpatients who experience their birthdays in hospital supported by the Walton Charity
- launched Carers Passport which developed with carers for carers by the Cheshire & Merseyside Head of Patient Experience Network
- introduced a Meet & Greet service front of house supported by volunteers to provide patients and visitors with face masks advise them to undertake hand sanitisation before entering the hospital
- in partnership with Healthwatch Liverpool & Sefton held virtual engagement events to seek the views of patients using the service
- accommodated junior doctors in Home from Home during refurbishment of the Drs mess and the instruction of the 24-hour thrombectomy service
- safely reintroduced families staying in Home from Home in line with infection prevention precautions
- provided emotional support to patients and families during emergencies and following bereavements

- reviewed memory boxes for bereavement to include connecting hearts kindly knitted by volunteers

3. Annual Complaints Activity

- In June 2021 the Mersey Internal Audit Agency (MIAA) carried out an audit in relation to the Trust's complaints procedure and process. This resulted in the Trust being awarded High Assurance demonstrating there is a strong system of internal control which has been effectively designed to meet the system objectives, and controls were consistently applied in all areas.

- 100% of Trust KPIs were met for 2021/22, as complaints were acknowledged and responded to within the negotiated timeframe with an average response time at 23 working days. An excellent outcome below the 25-working day target, breakdown below:

Average Response – working days	**Q1**	**Q2**	**Q3**	**Q4**
Overall Levels 1 & 2	20	27	25	22
Level 1	13	23	22	17
Level 2	33	44	44	36

The metrics for complaints and concerns are included in Appendix 2 in graph form.

- 76 new complaints were received in 2021/2022, Q1(16), Q2 (16), Q3 (22), Q4 (22) which is a 13% increase from 67 in 2020/2021. This is still a significant improvement compared to previous financial years (129 in 2019/20).

- Of the 76 complaints, 10 were upheld *(admission arrangements, diagnosis/treatment, lack of dignity/patient care, delay in treatment, approach/manner/dignity, appointment arrangements, discharge arrangements)*, 19 partially upheld *(care/treatment, admission arrangements, appointment arrangements, communication, approach & manner)*. 41 were not upheld, 1 was retracted and 5 remain under investigation. Actions/lessons learnt are recorded in Datix and managed via divisional risk and governance meetings

- 11 complaints were re-opened as further clarity was requested. A deep-dive review by PET revealed this was not because of the quality of the investigation or response but a difference of opinion by the complainant/Trust in relation to the factual/clinical information provided. There was no trend in area, individual or theme of subject of re-opened complaints.

- 743 concerns were received and successfully resolved in 2021/22, demonstrating a 44% increase from 515 in 2020/21. The aim is to see the number of formal complaints decrease whilst the number of concerns increase, this demonstrates an open and proactive approach to resolving issues. All concerns and complaints are reviewed with the divisional teams on a weekly basis to ensure timely responses.

- 307 enquiries/requests for support were responded to in 2021/22, which is a 17% increase from 262 received within 2020/21. The general themes of our enquiries relate to the referral process, general hospital enquiries and PET support in clinic appointments.

- 83 formal complaint cases were closed in 2021/22; 11 upheld, 22 partially upheld and 50 not upheld. Themes of those not upheld mainly related to diagnosis, treatment and patient care whereby the patient often disagreed with the clinical diagnosis or treatment decisions or their expectations regarding level of care was not met. The deciding factor as to whether these complaints were upheld or not often revolved around a clinical review of the case by the clinical lead and/or a patient journey review against National or local Trust standards.

- **Protected Characteristics -** 8 in total *Disability* (5) deaf [3] & visual impairment [2] *Gender* (2) all patients asked if they could be pregnant, trans status referred to in clinic letter, *Religion* (1) recorded incorrectly – All appropriately actioned. Disability Working Group to be implemented from May 2022.

- **New Service Introduced -** the introduction of a 7-day Patient Support Assistant roles introduced in March 2022 has demonstrated a positive impact for patients with over 70 contacts in the first two weeks, in addition to documenting more than 25 Trust wide compliments and successfully resolving concerns at the earliest opportunity and providing support for patients and families.

Key themes for complaints/concerns: Appointment arrangements (multifactorial) were the highest theme in Q4 and communication the highest annually this is also reflected in concerns. Approach and manner have significantly reduced in comparison to previous years. As of May 2022, a working group to review appointment arrangement and communication issues has been set up involving representatives from each divisional management team, our informatics and patient access team and PET.

4. Compliments

There were 211 compliments received in 2021/22 which is an increase compared to 2020/21. All compliments received are shared with any named staff members via email as well as their line manager/senior team as well as being included in appraisal data. Compliments are also reported at divisional governance meetings monthly and are used in Trust communications such as Team Brief, Walton Weekly and the daily Safety Huddle.

5. Volunteer services

- Services have resumed in almost all areas across the Trust with >50% of the current 59 volunteers active in roles across the Trust

- volunteer service provides a number of roles across the Trust including meet and greet, neurobuddies and trolley service across the wards

- Roles continue to be re-introduced in a balanced way in line with infection prevention and control guidance

- During covid restrictions volunteers provided support with making up LAMP testing kits and supported with a project in outpatients, together with infection control volunteers front of house.

6. Police/Coronial Requests

- Annually, a total of 51 police requests were dealt with in 2021/22 which was a 13% increase compared to the following year

- There was a slight reduction in coroners requests at 20 compared to 21 in 2020/21. The number of requests received are indicative of the nature of our patient group and links with the Trauma Network.

7. Claims & Coronial Inquests

Appendix 3 highlights details of the claims received by quarter, division, and value of closed claims.

A Clinical Negligence trial was held in January 2022. The Judge preferred the evidence of the Trust, and the claim was discontinued at the end of the trial with only defence costs to pay as qualified one-way costs shifting (QOCS) applies. This was partly due to the excellent consent process and good quality documentation.

Lessons learned from closed claims from 2021/22 include:

- **Communication**:Clinical Lead has written to medical/clinical staff to remind them of process for urgent referrals to radiology from OPD clinic.

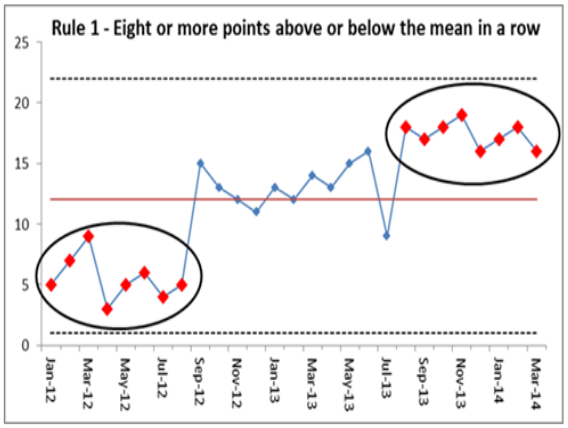
Thematic Review:

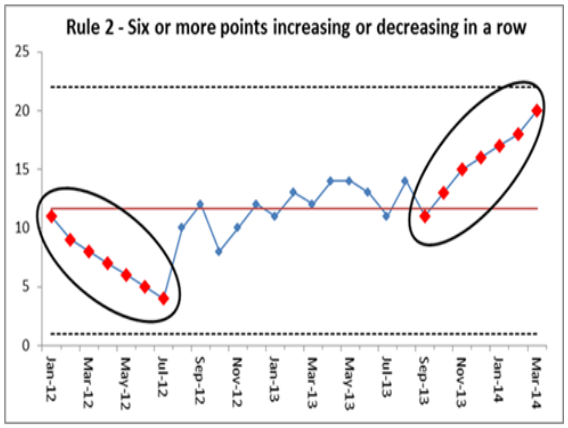
- Poor documentation and allegations relating to informed consent remains an ongoing theme in many of the claims received following the Montgomery vs Lanarkshire 2015 ruling and this is highlighted to medical staff during induction and to junior doctors at mandatory training sessions to raise awareness. This is also discussed at Work continues with regards to informed consent with the support of Trust's solicitors.

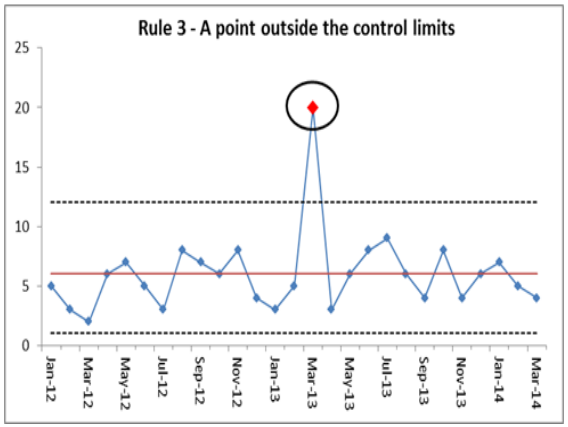
- 10 Coronial Inquests were attended in 2021/22 and the Trust did not receive any Regulation 28 (Report on Action to Prevent Future Deaths) during this time but were required to provide two follow up reports to the coroner for assurance. There are 5 Coronial Inquests scheduled to take place over the coming months.

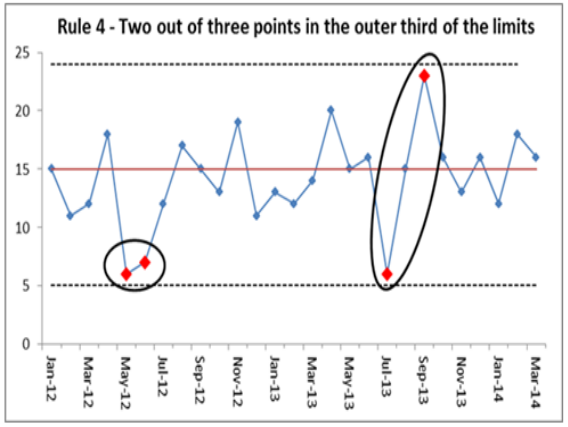
Appendix 2 – SPC charts & guidance

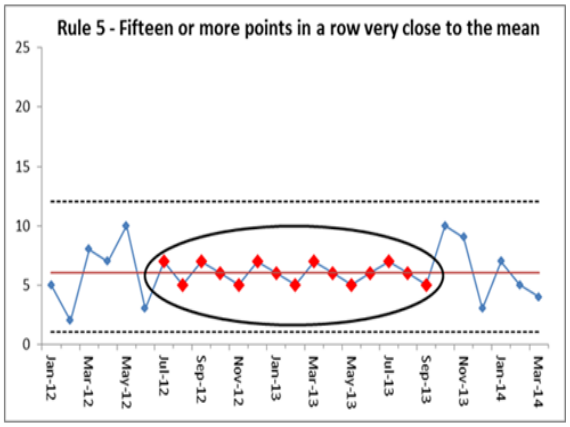
SPC Charts Special Cause Rules



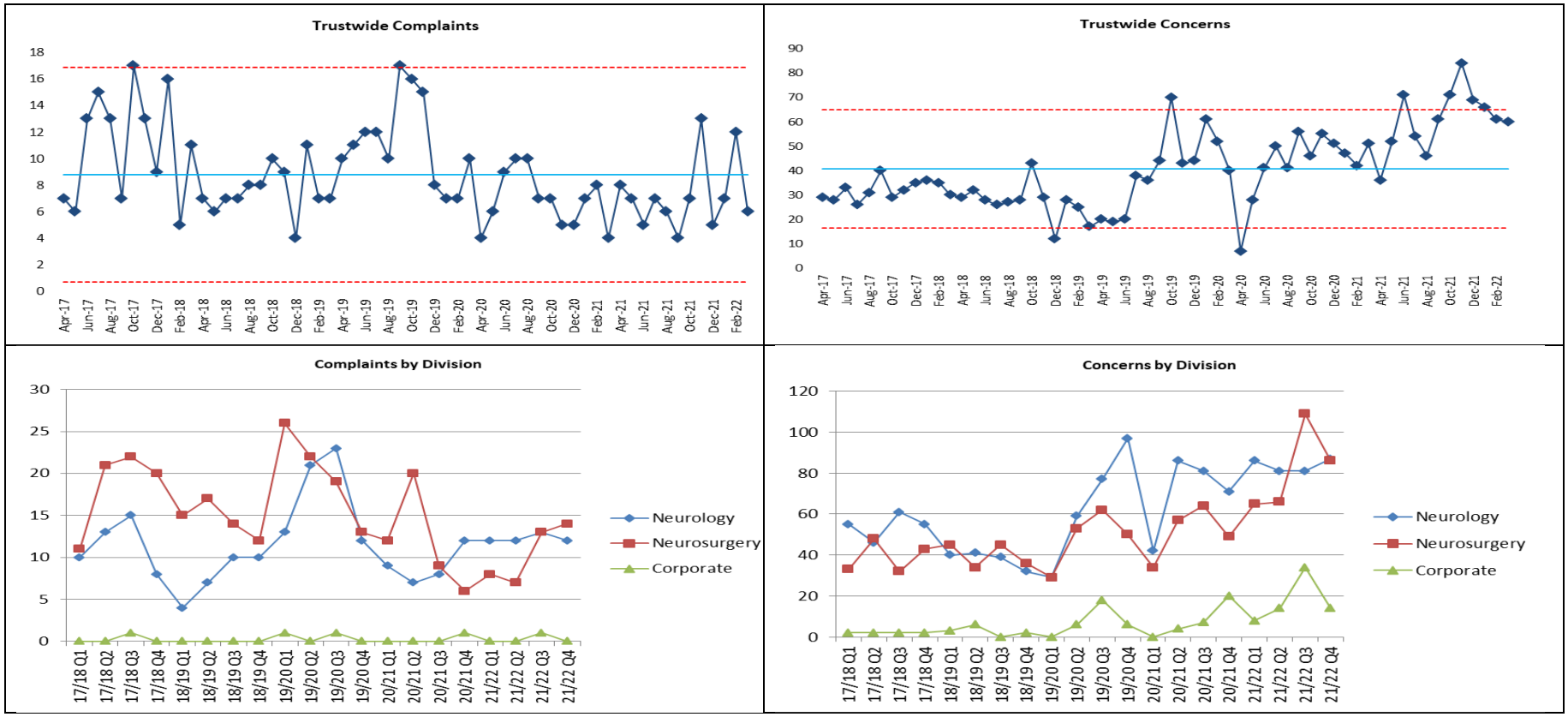


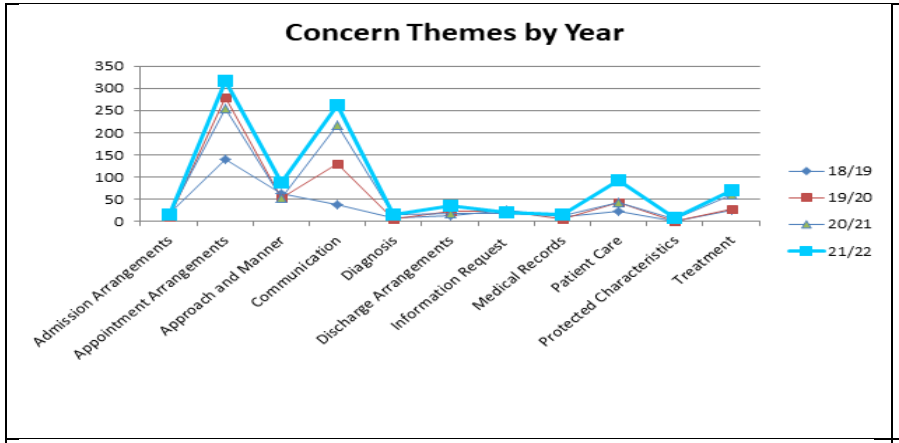


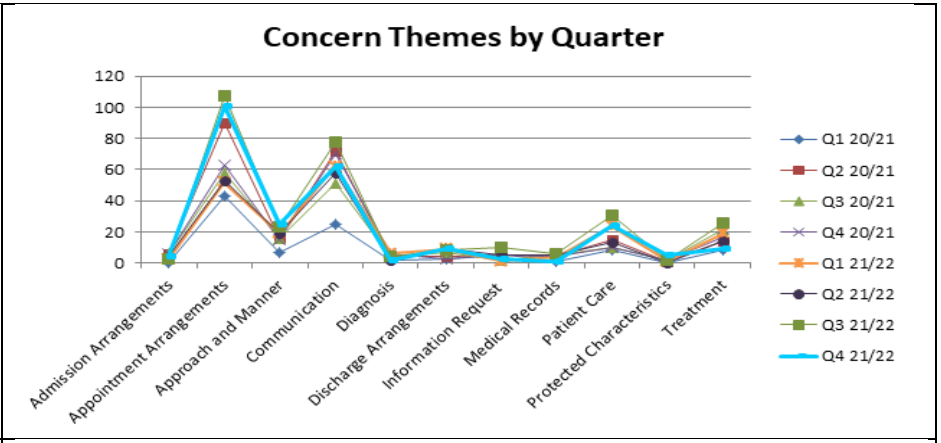


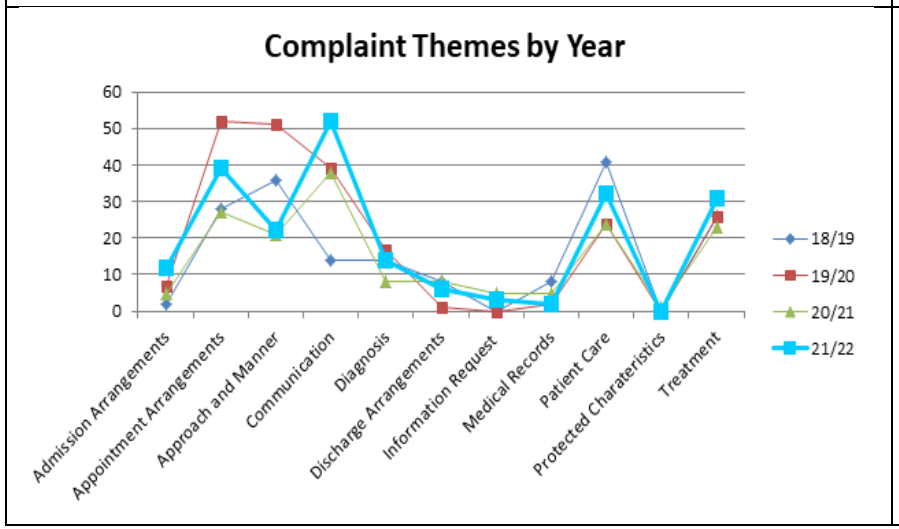


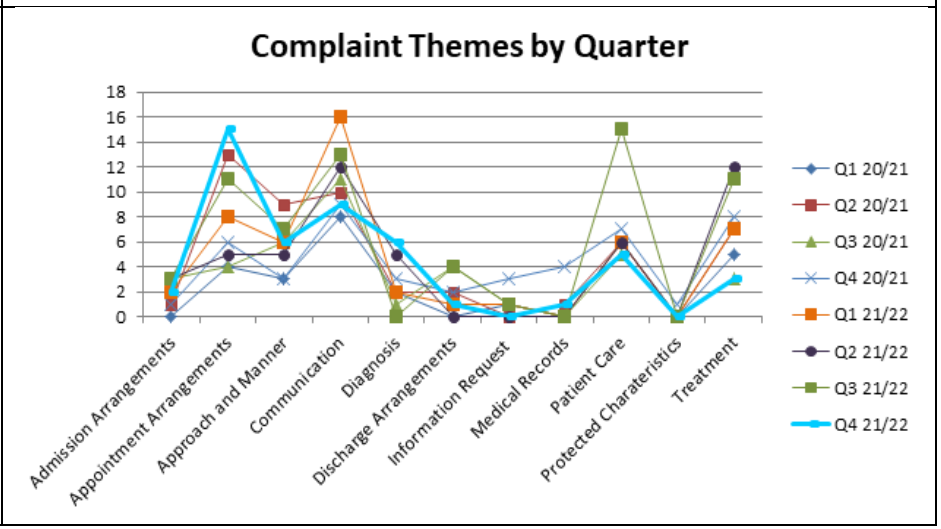
Complaints & Concerns overview




Concern Themes by Year
350
300
250
200
150
100
50
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Characteristics
Treatment
18/19
19/20
20/21
21/22


Concern Themes by Quarter
120
100
80
60
40
20
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Characteristics
Treatment
Q1 20/21
Q2 20/21
Q3 20/21
Q4 20/21
Q1 21/22
Q2 21/22
Q3 21/22
Q4 21/22


Complaint Themes by Year
60
50
40
30
20
10
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Charateristics
Treatment
18/19
19/20
20/21
21/22


Complaint Themes by Quarter
18
16
14
12
10
8
6
4
2
0
Admission Arrangements
Appointment Arrangements
Approach and Manner
Communication
Diagnosis
Discharge Arrangements
Information Request
Medical Records
Patient Care
Protected Charateristics
Treatment
Q1 20/21
Q2 20/21
Q3 20/21
Q4 20/21
Q1 21/22
Q2 21/22
Q3 21/22
Q4 21/22

Appendix 3

Trust Wide	Q3 20/21	Q4 20/21	Q1 21/22	Q2 21/22	Q3 21/22	Q4 21/22
Total new claims received	9	4	4	1	7	7
Neurosurgery claims	5	1	1	1	4	4
Neurology claims	2	3	1	0	2	1 Neu/NS
Corporate claims	2	1	2	0	1	2
Total number of pre-action protocols in quarter – contact made prior to submitting a claim	7	7	16	4	10	8
Number of closed claims in quarter	3	3	10	7	6	6
Value of closed claims - Public liability	£0.00	£5,000	£3,920.	£1,250.	£0.00	£0.00
Value of closed claims - Employer liability	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Value of closed claims - Clinical Negligence	£209,929.	£128,261.	£374,658.	£337,153.	£29,824	£1,291,650.

- One claim was a Trial in Court in 2021 where the Judge preferred the claimant's evidence and won the trial.
- One claim had been ongoing for some time with lessons learned at the time of the incident through RCA

UNCONFIRMED

MINUTES
Council for Governors Membership and Engagement Group
16 May 2022
MSTeams

Present:

John Taylor	CHAIR Public Governor – North Wales	Chair
Amanda Chesterton	Staff Governor – Clinical	Gov
Jonathan Desmond	Public Governor - Merseyside	Gov
Katharine Dowson	Corporate Secretary	CS
William Givens	Public Governor - Merseyside	Gov
Nanette Mellor	Partnership Governor The Brain Charity	Gov
Barbara Strong	Public Governor Merseyside	Gov
Elaine Vaile	Communications Marketing Manager	CMM
Carol Miller	Corporate Governance Officer (minutes)	CGO

Apologies:
None

1. Apologies

1.1. No apologies were received, the meeting was confirmed to be quorate.

2. Declarations of Interest

2.1. None

3. Minutes from Previous Meeting

3.1. The minutes of the 15 February 2022 had previously been agreed by email and no further comments were received.

4. Matters arising Action and Decision Logs

4.1. The Action Log was updated and the following items were closed as they were on the meeting agenda:

15/02/22	6.1	Governor Engagement Update
15/02/22	6.1	Governor Engagement Update
15/02/22	7.1	Membership Strategy Review and Action Plan
15/02/22	7.2	Membership Strategy Review and Action Plan

4.2. The following item was closed as it had been actioned and approved by the Council of Governors meeting in March 2022

15/02/22	9.2	Review of Terms of Reference

5. Membership and Governor Engagement Events

5.1. Gov BS and NM reminded members of the Virtual Pain Management Services Membership event on 18 May 2022 which they would be attending and they would provide feedback at the

next meeting particularly as this was the first of a programmed series of membership events post Covid-19.

5.2. The CS explained that the event was part of a wider pan-Liverpool approach to membership events and that local acute trust members had also been invited. This would be a good opportunity and mechanism for engaging with Trust members and other members of the public. A number of other events were planned for the rest of the year.

5.3. The CMM confirmed that the Walton Centre had featured in national and BBC coverage on pain management trials which were being carried out with GPs and that filming had recently taken place at the Trust and had featured Consultant Psychologists and patients.

5.4. Gov NM emphasised the availability of community assistance and the need to re-establish signposting to external services following Covid.

5.5. Gov BS advised that she had attended an NHS Providers training session on Holding to Account and Effective Questioning and she would circulate the slides to all governors for information.

The Membership and Engagement Group noted the update.

6. Membership Strategy Review

6.1. CS presented the final draft of the Membership Strategy which had been updated following the meeting in February 2022. The members were asked to agree that they were happy to recommend the Strategy for approval at the Council of Governors meeting in June 2022.

6.2. Gov-BS requested that an explanation be put on the membership maps to clarify what they depicted.

Action: With 1 minor change, the Membership Strategy was agreed and would be presented at the June Council of Governors to be approved.

7. Membership Strategy Action Plan

7.1. CS led a discussion on possible actions which could be put in place to operationalise the Strategy including Governor involvement in NED walk arounds and how Governors could engage with members once Covid restrictions were lifted.

7.2. Govs and the CS discussed:

- The importance of high profile two-way community engagement
- Providing engagement opportunities for members and governors to meet
- The importance of collaborative discussions which could arise from face-to-face engagement
- Membership surveys
- The importance of governor understanding on how to fulfil the requirement to engage and appropriately ‘represent’ the interests of members of their constituencies and the processes for raising concerns and questions

7.3. The CGO confirmed that all new governors were invited to induction training and that additional training and governor engagement opportunities were offered throughout the year to further develop governor understanding of their role.

7.4. The CS confirmed that a consultation on the revision of the Foundation Trust Code of Governance had commenced and that the revision would contain an addendum for Governors which would support Governors in understanding their roles and that once published a training/engagement session would be organised for governors.

Action: Action Plan to be presented at the next meeting

8. Annual Report of Committee's work

8.1. The CS presented the annual report on the work of the Membership and Engagement Group in 2021/22.

8.2. The key work and achievement of the group had been the revision of the Membership Strategy and membership engagement events.

The Membership and Engagement Group noted the annual report and achievements report

9. Draft Election documentation and Membership Election Figures

9.1. The CS presented the reports on the 2022 Governor Elections

9.2. Following a question from Gov-JT on the cost of an election the CS confirmed that costing were dependent on the number of vacant seats and membership numbers within those constituencies but the average costings were between £6k to £9k

The Membership and Engagement Group noted the Membership Election reports

10. Governor Election Engagement Events

10.1. The CS led a discussion on Governor involvement and possible engagement opportunities during the election including opportunities for members to talk to governors.

10.2. The importance of engaging with the public as part of existing networks was discussed as well as joining existing community and patient groups.

10.3. The group agreed that offering a governor-led virtual election event would be beneficial and that they would be available to participate and also provide any quotations which could be used on social media during the election.

10.4. The governors agreed that it was important to start with a clear understanding of what a governors responsibilities were to engage with members.

Action: Governors to take an active role in election engagement opportunities and a virtual Governor Led virtual event to be organised

11. Communication Activities

11.1. The CMM gave an overview of communication and marketing work undertaken to increase the awareness and profile of the Trust as the only dedicated specialist neurosciences Trust in the country:

- Trust Strategy – internal and external communication and engagement
- BBC - Pain Service Innovations
- Consultants/specialist nursing teams/clinical leads - Conducting face to face meeting to identify potential areas of work, good practice and innovation
- Granada - Trans-cranial MR-guided Focused Ultrasound or Focused Ultrasound, this was also picked up regionally in print and on radio
- 24/7 thrombectomy service

- Update of Trust Website – work ongoing, high scores for accessibility
- Tender process for the Intranet site had started
- Social media – increased followers and engagement

11.2. Following questions from Governors the CMM gave assurance that an accessible easy to read document which contained the key points of the strategy was being produced. Work was ongoing to raise the profile of the Trust to increase awareness and understanding of the innovation, work and services offered by the Walton Centre.

The Membership and Engagement Group noted the communication activity update

12. Any other business

12.1 The Chair thanked CGO for her support to the meeting over the last few years as this would be her last meeting before she left the Trust.

13. Close of meeting

Date of next meeting – 16 August 2022

The Walton Centre
NHS Foundation Trust

Council of Governors
14 June 2022

Report Title	Membership Strategy 2022-25
Executive Lead	Max Steinberg, Chair
Author (s)	Katharine Dowson, Corporate Secretary
Action Required	To approve

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

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

Key Messages *(2/3 headlines only)*

- New Membership Strategy for 2022-25 to support Governors to fulfil their duty to represent the interests of members
- Aligns with approved Trust strategic ambitions and cross-cutting themes approved by Board in May 2022

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

- To develop an action plan for monitoring by the Membership and Engagement Group

Related Trust Strategic Ambitions	**Impact** *(is there an impact arising from the report on any of the following?)*		
Choose an item	Choose an item.	Choose an item.	Choose an item.

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

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

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

Strategy ☐	Policy ☐	Service Change ☐

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

Committee/ Group Name	**Date**	**Lead Officer (name and title)**	**Brief Summary of issues raised and actions agreed**
Membership and Engagement Group	15 Feb 2022	K Dowson, Corporate Secretary	To align with the new Trust Strategy once approved. To engage with other stakeholders To add some photos
Membership and Engagement Group	16 May 2022	K Dowson, Corporate Secretary	Agreed, recommend for approval by CoG

Membership Strategy 2022-25

Executive Summary

1. This is the final draft of the new Membership Strategy that has been developed by the Membership and Engagement Group since February 2022.

Background and Analysis

2. A Membership Strategy for the Trust had been pending for some time as the last strategy ran from 2016-19. Revision of the strategy was postponed by staffing gaps and the Covid-19 pandemic. There had been also some discussion about incorporating membership within the general Communications and Engagement Strategy, but the Foundation Trust Code of Governance is clear that each Trust should have a standalone Membership Strategy.

3. The first draft of the new strategy was reviewed by the Membership and Engagement Committee in February and in May they agreed this final version to be received by the Council of Governors for approval.

4. The strategic ambitions and cross-cutting themes of the new Trust Strategy 2022-25 have now been approved by Board and have been included in this strategy.

5. The next step will be to develop an action plan for the Membership and Engagement Group to monitor.

Recommendation

To approve.

Author: Katharine Dowson
Date: June 2022

The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Membership Strategy 2022 - 2025

Table of contents

1. What is a Member?

NHS Foundation Trusts (FT) were established as a new type of NHS Trust that would have more freedoms to act. The Trust would be more accountable to the communities that they serve as they can become members of that Trust.

Members are given a greater say in the management and provision of services within the FT, directing their services more closely to their communities so that hospital services more accurately reflect the needs and expectations of local people (patient-led NHS services).

The Walton Centre believes our members make a real contribution to improving the health of our communities. Many of the Trust's patients, former patients and carers feel a strong allegiance to the Trust due to the life-saving and life changing nature of the conditions we treat and the services we provide. We believe that a membership that is actively engaged will help us achieve our Trust's Strategic ambitions.

By acting as ambassadors of the Trust, fundraising, assisting in health promotion, member recruitment and voluntary work our members, alongside members of the public, will enable the Trust to better serve its communities and ensure that its services are designed and developed around the needs and expectations of its patients and their carers.

We anticipate and proactively encourage our staff to continue to be members and actively engage with the organisation and raise our local, regional and national profile.

There are many different reasons why someone may choose to become a trust member. They may want to support their local trust, they may wish to have a say in how services are developed or how the Trust is run, or stand as a Governor of the Trust.

2. About us

The Walton Centre NHS Foundation Trust is the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services. We offer a world-class service in diagnosing and treating injuries and illnesses affecting the brain, spine and peripheral nerves and muscles, and in supporting people suffering from a wide range of long-term neurological conditions.

We serve a catchment area of 3.5 million people across Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man and North Wales and beyond. We have service partnerships with 18 NHS hospitals across the area we serve.

The Trust has been rated as 'Outstanding' by the Care Quality Commission twice. The independent regulator of all health and social care services in England published its first rating on Friday 21 October 2016, following announced and unannounced inspection visits to the Trust in April 2016. The second was announced in August 2019 after inspections in March and April 2019.

3. Trust vision

Our vision is Excellence in Neuroscience. We are always striving for outstanding patient outcomes and the best patient, family and carer experience. We will continue to cherish the standards we have achieved, whilst exploring how we can enhance these further, shaping neuroscience treatments and care for the future.

4. Our purpose and ambitions

Our purpose has been chosen by our staff to reflect our culture, what we believe in and what we strive to deliver for our patients and their families. As a specialist trust we have a strong track record of consistently performing well, delivering excellent patient outcomes in our specialist area of neurosciences care. We have a therapeutic focus and world class expertise in many rare and complex patient conditions in our specialist field. To deliver our vision and to meet our purpose, we have consulted with staff, patients and partners who agreed a set of ambitions together.

Our key ambitions are:

- Education, teaching and learning
- Research and innovation
- Leadership
- System working
- Social responsibility

These ambitions are underlined by a series of cross-cutting themes:

- People: Committed to a safe, healthy and productive workplace that promotes diversity of thoughts, heritage and social background
- Quality care: Ensuring the delivery of the highest quality of care to our patients and their families
- Health inequalities: We play a key role in tackling health inequalities across the system

- Digitalisation: Industry leading digital solutions for our patients and our people
- Best value: We will maximise use of resources, improve productivity and develop market opportunities to deliver best value for the Trust and the wider system

5. Our values

Our values underpin everything we do. They are:

- Caring
- Dignity
- Respect
- Pride
- Openness

6. Key drivers for Member, patient and public engagement

- The NHS Constitution sets out rights of individuals to be involved in decisions about their own healthcare and also in the planning of healthcare services. It also sets out the responsibilities of patients and public. The Walton Centre will aim to promote these rights and responsibilities through its engagement activities

- The NHS Act 2006 Section 242 (1B) places a duty on NHS organisations to involve and consult people when it comes to making changes to services

- The Health and Social Care Act 2012 empowers patients, giving a focus to public health; it extends the duty of governors to represent the interests of the public as well as membership

- The report of the Mid Staffordshire NHS Foundation Trust Public Inquiry – emphasised the importance of putting the patient first and made recommendations about enhancing accountability to the public, through the Governors

- NHS Improvement's (formerly known as Monitor)' Code of Governance refers specifically to patient and public engagement and the need for clarity about how public interests will be represented

- Monitor's Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors which highlights areas of best practice identified as a result of research with a number of Foundation Trusts.

7. Our Membership Strategy – Key aims

The COVID-19 pandemic has made it challenging to engage with members over the last two years. The Walton Centre and the NHS face ongoing challenges of managing COVID-19, alongside the other medical and healthcare needs of its patients and with limited finances. The aims of our Membership Strategy for 2022-25 reflect this environment.

The key aims are summarised as follows:

Maintain a membership that is representative of our patient population. We have a minimum membership figure of 5,000 and a current figure of approximately 7,500.

- Governor-led review of the Trust's Membership Strategy and the Membership Recruitment, Engagement and Communication plans in response to the needs of local communities
- Regular review of membership demographics
- Encourage new members who are less well represented within our patient population and profile of the public population

Communicate with members whilst ensuring the Trust achieves effective membership communications for a minimal cost.

- Embracing new ways of communicating such as online platforms and email while still ensuring that all members can access information in a way that they choose
- Running events, virtual and face to face for members, that provide insight into the services the Trust offers
- Encourage our members and members of the public to share experiences and spread the word about the excellent care received, enhancing the Trust's reputation or let us know how we can do better
- Ensure there are easy and effective methods for members to contact Governors

Engage with members throughout the year

- In service redesign, by seeking feedback from patients and families to ensure there is a balanced perspective in delivering our goals
- Ensure that governors are invited to attend regular Trust and partner events to help them engage and represent the communities they serve and gauge opinion on our care delivery
- Encourage participation in the Governor elections, either as a candidate or by voting

8. What is Membership?

Membership is free and members can choose the extent of involvement they wish to have by indicating on their Membership Registration Form which aspects of membership interests them. They can opt to increase or reduce their level of involvement at any time.

- Receive information about the Trust e.g. receive a printed or emailed newsletter four times a year. This will also be accessible on the website
- Participate in surveys, e-surveys and focus groups on areas of specific interest
- Attend meetings and events
- Consider standing for election as a Governor
- Find out more about volunteering
- Find out more about The Walton Centre Charity

The Trust will communicate and interact with members in accordance to their membership preference, to ensure members are given the opportunity to become involved in what interests them.

You can sign up online to become a member

https://secure.membra.co.uk/WaltonCentreApplicationForm/

Alternatively:

- Write to the Membership Manager, Executive Offices, The Walton Centre NHS Foundation Trust, Lower Lane, Fazakerley, Liverpool, L9 7L
- Phone our Membership Manager on 0151 556 3484
- Email to: membership@thewaltoncentre.nhs.uk

Members have a dedicated membership page on the Trust website.

https://www.thewaltoncentre.nhs.uk/get-involved/membership.htm

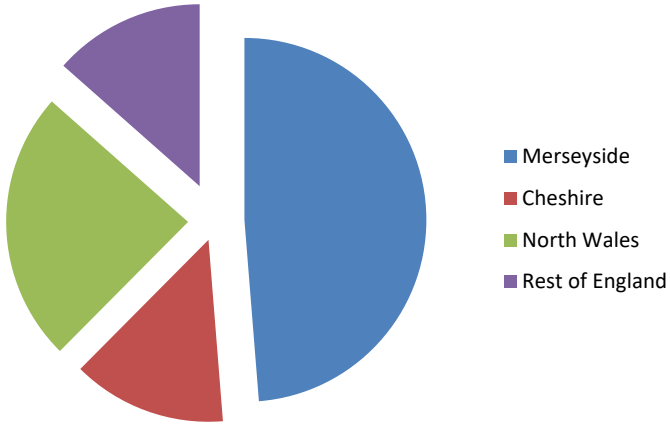
The Trust has a responsibility to ensure that all membership recruitment, communications and engagement activity is carried out in the most cost-effective way possible, achieving value for money. To achieve this all members will be encouraged to provide an email address on registration, enabling them to receive Trust information electronically. Hard copies of the membership magazine remain available to all members who prefer to receive it this way. Members are also encouraged to vote electronically when taking part in Governor elections but a postal return is also provided as an option.

9. Defining the membership community

Everyone is welcome who is willing to accept the responsibilities of membership, irrespective of age, gender, disability, social, racial, political, sexual orientation or religious belief (within the restrictions of Trust Membership). As a specialist Foundation Trust we have two membership constituencies

A **public constituency** divided into four defined voting areas, representing public, patients, carers and volunteers residing in these defined areas (see graph below).

Public membership by constituency



Constituency	Classification	Restrictions	Age	Rationalisation
Public **"Opt in"**	A Merseyside B Cheshire C North Wales D Rest of England and Wales	Vexatious complainants Any person who has made an assaults on staff or volunteers	16 years or over	Patients, carers, volunteers and public will be members of one of the four defined areas of the public constituency, determined by where they live. The defined areas of the public constituency are based on local authority electoral wards to ensure that all areas are fully and proportionately represented.

Distribution of membership across Constituencies A, B and C can be found in Appendix A.

A **staff constituency** divided into four defined classes

Staff: **"Opt out"**	• Registered Medical Practitioners • Registered and Non Registered Nurses • Allied Healthcare • Professionals -Technical and Scientific • non-clinical staff	Permanent or Fixed term contract >12 months	N/A	Rationale is for the inclusion of all staff in the change process for the future development of the hospital and the value the Trust places on staff involvement. Excludes volunteers and all honorary contracts of employment. Membership would be on a "opt in" public basis for these groups.

10. Engaging with our membership

As a Foundation Trust we recognise that recruiting and retaining a genuinely active membership will be challenging. Our membership provides an important vehicle through which to channel patient and public engagement activity and influence how we plan, redesign and deliver our services.

Our Governors are encouraged to engage within their own constituencies, including any community groups they are involved with, and they will continue to be supported by the Trust's Membership Office to improve this engagement. This has been particularly challenging through COVID-19 as many of the regular activities have not been possible.

In 2022 the Trust is trialling a series of virtual membership events which can be recorded and sent out to all members to watch in their own time.

These events focus on a particular area or services and are led by senior managers or clinicians talking about their area of specialism. We recognize that virtual events do not suit all members and will be reinstating face to face events as soon as we can. We will also continue to be mindful of making best use of resources and wherever possible seek opportunities to work with community groups or forums to create engagement activity.

Our aim is to continually increase the quality of participation and involve the patients of tomorrow as well as those of the past and present in order to ensure a balanced perspective in delivering our goals. Every member will have a different approach to how they wish to engage with us and the Trust aims to ensure that there are options that suit a wide cross-section of our membership community. We

understand that a proportion of our members simply wish to be kept informed of news and developments from The Walton Centre. However there is a proportion of our membership who would also like to be more engaged with the work of The Walton Centre. This is the group of members we will specifically focus on encouraging to become more involved and actively engaged.

The range of communication and involvement activities that we have identified for public members are as follows:

- On receipt of application, all public members will receive a welcome letter with a communication highlighting the Governors who represent them
- Neuromatters magazines will be distributed three times per year. In order to reduce costs all members providing permission to receive email communications will receive this electronically. This magazine is targeted at public members and members of the community in addition to all staff, patients and key stakeholders
- Member surveys to understand how members wish to be communicated with and areas they would like to be included in members events
- Invitation to Annual Members' Meeting, which is key meeting for accountability and an opportunity for Governors to report to members on their work in delivering the Membership Strategy
- In addition to other Membership events, members of the public are also welcome to attend and observe Council of Governors and Board of Directors meetings which are held in public
- Targeted invitations and mailshots/e-shots to participate in topical surveys, e-surveys or focus groups on specific issues to tie in with the Trust strategy
- Dedicated Members web pages on the Trust website which includes a feedback mechanism to Governors and the Membership Office.
- Members are encouraged to follow the Trust on social media e.g. Twitter and Facebook to hear more live information and news as and when it happens and use this as a means to be more interactive. This is also an important means for promoting membership events and newsletters. This is a cost-effective method of communicating and engagement and one that will be encouraged more in the future through the use of imagery and video.
- Organise Council of Governor walkabouts to enable engagement with staff members and patients and families
- Members can vote or stand for election to the Council of Governors
- Members are eligible to be appointed as a Non-Executive Director or Chairman of the Foundation Trust (subject to meeting criteria determined by the Foundation Trust)

- Become involved in fundraising for The Walton Centre Charity

The Membership Office will continue to seek new and innovative ways to communicate and engage with members and members of the public.

The following communication and involvement activities are also available to Staff Members:

- Receive a range of dedicated staff communications including dedicated Staff Intranet, Weekly Walton Way e-bulletin, global email communications and monthly Chief Executive Team Brief. This is in addition to the Neuromatters magazine.
- Induction of all new staff – including their role as a member

The Trust is also committed to offering translation and interpreting services to enable us to engage effectively with any member or community group where English is not the first language.

11. Measuring success

The Trust has identified the following indicators that will be used initially to measure the success of its membership representation:

- Maintaining minimum membership level of 5,000
- Identifying under-represented groups in the Trust's membership and improve this over time
- Election turnout – a year on year improvement with an ambition to be above the national average
- Results and return rate from bi-annual Membership Survey – to match or exceed the return rate of the last members survey (summer 2015) of 6.8%
- Fully functioning Council of Governors

The Council of Governor's Membership and Engagement Committee are supported by the Corporate Secretary and the Membership Office. They will monitor and support implementation of the Membership Strategy and regularly review the Membership Strategy and recommend revisions to the Council of Governors and Board of Directors. An annual report of activity against this strategy will be completed each year by the Membership and Engagement Committee and presented to the Annual Members' Meeting.

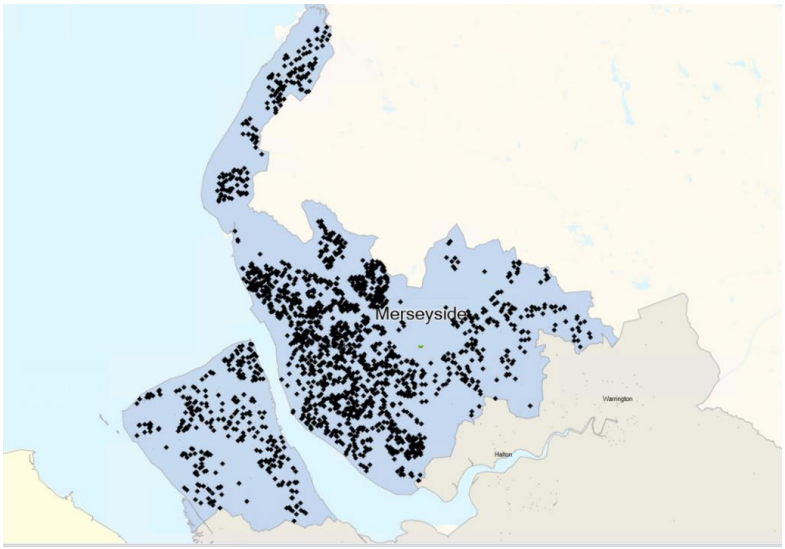
12. Privacy notice

We collect and hold public and staff member information for the purposes of the Trust to meet the legal requirements set out in UK law, or exercise the official authority established for a Foundation Trust as a public body. Personal information will only be used to fulfil the requirements in relation to the individual's membership of The Walton Centre NHS Foundation Trust and not shared elsewhere.

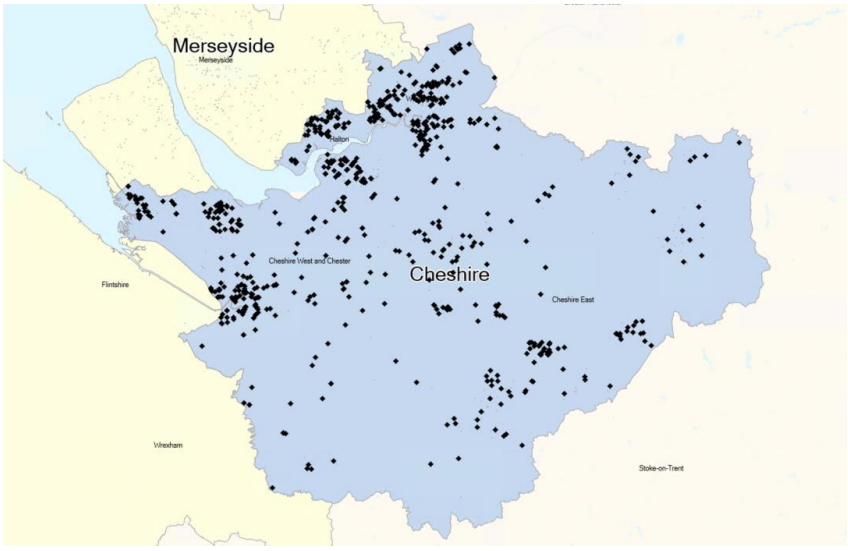
Staff and Public Members can opt out at any time by contacting the Membership Office on 0151 556 3484 or by emailing membership@thewaltoncentre.nhs.uk

Appendix 1 – Location of Trust Members

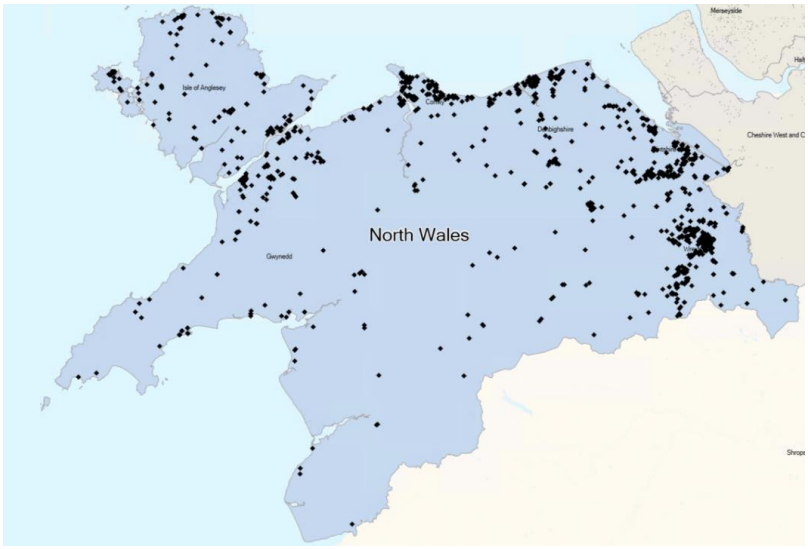
Merseyside



Cheshire



North Wales



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The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

The Walton Centre NHS Foundation Trust

UNCONFIRMED

Minutes of the Council of Governors Nominations & Remuneration Committee

Wednesday 11 May 2022

Virtual meeting held on MS Teams

Present

Su Rai	Senior Independent Director (SID) - Chair
Barbara Strong	Lead (Public) Governor (LG)
Ella Pereira	Partnership Governor (Gov)
John Kitchen	Public Governor (Gov)
Jan Vaughan	Partnership Governor (Gov)
Louise Pate	Staff Governor (Gov)

In Attendance

Katharine Dowson	Corporate Secretary (CS)
Jan Ross	Chief Executive Officer (CEO)

Apologies

Max Steinberg	Chair

Ref.	Item
1	**Welcome and Apologies**
1.1	Apologies as above.
1.2	SID advised that she would be chairing the meeting as the Chair had sent apologies.
2	**Welcome and Declaration of Interests**
2.1	SID advised that she would be excusing herself from the meeting for item 6 due to an interest in this item. LG would chair the Committee for this item.
3	**Minutes of the previous Meeting**
	The minutes of the previous meeting, held on 24 January 2022, were agreed as a true and accurate record. There were no open actions for discussion.
4	**Non-Executive Director (NED) Roles**
4.1	The update on NED roles was noted; this followed a review when the Chair started in April. SID added that she was also a member of the Strategic BAME Advisory Group and Chair of the Walton Charity Committee.
5	**NED Recruitment**
5.1	SID outlined the proposal in the paper which was to agree the process for the recruitment of a new NED to fill the vacancy created by the retirement of Seth Crofts former Acting Chair. The Committee were also being asked to decide whether to appoint a recruitment partner and if so which of the two proposals should be taken forward.
5.2	SID advised that the Board had recently conducted a review of Board strengths, skills and identified any gaps and it was proposed that the recruitment process would address these. The Board felt it was most important to increase the diversity of the Board and therefore one of the proposals for support was from a specialist agency in this area. Other skill areas identified that would enhance the Board were branding and communications and digital. It

5.3	had also been recognised that someone with attention to detail would be welcome.
5.4	LG noted that only one proposal included unconscious bias training. CS replied that this was an additional option provided, but the Trust was planning to deliver this in house.
5.5	SID asked the Committee to consider whether an external recruitment partner was the right option at this time and outlined the advantages which came with a resource cost. JR added that the Trust had considered the best approach to take and believed that using a partner this time was the right option to increase the pool of candidates. The Trust had last used an agency in 2019 when the SID and Professor Nalin Thakkar had been appointed and they had fulfilled the brief of increasing diversity at that time.
5.6	The Committee noted the cost but agreed that this was the right approach for this recruitment. Gov-JK clarified whether the Trust would have to pay the VAT and SID confirmed that this was the case and it would not be recoverable.
5.7	LG commented that the Audeliss proposal was very professional but was primarily about them rather than what they would bring to The Walton Centre in particular. Their experience in the NHS was also not as wide as the Gatenby Sanderson (GS) proposal and therefore she would support the GS proposal as they were also more cost-effective.
5.8	CS commented that Audeliss had been approached as they were a more specialist, smaller agency who focused on the recruitment of candidates from diverse backgrounds and worked across the public and private sectors. Because of the specialist nature they were more expensive, but the recommendation of the Head of Equality, Diversity and Inclusion had been to use a specialist agency. CS added that she had worked with GS previously and found them to be excellent partners who provided a very good service.
5.9	Gov-JK asked the SID how the process with GS had felt as a candidate and she replied that it had been very thorough; she had felt very supported and prepared by the process.
5.10	The Committee agreed that the GS proposal was very comprehensive and that GS should be appointed for the reasons outlined above including the price differential of £8k plus VAT between the two proposals. **Resolved:** • **To advertise for a new NED using an agency, with particular emphasis to be placed on recruiting someone from a more diverse background** • **To appoint Gatenby Sanderson as the recruitment partner** *SID left the meeting* *LG took the Chair*
6	**Reappointment of NED to a second term**
6.1	LG reminded the Committee that the SID had originally been appointed as Chair of Audit Committee due to her specialist financial background, since then she had taken on additional roles. SID was an effective and valued member of the NED team who had discharged her duties effectively and been subject to appraisal each year which have been positive. LG added that she would want to support SID being in post for a further three years. JR confirmed that this was the view of the Executive as well. **Resolved: The Committee would recommend to the Council of Governors that the SID be asked to serve a second term of office from 1 August 2022**

SID returned to the meeting and took the Chair
LG took the Chair

7 NED and Chair Appraisals

7.1 SID advised that a timetable had been prepared for appraisals and the approach was being shared today for information.

7.2 CS reported that the Trust is asked each year by NHS England to provide evidence that appraisals have been completed by 30 June (for Chair) and 30 Sept (for NEDs). This is not a requirement for Foundation Trusts, but the Trust has previously made the decision to support this process.

7.3 CS advised that timings were difficult this year as the Trust had a new Chair in post from 1 April and it would not be effective for the Chair to start with his own appraisal or that of NEDs until he has had chance to get to know individuals and the Trust. Therefore, NHS England have been advised that the process will be delayed this year as per the timetable below.

Chair Appraisal

Task	Participants	Date
Meet to set expectations and agree approach	Chair, SID, CS	Early September
Get Stakeholder Responses	CS	1- 20 Oct
Appraisal	Chair/SID	By 12 November
Sign off by both parties	Chair/SID	25 November
Report outcome to Council of Governors	SID	8 December
Submit appraisal	CS	31 December

NEDs Appraisal

Task	Participants	Date
Meet to set expectations and agree approach	Chair, CS	Early June
Get Stakeholder Responses	CS	20 June – 4 July
Appraisal	NEDs/Chair	By 18 August
Sign off by both parties	NEDs/Chair	25 August
Report outcome to Council of Governors	SID	9 September
Submit appraisals	CS	30 September

7.4 As part of the process the Trust would seek stakeholder feedback for all appraisals. For the Chair this includes external stakeholders as well as internal stakeholders which would be the other Board members and Governors

7.5 SID asked if the Chair has been set objectives and CEO confirmed that these were in place.

8 Any Other Business
There was no further business.

7 Date, time and venue of next meeting
The date, time and venue for the next Committee meeting in would be confirmed in due course when the NED recruitment timetable is set.

UNCONFIRMED

COUNCIL OF GOVERNORS ADVISORY COMMITTEE

23 May 2022

Present		
Barbara Strong - (Chair)	Public Governor	Chair
John Taylor	Public Governor	Gov
John Lloyd-Jones	Public Governor *(to item2 only)*	Gov
Apologies		
Melanie Worthington	Partnership Governor	Gov
In attendance		
Julie Kane	Quality Lead *(to item 3 only)*	QL
Katharine Dowson	Corporate Secretary	CS
Carol Miller	Meeting Administrator	MA

1. Apologies

1.1. Apologies as noted above

1.2. It was noted that the meeting was Quorate.

2. Minutes from Previous Meeting and action log

2.1. The minutes of the previous meeting had previously been confirmed by email as a true and accurate record and no further comments were received.

2.2. It was noted that all items on the action log had been actioned at the March meeting of the Council of Governors and were therefore closed.

3. Annual Quality Accounts

3.1. The QL presented the Draft Quality Accounts noting that several of the priorities had not been met due to Covid but offered assurance that these were being taken forward into 2022/23. Governors were requested to provide an opinion on the Quality Accounts.

3.2. Following questions from Govs, the QL clarified the process that had been used to identify Quality Account priorities:

- Possible clinical patient focused priorities were initially identified by identifying trends in incidents and complaints and by consultation with department heads
- The final priorities to include within the Quality Accounts were selected by engagement with Healthwatch, Governors and external stakeholders.

3.3. The CS clarified that key external stakeholders such as Healthwatch had always provided a commentary against the final Quality Accounts report and whilst Governors had historically not been approached to provide comment the CS and QL agreed that it would be appropriate that they were given the opportunity going forward.

3.4. It was noted by GOVs that whilst the report was transparent, honest, and open they had not had sufficient opportunity to fully digest the report yet to provide a view. It was agreed that sight of a previous report would be useful as an indicator of what was required and that Govs would be given additional time to consider the report fully and provide a commentary to CS.

QL left the meeting

ACTION:

- MA to send 2021/22 report to Governors
- Governors to submit a commentary to CS by 31 May 2022

4. Council of Governors Effective Review

4.1. It was noted that John Lloyd-Jones had left the meeting due to technical difficulties and the meeting was no longer quorate. As there were no decisions to be made the Chair made the decision to carry on with the meeting.

4.2. The CS presented the result of the Annual Council of Governors Effectiveness review which had taken place in March and April 2022. The results would be presented to the June 2022 Council of Governors meeting. Areas highlighted and actions which had been put in place included:

- The challenge of holding the Non-Executive Directors (NED) to Account
  - The Council of Governors agendas had been changed to emphasis NED accountability and allow time for in depth questioning to take place between governors and NEDs.

- A small number of negative responses received regarding face-to-face meetings and engagement with members
  - The Membership Strategy which was being presented to the March CoG for agreement which should address these issues
  - Quarterly virtual membership events had been organised for 2022/23 and the first event had been well attended by stakeholders and service users.

- The consistent negative responses which had been identified in the MIAA Governor survey presented to the March 2022 Council of Governors had not been repeated in the responses received this time

- Governor and member engagement on the revised Trust Strategy had been well received and Governors felt that they had been offered an informal opportunity to comment which was a good foundation for building engagement in the future.

4.3. A discussion took place on the response rate of 55% to the survey. CS agreed that it was disappointing and Governor engagement was important. It was hoped that this would improve following the reintroduction of face-to-face meetings and vacant CoG posts being filled at the forthcoming election.

The CoG Advisory Committee: Noted the report

5. Draft Action Plan

5.1. The CS presented the draft action plan.

Following discussions, the action plan would be updated as follows:

- **1. I understand the COGs role in holding the NEDs to account**
  - The Council of Governors agendas had been changed to increase NED accountability and involvement
  - All governors to be invited to annual Governor Induction training and pan-Liverpool membership and training opportunities
  - The Chair is to introduce small face to face informal meetings between NEDs and governors

ACTION: Action plan to be updated and presented at the June 2022 Council meeting

6. AOB

6.1. **Governor Pen pictures**

Following a request from the Chair for governor pen pictures it was agreed that this was already provided on the 'Meet the Governors' website page and would be enhanced by the reintroduction of Chair and governor face to face meetings.