NHS
The Walton Centre
NHS Foundation Trust

Public Trust Board Meeting

Thursday 4th February 2021

Agenda and Papers

Excellence in Neuroscience

OPEN TRUST BOARD MEETING
AGENDA
4th February 2021
Virtual Meeting
WCFT
09:30 – 10:30

v = verbal d = document p = presentation

Item	Time	Item	Owner	Purpose
1	09.30	Welcome and Apologies	J Rosser	N/A
2	09.30	Declaration of Interests	J Rosser	N/A
3	09.35	Minutes and actions of meeting held on 3rd December 2020	J Rosser	Decision (d)
STRATEGIC CONTEXT				
4	09.40	Chair and Chief Executives Update - verbal	J Rosser/ H Citrine	Information (v)
5	10.00	COVID-19 Update	H Citrine/ Execs	Information (v)
CONSENT AGENDA				
Subject to Board agreement, the recommendations in the following reports will be adopted without debate:				
6	10.20	Q3 Governance Report	L Vlasman	Information (d)
7		Q3 Mortality and Morbidity Report	A Nicolson	Information (d)
8		Integrated Performance Report	CEO/Execs	Assurance (d)
9		Quality Account 2019/20	L Vlasman	Assurance (d)
10		Charitable Fund Accounts	M Burns	Ratification (v)
11		Audit Committee Chair's Report	S Rai	Assurance (d)
12		Quality Committee Chair's Report	S Crofts	Assurance (d)
13		Business Performance Committee Chair's Report	D Topliffe	Assurance (d)
14		Research, Innovation and Medical Education Committee Chair's Report	S Crofts	Assurance (d)
15		Neurosciences Programme Board Chair's Report	M Burns	Assurance (d)
16		Charity Committee Chair's Report	S Rai	Assurance (d)
17		Strategic BAME Advisory Committee Quarterly Summary	H Citrine	Assurance (d)
CONCLUDING BUSINESS				
18	10.20	AOB	J Rosser	Information

Date and Time of Next Meeting:
4th March 2021 commencing at 9.30am

UNCONFIRMED

Minutes of the Open Trust Board Meeting

Meeting via MS Teams

3rd December 2020

Present:

Ms J Rosser	Chair
Ms K Bentley	Non-Executive Director
Mr S Crofts	Non-Executive Director
Ms S Rai	Non-Executive Director
Professor N Thakkar	Non-Executive Director
Mr D Topliffe	Non-Executive Director
Ms H Citrine	Chief Executive
Mr M Burns	Director of Finance and IT
Dr A Nicolson	Medical Director
Ms J Ross	Director of Operations and Strategy
Ms L Vlasman	Acting Director of Nursing and Governance
Mr M Gibney	Director of Workforce and Innovation

In attendance:

Mr J Baxter	Executive Assistant
Ms J Hindle	Corporate Secretary
Ms J Makin	Accommodation & Patient Experience Officer (item TB100-20/21 only)
Ms H Wells	Deputy Director of Finance (Observing)

Observing:

Ms B Strong	Public Governor - Merseyside

Trust Board Attendance 2020-21

Members:	Apr	May	Jun	Jul	Sept	Oct	Nov	Dec	Feb	Mar
Ms J Rosser	✓	✓	✓	✓	✓		✓	✓		
Mr S Crofts	✓	✓	✓	✓	✓		✓	✓		
Ms S Samuels	✓	✓	✓	✓						
Ms B Spicer	✓	✓	✓	✓	Apols					
Ms S Rai	✓	✓	✓	✓	✓		✓	✓		
Prof N Thakkar	✓	✓	✓	✓	✓		✓	✓		
Mr D Topliffe							✓	✓		
Ms K Bentley							✓	✓		
Ms H Citrine	✓	✓	✓	✓	✓		✓	✓		
Mr M Burns	✓	✓	✓	✓	✓		✓	✓		
Mr M Gibney	✓	✓	✓	✓	✓		✓	✓		
Dr A Nicolson	✓	✓	✓	✓	✓		✓	✓		
Ms J Ross	✓	✓	✓	✓	✓		✓	✓		
Ms L Salter	✓	✓	✓	✓	Apols		Apols	Apols		

TB97-20/21 Welcome and apologies

Ms Rosser welcomed those present to the meeting via Microsoft Teams and noted that Ms Wells was attending in an observation capacity as part of a Leadership Academy training course.

Apologies were received from Ms L Salter

TB98-20/21 Declarations of interest

There were no declarations of interest in relation to the agenda.

TB99-20/21 Minutes of the meeting held on the 5th November

It was noted that Mr Burns presented item TB94-20/21. Following completion of this amendment the minutes were agreed as a true account.

It was noted that Mr Burns would clarify with Ms Hindle if the amendments to approval limits within the Scheme of Reservation and Delegation could be implemented immediately.

TB100-20/21 Patient Story

Ms Makin joined the meeting to share a story from the mother of a patient who had been diagnosed with breast cancer in 2018 at another Trust and later presented at their local accident and emergency with excruciating headaches in July 2020. A CT scan was performed which confirmed a brain lesion and the patient was informed that the cancer would be terminal. The patient sought a second opinion and was referred to the Walton Centre and noted difficulty in contacting the Patient Access Centre so contacted the Patient Experience Team for assistance. The Patient Experience Team assisted the patient by forwarding the referral on to the Divisional management team for a multi-disciplinary team (MDT) review and worked with the referring Trust to ensure diagnostic scans were available for review. The patients mother articulated their relief at having the Patient Experience Team as a point of contact during treatment at Walton and afterwards whilst her daughter was in the hospice and sadly deteriorated and died. She wished to record her thanks to the team for their support and assistance during such a difficult time.

Ms Vlasman noted that a number of letters had been received from the family all of which had been complimentary and detailed how supported they felt by Ms Makin throughout the patients pathway.

Ms Rai queried if the Patient Experience Team would normally work in this way and Ms Makin clarified that the team spend a lot of time offering emotional support to patients and their families and were not just there for complaints.

Ms Citrine recorded her thanks to Ms Makin and recognised that the level of support provided must have been huge for the patients mother to write to the Trust with such praise.

The Board thanked Ms Makin for sharing the patient story and she left the meeting.

Mr Topliffe recognised that this was a very emotional case for Ms Makin and queried what support was in place for staff. Ms Vlasman confirmed that the Patient Experience Lead supported her team and the team was now based in a shared office with the Matrons who were also on hand to offer support. Mr Gibney highlighted that there was a support network around teams including a counselling service that staff could be referred or self-refer into. The counselling service was provided by the Network of Staff Supporters (NOSS) and was very well utilised with a number of counsellors available. The need to be pro-active in providing support was recognised by all.

TB101-20/21 Chair & Chief Executive Report

Ms Citrine reported the appointment of a Head of Communications and Marketing following a strong field of candidates. The start date for the successful candidate had not yet been confirmed.

Ms Citrine and Mr Gibney had recently met with Clive Lewis from Globis to discuss the provision of a Civility Unconscious Inclusion session at the next Board Development Day which was to be held on 14th December.

Discussions had been held with Tony Marsden around the Neuroscience approach to the Liverpool Health Partners (LHP), it was noted that this work had been paused due to COVID.

It was noted that there had been improvements in relation to COVID infections across the North West with the R rate in the North West currently the lowest in the country however there remained a significant North / South divide. Concerns were noted regarding scientific modelling that indicated the likelihood of a third wave with infections expected to increase during January and February. It was highlighted that 18% of regional beds were filled by COVID positive patients. A programme of lateral flow self-testing was underway with all frontline staff invited to take part and complete a self-test twice weekly, bank and agency staff were included in this programme along with ward clerks.

Preparations to administer a COVID vaccination programme were underway and the Trust was working in collaboration with Liverpool University Foundation Trust (LUFT) to deliver this. Work around this was moving quickly and the vaccination programme could commence as early as the week commencing 7th December.

It was noted that the seasonal flu vaccination programme had been successful with 77% of frontline staff receiving the flu vaccination and 80% of Trust staff overall vaccinated.

The in-hospital cell had established a much improved governance structure which was beginning to take shape, it was planned this would migrate to becoming the Provider Alliance which would involve all Trusts in readiness for April 2021. It was noted that NHSE&I had published a paper in relation to readiness which contained some of the proposals for financial and system working going forward.

The Chair gave formal notification of Non-Executive Directors joining committees. It was noted that Mr Topliffe would be joining Audit Committee and Business Performance Committee and Ms Bentley would be joining Quality Committee and Business Performance Committee.

Ms Rosser provided an update from the North West Chairs meeting and highlighted discussions regarding the distribution of the COVID vaccine and noted that the storage requirements for the Pfizer vaccine meant that it was not suitable for primary care and community use. Professor Calum Semple has produced a blog for Alder Hey explaining how the vaccine works and the possibility of sharing this was being explored.

It was noted that mass testing continued across the city and the delivery of this programme had been transferred from the army to the city council.

Mr Gibney noted that trade unions supported staff receiving a vaccine however would not mandate this. It was also recognised that some vaccines were bovine based which raised some ethical issues. Professor Thakkar queried the prioritisation of staff groups for receiving the vaccine and it was stated that due to the volatility and stability of storing the Pfizer vaccine staffing groups would be targeted as far as possible and it would be available for as many staff as possible.

Ms Ross informed that there was a national trial around COVID testing within care homes however the model within Liverpool was stricter than the national model. Visiting over the Christmas period was under review and national guidance around this was being awaited.

The Chair informed that the Chair of LHP was stepping down and a recruitment process

was underway. It was recognised that this was a good opportunity to help shape the direction of LHP. Mr Crofts noted that he was a member of the Remuneration Committee for LHP and the LHP was currently engaging with the membership regarding the person specification for the position of Chair. This was recognised as a positive process and ensured consistent views in the direction of travel regarding health development across the city.

The Chair reported that the Countess of Chester hospital were currently recruiting to the position of Chair.

The Board:

- **noted the report.**

TB102-20/21 **Integrated Performance Report**

Ms Citrine provided an overview of performance noting that the report had been discussed in detail at both Quality Committee and Business Performance Committee as the chairs reports noted. It was noted that good progress had been made regarding patient waits however this was expecting to dip during winter months and COVID surges. It was highlighted that cancer targets continued to be met.

Staffing levels had stabilised with a reduction in staff turnover noted. Good mandatory training levels had been maintained and it was recognised that infection prevention and control indicators were good ant the challenges previously noted with PE/VTE and MSSA indicators having stabilised with actions taken.

Quality

Mr Crofts provided an update on hospital acquired infections and noted that there were currently 7 reported cases of MSSA against a trajectory target of 8. A working group had been formed and deep dives were underway for all MSSA infections with a strategy put in place to try and to reduce the number of infections. There had been no cases of VTE reported during October and it was noted that the recent spike in numbers was strongly related to COVID. The challenges in meeting targets related to risk assessments was recognised.

Ongoing improvement actions regarding pressure ulcers and falls were in place however it was noted that this was not a big issue at the moment. An increase in waiting times had been noted and this was under surveillance at Quality Committee and Business Performance Committee.

Ms Vlasman stated that international recruitment work was underway across the Cheshire and Merseyside region and updates would be provided as this work progressed. The Trust was working in collaboration with other Trusts across the North West.

The Chair noted that risk assessments had been discussed at Business Performance Committee and it had been highlighted that all patients were risk assessed on admission. Ms Vlasman informed that a lot of patients were admitted as day cases on Jefferson ward and risk assessments were completed but these were not always being sent to the wards on a patient transfer.

Performance

Ms Ross noted the challenge to see and treat patients in a timely manner however big

improvements had been made and it was noted that challenges remained regarding 52 week breaches. Activity and recovery had improved however challenges remained; work was underway to recover elective activity across the region.

Workforce

Mr Gibney advised members that sickness levels had improved and was now at 6.4% with 1.4% of this figure due to staff isolating. 0.5% of this figure was due to COVID related illness and the core sickness level was 4.5%.

There were currently 22 Nursing vacancies across the Trust which was higher than normal and this was why the Trust was participating in the regional international recruitment process.

Finance

Mr Burns provided a high-level summary of the financial position and noted that the Trust was now being monitored against the year-end forecast of a deficit of £1.5m submitted in October. It was noted that a revised forecast of a £1.3m deficit had been submitted during November. The Trust reported a surplus of £194k at the end of month 7 which was an improvement of £253k against a planned deficit of £59k. This was primarily driven by underspends on excluded drugs and devices.

It was noted that the Trust had spent approximately £2m on COVID year to date and all costs related to COVID were subject to independent audit if requested through NHS Improvement.

Key financial risks and actions for 2020/2021 were highlighted.

Mr Topliffe requested a detailed financial plan to be submitted to the next Business Performance Committee meeting and it was recognised that a mitigation plan was in place with detail around this to be provided.

The Board:

- **noted the integrated performance report.**

TB103-20/21 **Infection Prevention and Control Board Assurance Framework**

Ms Vlasman presented the Infection Prevention and Control Board Assurance Framework and noted that this had previously been presented in May and was part of the national requirement for COVID reporting. The report contained a lot of detail and provided an assessment of compliance against Public Health England guidelines published by NHSE/I. Some of the risks were being managed via the Senior Nurse Team and Infection Prevention and Control Committee meetings and this framework was monitored at quarterly meetings with NHSE as well as monthly meetings with the CQC. Feedback provided thus far had been positive.

Ms Rai queried if the outbreak within theatres had been resolved and Ms Vlasman confirmed that this was resolved with all staff having returned to work and no further issues reported. Work had been completed on staff rooms with tables and chairs removed to ensure social distancing measures could be observed.

Ms Bentley highlighted mitigations included training in infection prevention and control

protocols and queried if this had been difficult to complete during the current pressures. It was confirmed that mandatory training levels had been maintained and additional training had been provided on the wards.

It was noted that the report would be presented again in 6 months to review the position.

The Board:

- **noted the Infection Prevention and Control Board Assurance Framework.**

TB104-20/21 **Modern Slavery Act Statement**

Ms Vlasman submitted the Modern Slavery Act statement for approval and stated that this provided assurance that the Trust met the requirements to ensure standards were in place in relation to the Act.

Ms Rai queried if any issues had been identified since the Act was introduced and Ms Vlasman confirmed that there had been instances affecting both staff and patients. Ms Rai queried how learning from the Act was embedded with staff and Ms Vlasman clarified that there was a session as part of the annual safeguarding training and a recent case showed how well this knowledge had been embedded with staff.

Ms Bentley queried if a register of incidents and how these were reported and responded to was kept. It was confirmed that this was the case.

The Board:

- **approved the statement for publication on the Trust website.**

TB105-20/21 **Emergency Preparedness & Readiness Response Self-Assessment**

Ms Ross submitted the emergency preparedness and readiness response self-assessment against the NHS England core standard report for approval and stated that this would be reported in summary as part of the annual report. Actions rolled over from the previous year had all been reviewed to ensure the Trust was compliant. There were 51 standards relevant to the Trust and 4 standards that did not apply. The trust was declaring compliance with all 51 relevant standards.

Ms Bentley queried if there was a log of lessons learned. Ms Ross informed that there was an emergency preparedness and readiness response group which met regularly and fed into the regional group. An action log was managed which fed into the regional system with shared learning identified at regional level.

The Board:

- **approved the self-assessment report for inclusion in the annual report.**

TB106-20/21 **Quality Committee Chair's Report**

Mr Crofts provided an update from the meeting of the Quality Committee held on 19th November .He noted the patient story provided by a patient who was registered blind and had experienced difficulties in using the Trust which highlighted the challenges for this group of patients. A presentation had been received from the spinal Nurse team detailing how the roles of the team had developed over the last 4 years. It had been noted that walkabouts from the Executive and Non-Executive team had diminished due to the ongoing pandemic; feedback from virtual huddles had been positive however it was

recognised that challenges remained.

It was noted that all Quality Account priorities had been achieved. Ms Rai queried where the priorities for 2021/22 had been identified. Ms Vlasman informed that a number of ideas had been put forward and these would be presented to the Council of Governors for discussion and agreement.

The Board:

- **noted the update from the Quality Committee.**

TB107-20/21 **Business Performance Committee Chair's Report**

Ms Rosser provided an update from the meeting of the Business Performance Committee held on 24th November focussing on the cost improvement programme (CIP) and how efficiency targets had been applied nationally. It was recognised that efficiency schemes don't always release cash and it was not known what CIP would be required in 2021/22. An update against the agile working policy had been provided detailing how a number of agile working schemes had worked across the Trust since implementation.

A presentation about the Patient Initiated Follow Up (PIFU) project had been provided and there was some discussion around how the project would work in practice and whether the patients currently waiting for a first appointment would be part of a separate project.

It was noted that the committee had approved the intelligence strategy which aimed to put data and analytics at the heart of all decisions across the Trust to support and improve the care and experience of all service users.

The committee had also approved an agreement with Boston Scientific to provide the Trust with a Guide XT license and software package in support of Implantable Pulse Generators purchased via the High Cost Tariff Excluded Devices scheme. A lengthy debate took place following an explanation of the purpose for the agreement and it was agreed to approve the agreement however this would be reviewed in 6 months time.

The Board:

- **noted the update from the Business Performance Committee.**

TB108-20/21 **Charity Committee Chair's Report**

Ms Rai provided an update from the meeting of the Charity Committee held on 12th November noting that an item relating to solicitors being on site was still under review and would be presented when this review was complete. An update on the investment position was provided along with detailed reports on the performance of the investments. It was noted that the Trust had received donations of approximately £145k from NHS Charities Together and a breakdown of how this had been utilised was provided. It was noted that the ethics of investments would be reviewed by the committee to ensure social responsibility.

Applications for funds for study leave, long service awards and a staff reward and recognition platform titled Highfive had been approved.

The Board:

noted the update from the Charity Committee.

TB109-20/21 **Neuroscience Programme Board Chair's Report**

Mr Burns provided an update from the meeting of the Neuroscience Programme Board held on 8th October noting that there was very good external representation at the meeting which provided a good balance in terms of debate which was key to the success of the meeting. A presentation was provided regarding the Movement Analysis Laboratory (MAL) which was well received and Dr Rose was invited to present this to the Neurological Alliance. Lessons learned from COVID were shared and discussed and positive comments had been received from stakeholders on how the Trust had responded during the first wave. A group would be established to review neurology services across the region following the conclusion of Getting it Right First Time (GiRFT) visits at all Trusts. It was noted that a back pain pathway was being explored which could potentially be adopted to manage patients consistently wherever they present.

The Board

- **noted the update from the Neurosciences Programme Board.**

TB110-20/21 **Items for inclusion in the Board Assurance Framework**

Ms Rai noted that the changes in the way the Trust was funded and where patients go to be treated required inclusion in the Board Assurance Framework (BAF), Mr Burns agreed that the finance risk required updating to reflect this.

Ms Ross stated that the Integrated Performance Report informed the Board Assurance Framework so waiting times were reflected in the BAF.

Ms Citrine informed that a paper from NHSE/I regarding the Integrated Care Services framework would be discussed at the Executive Team meeting on 9th December and the associated risk would need to be updated regarding this consultation and the finance elements would be included in this.

Ms Bentley stated that the patient story raised issues around information being flagged on some systems but some systems do not transfer this information across to other systems. It was clarified that this risk was recorded on the corporate risk register. Mr Crofts clarified that the risk was around inclusivity and work was ongoing around this and linked to the Equality, Diversity and Inclusion risk.

Ms Rai queried if the BAME agenda was covered by other risks or if this needed to be added. It was clarified that there was an expectation that all Trusts would have BAME as business as usual rather than it being recorded as a specific risk.

The Board

- **noted the above items for inclusion in the Board Assurance Framework.**

TB111-20/21 **Reflections on the Meeting**

Ms Strong felt that there was a good balance between high level information and detail with good debate during the meeting. Mr Gibney stated that although it was a shorter

meeting it was rich in detail. Mr Thakkar felt the meeting was efficient and constructive with the detail of reports discussed at committee level.

Mr Topliffe reflected that the meeting was assurance centred and the direction of travel was clear however felt that it was light on strategy and decisions to be made and queried if this was normal or an exception. The Chair clarified that this was reflective of the cycle of business and that we were currently in a pandemic. Ms Bentley stated that she had a better understanding on how the information flowed up to Board level now that she was a member of sub-committees.

The Board:

- **noted the reflections on the meeting.**

TB112-20/21 **Any Other Business**

Power Outage

Ms Ross informed that the Trust had experienced a power outage on 2nd December. A planned generator test was performed and an issue relating to fuses was identified with the back-up generator so this delayed patients going to theatre. This was resolved quickly however a further power outage occurred where both uninterrupted power supplies failed. Emergency preparedness, resilience and response contingency measures were immediately put into place; actions including those in theatre were shared. All patients were informed of the situation under duty of candour and all procedures were re-booked to take place within a week of this date. Critical care patients were all moved across to the main power supply and the incident was externally reported to Gold Command however a major incident was not declared. A specialist engineer arrived on site later in the afternoon and the issue was fully resolved. It was noted that the two incidents were not connected and a full review was underway which would be reported back via Business Performance Committee upon completion. Ms Bentley queried if there were any remaining lasting issues and Ms Ross stated she would check and confirm following the meeting.

CQC Visit

Ms Vlasman informed that the CQC would perform a review of the Trusts compliance with the Mental Health Act (MHA), patient pathways and the detention of patients on 7th December. The review would take place virtually and it was confirmed that patient notes would not be required as part of the review. A number of staff would be interviewed and Trust policies had been forwarded along with training records and an agenda for the review would be agreed by Ms Vlasman with the CQC. Ms Citrine confirmed that the review was being held following a case of whistleblowing raised with the CQC regarding a patient that the Trust had cared for. The Trust had also contacted the CQC for clarification of which certification was required by the MHA. The Trust was taking steps to ensure an out of hours service level agreement is put place with Mersey Care regarding the detention of patients and steps taken shared. Policy changes were required and a paper had previously been submitted to the Executive Team prior to submission of a business case to the Executive team in February 2021.

Mr Crofts queried which patients could be detained under the MHA and it was clarified that the Trust can detain some patients however this issue had demonstrated the need for a service level agreement with Mersey Care.

Charity Committee Accounts
Mr Burns noted that the Charity Committee accounts would normally be submitted to Audit Committee prior to submission to Trust Board in December before being published externally .However the external auditors had informed the Trust that due to pressures within local authorities the audit would need to be deferred. Mr Burns asked whether the Board was happy to delegate approval of charitable funds accounts to the Charity Committee meeting to be held in January 2021 to enable timely submission to the Charities Commission and then be ratified at the next Board meeting.

Mr Topliffe queried who would normally sign off these accounts and it was clarified that Ms Rai would normally sign them off prior to approval by the Trust Board.

The Board:

- **approved delegation of authority to approve charitable funds accounts to the Charity Committee prior to ratification at the Board meeting in February.**

Brexit
Ms Ross stated that the Trust had received additional readiness checklists of key risks for the end of the transitional period on 2nd December. It was noted that the additional checklists did not contain anything that had not previously been raised at Trust Board. Mr Thakkar queried if there was anything of concern contained in the checklists and it was clarified that there was nothing of concern foreseen. The main risks identified related to procurement and pharmacy and meetings continued to be held each week to review these risks with good processes in place to mitigate against risk.

There being no further business the meeting closed at 12.25pm

TRUST BOARD
Matters arising Action Log
December 2020

	Complete & for removal
	In progress
	Overdue

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
05.11.20	**TB78-20/21**	**Patient Story** Ms Bentley to contact Ms Greenwood-Davies regarding information sharing.	K Bentley	**December 2020** Ms Bentley contacted Ms Greenwood-Davies to discuss information sharing.	December 2020	
05.11.20	**TB87-20/21**	**Q2 Governance, Risk and Patient Experience Report** Acting Director of Nursing and Governance to review how many incidents of violence and aggression were attributed to one particular patient	L Vlasman	**December 2020** It was confirmed that future reports would include information regarding how many Datix reports of violence and aggression related to a particular patient.	December 2020	
22.05.20	**TB16/20-21**	**COVID 19 Update** Director of Workforce to provide an update on the national and local position in relation to annual leave of staff.	M Gibney	**June 2020** There had been no national update on the matter and it was not expected until the end of the financial year.	~~June 2020~~ February 2021	
03.12.20	**TB99/20-21**	**Matters Arising** Mr Burns to clarify with Ms Hindle if the amendments to approval limits within the Scheme of Reservation and Delegation could be implemented immediately.	M Burns		February 2021	
03.12.20	**TB102/20-21**	**Integrated Performance Report** A detailed finance plan to be submitted to Business Performance Committee	M Burns		February 2021	
03.12.20	**TB103/20-21**	**Infection Prevention and Control Board Assurance Framework** An update report to be added to the cycle of business for June 2021	J Hindle		February 2021	

03.12.20	**TB112/20-21**	**<u>Any Other Business – Power Outage</u>** Ms Ross to confirm if any lasting issues remain following the power outage	Ms Ross		February 2021	
03.12.20	**TB112/20-21**	**<u>Any Other Business – Charity Committee Accounts</u>** Charity Committee accounts to be submitted to Board for ratification following approval at January Charity Committee meeting	Mr Burns		February 2021	

Actions not yet due

Date of Meeting	Item Ref	Agenda item & action	Lead	Update	Deadline	Status
27.06.2019	TB 78/19	**<u>Annual Safeguarding Report/DBS Checks</u>** Director of Workforce & Innovation to provide an update on benchmarking with other organisations regarding DBS check approach/ funding	M Gibney	M Gibney to provide a paper outlining the position, options and risks. **<u>January 2020</u>** Item on the agenda. Regional solution awaited. Update to be provided when agreement reached. **<u>May 2020</u>** Work on hold until after COVID-19	~~Oct 2019~~ ~~Jan 2020~~ ~~June 2020~~ March 2021	

The Walton Centre NHS Foundation Trust

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REPORT TO THE TRUST BOARD
Date: 4th February 2021

Title	**Governance, Risk and Patient Experience Quarter 3 2020/21 Report**
Sponsoring Director	**Name:** Lindsey Vlasman **Title:** Acting Director of Nursing and Governance
Author (s)	**Name:** Lisa Gurrell **Title:** Head of Patient Experience **Name:** Tom Fitzpatrick **Title:** Head of Risk and EPRR **Name:** Kate Bailey **Title:** Clinical Governance Lead
Previously considered by:	• NA

Executive Summary
The purpose of the report is to:

- Provide a Quarterly summary of Governance activity across the Trust for Quarter 3 2020/21, comparing results of data with the previous financial Quarter (Quarter 2 2020/21).

- Provide assurance to the Trust Board that issues are being managed affectively, that robust actions are taken to mitigate risk and reduce harm and that we learn lessons from Incidents, complaints, concerns and claims.

The Report has been compiled using a collaborative approach with key services across the Trust, including Nursing, HR, Quality and Divisional Management to ensure those themes and trends identified are actioned appropriately.

Themes and Trends have been identified and agreed via a multidisciplinary approach, with input from the following colleagues: Matrons of Neurology and Neurosurgery, Deputy Director of Workforce, Neurosurgery Operational Services Manager, Neurology Operational Services Manager, Quality Manager and Freedom to speak guardian, Neuroscience Laboratories Quality and Governance Manager, Radiology Manager, Radiology Clinical Governance Lead, Estates Manager & Digital Health Records & IG Manager.

Related Trust Ambitions	• Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	The risk of the failure to inform committee of the board of the risk profile of the organisation.
Related Assurance Framework entries	• None
Equality Impact Assessment completed	• No
Any associated legal implications / regulatory requirements?	• Yes – Failure to comply with CQC/HSE regulations
Action required by the Board	• To consider and note

Revised in July 2018
Filepath: S:drive/BoardSecretary/FrontSheets
S:drive/ExecOfficeCentreMins/FrontSheets

The Walton Centre NHS Foundation Trust

Excellence in Neuroscience

Governance, Risk and Patient Experience

Q3 Report 2020/21

"Governance is a framework to receive, assess and act upon information we know about the services that we provide. Good governance provides assurance about the key issues and themes relating to the safety and experience of patients and staff. Governance is the backbone of the organisation."

1. Introduction

The report represents quarterly activity for patient safety, incident management, patient experience, complaints, claims, volunteering, risk management, resilience and health and safety.

The report has been compiled using a collaborative approach with key services across the Trust, including Nursing, Human Resources, Information Governance, Quality and Divisional Management to ensure that themes and trends are identified and actioned appropriately. These themes and trends, inform the Governance Assurance Framework process.

1.1. The purpose of this report is to provide:

1. A summary of governance activity across the Trust in Quarter 3 2020/21 compared to Quarter 2 2020/21.
2. Assurance to the Board that issues are being managed effectively.
3. To ensure that robust actions are in place to mitigate risk, reduce harm and ensure that learning is embedded.

The data is accurate from the date the reports were generated. Should incidents, complaints or claims be withdrawn, those figures will appear in subsequent reports.

2. Executive Summary

2.1. Incident reporting

Serious Incident (SI):

- No serious incidents were reported in Q3 compared with 2 in Q2

Moderate & above incidents (including Duty of Candour):

- 22 moderate incidents were reported in Q3 compared with 23 in Q2, one of which was not patient related, and therefore does not require a Duty of Candour letter
- All 21 incidents were reported in line with Duty of Candour requirements

2.2. Quarterly incident themes

Communication Incidents:

- there were 112 incidents reported in Q3 compared with 181 in Q2

Infection Control Incidents:

- there were 38 incidents reported in Q3 compared with 42 in Q2

Safeguarding Incidents and Concerns:

- there were 74 incidents reported in Q3 compared with 71 in Q2
- 48 incidents were related to DoLS (Deprivation of Liberty) breaches

Information Governance Incidents:

- there were 44 reported incidents in Q3 compared with 37 in Q2

RIDDOR:

- there were 2 reported incidents (staff affected) reported in Q3 compared with 1 in Q2

2.3. Governance Assurance Framework (GAF)

A new theme has been added to the GAF (GAF entry ref 309) which relates to the steady increase in Escherichia coli (E.coli) Bacteraemias across the Trust.

NB GAF entry ref 308 - Catheter Acquired Urinary Tract Infections has been merged with the E.coli Bacteraemia incidents (ref 309).

2.4. Risks

- a review of the Trust-wide, Divisional and Covid risk registers was conducted in Q3 to ensure risk descriptions were worded to reflect the standard of the Board Assurance Framework
- a further review was carried out to ensure risks were appropriately aligned to the correct assurance source (committee)
- additional work will be carried out in Q4, with a deep dive into wards and department risk registers, thus ensuring there is scrutiny of risks scoring below 12 within wards and departments
- risk registers will be also reviewed via the new Operational Management Board

2.5. Complaints and Concerns

- there were 16 complaints in Q3 compared with 25 in Q2
- 1 complaint from Q2 was re-opened as further clarity was sought
- the number of concerns remained fairly static from Q2 to Q3 with 145 received in Q2 and 151 received in Q3
- in addition to concerns, 34 enquiries were received, themes relating to the referral process and general hospital enquiries

2.6. Compliments

- there were 53 compliments in Q3 compared with 45 in Q2

2.7. Claims

- there were 9 claims in Q3 compared with 9 in Q2
- 1 claim was reopened in Q3

2.8. Patient Experience

FFT was still on hold in Q3 due to the Covid-19 pandemic; therefore no data is available for reporting purposes. Reporting commences January 2021.

3. Recommendation

Quality Committee is asked to receive and note this report.

4. Governance Assurance Framework (GAF) Log – Q3 2020/21

Theme	Context	Analysis	Action	Recommendation
Ref 287 Violence & Aggression 9th October 2017	Feedback from incidents continually highlights the issues of violence & aggression (V&A) against staff. This has also been highlighted in the staff survey. Issues of V&A are also identified and discussed at the daily safety huddle meeting. Furthermore there is also a risk relating to V&A on the Trust wide risk register. **Lead:** LSMS (Health Safety & Security Group).	During Q3 a slight increase of V&A incidents was evident, increasing from 97 in Q2 to 105 in Q3. Q3 data shows that 77 out of the 78 physical assaults against staff involved a patient that lacked capacity and 6 patients were responsible for 66 of these incidents. There were 2 RIDDOR related incidents regarding staff members, both received fractures.	1. V&A MDT working group meeting quarterly via MS Teams. 2. Review/audit of LASP LAP in Q4 20/21. 3. Personal safety training reviewed and updated (ward based training being delivered for areas with challenging patients). 4. LSMS/Personal Safety Trainer to continue to provide post incident support to ward/departmental managers. 5. Body worn cameras for security staff implemented in Q3. 6. Provide input to inform the Trust specification for a replacement CCTV/Access control system within capital plan. 7. Undertake a thematic review and analysis of the previous year to look at the impact of V&A to establish a baseline trajectory. 8. Violence and prevention and reduction standard – GAP analysis to be completed in Q4 on new national standards. These standards will be incorporated into the 2021/22 NHS standard contract.	It is recommended that this remains on the GAF for further monitoring. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 286 Appointments Cancellations/Delays 16th January 2018	Poor patient and staff experience due to cancelled or delayed appointments. Problems with appointment letters and patients not being able to get through to Patient Access Centre (PAC) on the telephone to book/cancel appointments. It is anticipated that there will be a significant increase in DNAs, complaints and this will affect staff/patient experience and patient outcomes going forward. **Lead:** Patient Access and Performance	There has been an increase in concerns received in 2020/21, regarding appointment issues. Increase in issues in 2020/21, relating to patients unable to get through via telephone or to cancel appointments.	1. MITEL IT/telephony system now fully installed and in operation. This system advises callers in to PAC of their queue position whilst waiting and keeps the caller updated whilst on hold. 2. Call recording functionality available also. 3. The system also allows for reporting of demand every 15 minutes. Organisational Change is currently being undertaken within PAC to amend the opening hours to ensure the service meets the demand. 4. The cancellation and delays with patient's appointments and the overall backlog for follow up review has increased further due to the Covid-19 pandemic. 5. Clinical validation of all patient appointments was cancelled due to Covid-19 and undertaken in April 2020. 6. Trust participating in the in PIFU, patient initiated follows up. 7. Business case approved to permanently recruit 2 additional Band 2 as opposed continuous use of Admin Bank and overtime. 8. Continuous review of patient concerns and complaints.	It is recommended that this remain on the GAF to monitor improvements in patient and staff experience to ensure that both are sustained. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 300 Rejection Of Pathology samples by LCL 2nd October 2018	Pathology samples may be rejected by Liverpool Clinical Laboratories (LCL) if request forms are incomplete and do not meet the acceptance criteria set out in both the Neuroscience Laboratories Specimen Acceptance Policy and LCL Minimum Data Standard Policy for Laboratory Investigations. This will lead to a delay in results and potential re-sampling requirements. **Lead:** Labs Quality & Governance Manager (Neurosurgery	Rejection data reports now received monthly from LCL. In total, approximately 60 samples a month rejected across the Trust. It is not possible to determine the number of tests this equates to or the percentage of requests affected. NOPD and HITU are the highest affected locations. Rejections may increase in the near future when samples will be rejected if time of collection is not included following an SUI.	1. Monthly rejection data now sent to Matrons, NOPD and HITU Ward Managers. 2. NOPD now preparing samples from late clinics and retaining at the Trust until the following day. 3. NOPD staff have received training on laboratory processes and specimen requirements. 4. Addressograph labels to be used on microbiology samples. 5. When applicable, communications to be given about rejections associated with lack of time on request. 6. IT have prepared a prioritisation document for an order communications system within pathology. This would ensure requests would be completed correctly and reduce number of rejections. This is managed and discussed in Neurosurgery Division.	Incidents to be monitored through Datix. **Recommendation:** Continue to monitor

Theme	Context	Analysis	Action	Recommendation
Ref 301 Fire Safety Compliance 17th January 2018	Following the OPD/NRC fire, and Merseyside Fire Service investigation and inspection of the Trust, the following legislative breaches were identified: 1. Maintenance of fire compartmentation lines. 2. Access to records of maintenance information provided by Liverpool University Hospitals (LUFT) Aintree Estates Department **Lead:** Estates Manager (BPC).	The Fire Service identified serious breaches in the OPD/NRC fire compartment lines post fire. These gaps were as a result of the original building works not being inspected and signed off in as compliant. A subsequent survey by a competent contractor in 2015 post a DH Estates Alert did not identify these breaches either.	1. Registered fire compartmentation contractor has undertaken and completed the works. 2. Fire Safety Advisor provides regular updates on progress to the Fire Enforcement Officer. 3. Outstanding areas are parts of OPD, Pharmacy and Jefferson Ward for which Kier have been called back to attend to. 4. Kier have not attended site and we are still trying to get them to attend. 5. All rectification works are entered into Dragon Software and the system has now been handed over to the Trust for management.	Continue to push Kier complete remedial works. Management of all contractors via application software. **Recommendation:** Continue to monitor

Theme	Context	Analysis	Action	Recommendation
Ref 302 Safeguarding 09th July 2019	Increase in safeguarding incidents reported both internally and externally to the commissioner in 2019/20, which has continued into 2020/21, as a result of the implementation of new safeguarding section in Datix **Lead:** Safeguarding Matron (Quality Committee)	Following the implementation of enhanced training for staff, there has been a significant increase in the identification of incidents of abuse/neglect. This continued increase in Datix reporting is a positive indicator around staff knowledge and appropriate action in response to safeguarding concerns. There is also an increase in the reporting of DoLS breaches due to untimely Local Authority assessment of the applications. This is in line with the revised Trust policy and processes for Deprivation of Liberty Safeguards (DoLS) applications.	1. The Datix reports will continue to be monitored with oversight from the Safeguarding Matron and Executive Safeguarding Lead to ensure that appropriate escalation/actions/referrals are addressed. 2. To await further guidance regarding changes to the DoLS.	To continue to monitor to ensure appropriate reporting of safeguarding incidents. **Recommendation:** Continue to monitor.

Theme	Context	Analysis	Action	Recommendation
Ref 304 – Communication 19th December 2019	Communication issues have been identified via a number of sources, including the staff survey (2019/20), incidents, concerns and complaints. **Lead:** Divisional Governance and Risk meetings.	It was identified from the 2019/20 staff survey results that communication is a Trust-wide issue. Visible decrease in incidents evident on review of quarterly statistics, decreasing from 181 Q2 to 112 in Q3. Also the theme communication seems to be a recurrent theme amongst Incident investigations, Root Cause Analysis and Situation, Background, Assessment, Recommendation (SBAR) investigations. Communication continues to be a theme in complaints and concerns and is detailed within section 7	1. Complaints continue to be monitored via the Board KPI Report. 2. Divisions continue to closely monitor concerns and complaint via weekly meeting with Patient Experience Team. 3. Continue to log actions/learning from concerns/complaints which are monitored at weekly PET/Divisional meeting. 4. Review feasibility of inclusion of FAQ (frequently asked questions) for patients on the new Trust website, to support good communication identified at the Quarterly Thematic review meeting.	Monitor via incidents, investigations, complaints and concerns. **Recommendation:** Continue to monitor in Q4.

Theme	Context	Analysis	Action	Recommendation
Ref 305 – Legionella 19th December 2019	Legionella positive samples found in water outlets in some clinical areas in the Trust. **Lead:** Estates Manager (BPC).	A problem was identified on Lipton Ward, in regards to water safety which led to the testing for legionella bacteria. The samples returned identified a number of positive outlets for legionella pneumophila serogroup 1. Further extended sampling across clinical areas has shown the existence of the same in various areas.	1. Legionella action plan is being monitored and now complete. 2. Additional measures have been undertaken which include the implementation of a thorough flushing regime to all areas and the installation of an additional hot water return shunt pump to improve water circulation. 3. Re-sampling results have shown that, although not eradicated, the readings obtained are showing a downward trend which suggests the measures that have been under taken has had a positive impact. 4. In order to maintain safety and protect the patients further, Point of Use filters (POU) have been fitted to all outlets where it is possible for them to be fitted. 5. Further samples of cold water identified another as positive. Following investigation, there appears to be possible reasons why this may have occurred and these have been rectified. 6. Works associated to eliminating legionella from the water systems are widespread and lengthy; therefore, there will be no “quick-fix” to the problems being experienced. 7. Engineering works have now completed to install a new 54mm hot water return pipe from ground floor to 3rd floor plantroom. 8. Roll out of the Hydrop “compass” software to non-clinical areas throughout the Trust. 9. Rolling programme to strip and clean all outlets prior to re-testing.	Continue with remedial, re-sampling regime and flushing. Continue to work through Water Safety Action Plan (from Hydrop). **Recommendation:** Continue to monitor and work through all actions.

Theme	Context	Analysis	Action	Recommendation
Ref 307 Medication Incidents 14th July 2020	Increase in medication incidents. **Lead:** Safer Medication Group	Added following a significant increase in medication incidents in Q2. Incidents statistics have now began to decrease, decreasing from 76 in Q2 to 70 in Q3.	1. Stock discrepancies will continue to be monitored via Safer Medication Group. 2. Pharmacy Risk register reviewed to ensure increase in reoccurring incidents is noted.	Continue to monitor in Q4 with a view to close if statistics continue to decrease in Q4. **Recommendation:** Continue to monitor Q4, with view to close.

Theme	Context	Analysis	Action	Recommendation
Ref 309 – E.coli Bacteraemia Incidents 7th January 2021	Healthcare Associated Infections can cause substantial patient morbidity, complicate treatment and increase cost to the NHS. A number of these infections are preventable through better application of good practice. The thematic review of 2019/20 investigations, identified that there has been 15 E-coli bacteraemia, against an internal trajectory of 9. This represents an increase of 5 since 18/19. Review of the subsequent investigations has shown 13 cases were related to urosepsis, a further 2 were as a result of abdominal sepsis. The presence of a urinary catheter in situ was identified in all cases. This increase reflects the national position; the government have set a goal to reduce healthcare associated gram negative blood stream infections by 50% by 2020/21.	The Trust infection control policies and procedures reflect the NICE Quality standard (QS 61). Quality Standard 4 states people who need a urinary catheter should have their risk of infection minimised by the completion of specific procedures necessary for the safe insertion and maintenance of the catheter and its removal as soon as it is no longer needed. This is important in terms of both infection prevention and patient comfort and experience. Previous reviews of catheter care (2017) have resulted in improvements in practice and education. The increase in E Coli bacteraemia suggests it is necessary to raise the profile of catheter care and ensure the guidance and education is relevant and robust.	The project will combine audit of practice and policy against NICE Quality standard 4 together with the use of Plan, Do, Study, Act (PDSA) audit methodology to review the indication for catheterisation, ongoing catheter care and the process for removal when no longer indicated. 1. **Theatre / recovery** - review the criteria for the need for insertion, together with technique and commence the removal plan. 2. **Acute ward team** - ongoing care, daily review. Plan for removal. 3. **IPC / Specialist nurses** - Review of specialist needs (Neurogenic bladder) icluding review of policy / education	The senior nursing team have commissioned a quality improvement project to reduce the complications associated with indwelling urinary catheters with the aim of reducing the incidence of E Coli bacteraemia. The project will require a multidisciplinary teams from all clinical areas together with the Infection control and governance teams with clear and focused goals with measurable targets (supported by Service Improvement Team). The measures are: 1. Avoid unnecessary urinary catheters. 2. All insertions to be undertaken with aseptic technique and managed in line with guidelines. All catheters to be reviewed daily and removed promptly in line with clinical requirements. **Recommendation:** Continue to monitor and work through all actions.

5. Incident Management

This section provides a detailed report of the number and type of incidents reported during the Q3. The Trust is committed to maintaining a high standard of health, safety and welfare of patients, their families, visitors, contractors and staff. Accurate reporting of incidents and near misses is essential in order to reduce risks and avoid untoward incidents.

TRUST WIDE	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21
Incident type	840	740	580	913	860
Neurosurgery	498	439	373	608	504
Neurology	299	269	186	260	318
Corporate	43	33	21	45	38
StEIS reported SUI's	3	1	0	2	0
Patient Safety Incidents reported to the NRLS	284	250	179	279	207
Accident	98	98	59	99	96
Communication	113	97	71	181	112
Death	37	28	38	25	25
Digital Systems	24	23	10	24	38
Environmental	31	19	29	32	34
Infection Control	30	39	44	42	38
Information Governance	49	51	20	37	44
Investigations, Images & Diagnosis	35	21	24	26	21
Medical Devices, Systems & Equipment	42	40	27	42	39
Medication	75	65	55	76	70
Nutritional and Hydration	8	11	14	12	17
Patient Care	83	76	63	106	85
Safeguarding	87	74	58	71	74
Protected Characteristics (added in Q3)	0	0	0	0	0
Security	13	11	7	14	15
Transfusion (added in Q3)	0	0	0	0	4
Treatment and procedure	47	25	15	29	43
Violence and aggression	68	62	46	97	105
RIDDOR	3	3	2	1	2
Percentage reported within 12 hours (as per Policy)	88%	89%	88%	92%	79%
% of level 2&3 incidents acknowledged in 24 hours (as per Policy)	86%	68%	79%	82%	61%
% of level 1 incidents acknowledged in 48 hours (as per Policy)	87%	89%	87%	46%	87%
% of level 0 incidents acknowledged in 48 hours (as per Policy)	89%	92%	93%	96%	58%
Rate of incidents per 100 admissions (excluding Jeff & OPD)	16.06%	13.31%	11.3%	15.84%	17.96%
Number where DOC (Duty of Candour) where patient/relative have been notified?	17	19	16	24	21

5.1. High level incident overview of Q3:

- there were 0 incidents reported to the Commissioners in Q3 compared with 2 in Q2
- 860 incidents reported in Q3 compared with 913 in Q2

5.2. Quarterly Incidents by Severity:

Incidents by Severity	**Q2 20/21**	**Q3 20/21**
No obvious harm	786	678
Minor harm may require aid/support	92	141
Moderate harm requiring aid/support	23	22
Major permanent harm	0	0
Catastrophic	1	0
To be determined following investigation	11	19
Total	**913**	**860**

5.3. Quarterly Themes:

Information Governance (IG):

- there were 44 incidents in Q3 compared with 37 in Q2
- there were 2 externally reportable incidents to the Information Commissioners Office (ICO) in Q3 compared with 1 in Q2
- there were no breaches of Subject Access or Freedom of Information requests in Q2

Communication:

- there were 181 communication incidents in Q3 compared with 112 in Q2

Safeguarding incidents and concerns:

- there were 74 incidents and concerns in Q3 compared with 71 in Q2
- there were 48 incidents (related to a breach of DoLS) compared with 39 in Q2

5.4. Key actions to note:

- Datix Incident Training continued during Q3 via MS teams and will continue throughout Q4
- An audit of both written and verbal notification compliance with Duty of Candour was conducted in Q3, the findings are as follows:
  - 100% (47) of the sample of 47 incidents complied with verbal notification
  - 89% (42) of the sample of 47 incidents demonstrated compliance with documenting verbal notification in patients notes
  - 100% of the sample of 47 incidents complied with written notification

- A recommendation identified from the audit was to develop an electronic Duty of Candour form within EP2. The EPR Team is currently in the process of developing the electronic form.

- Two new categories were added to the Datix incident reporting form, following identification of requirements for reporting, they are Transfusion incidents and Incident relating to the 9 Protected Characteristics.

6. Violence and Aggression

TRUST WIDE	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21
Incident					
Inappropriate Behaviour	7	9	7	4	5
Physical assault - patient on staff	40	29	22	56	78
Physical assault - staff on patient	0	0	0	0	1
Physical assault - visitor	1	1	1	0	1
Racial abuse - patient on patient	0	0	1	0	0
Racial abuse - patient on staff	1	2	2	6	1
Sexual abuse - patient on staff	0	0	2	0	1
Verbal abuse - other on staff	0	0	0	2	1
Verbal abuse - patient on staff	18	15	8	28	13
Verbal abuse - patient on patient	0	0	1	0	0
Verbal abuse - staff on staff	1	0	0	1	0
Verbal abuse - Visitor	0	6	3	0	4
Total	68	62	47	97	105

6.1. <u>High level incident overview of Q3 2020/21:</u>

- Increase from 97 incidents in Q2 to 105 in Q3
- Physical assault, patient on staff – 6 patients were responsible for 66 incidents. With 2 patients being responsible for 43 of those incidents
- Physical assault, patient on staff – 77 of 78 incidents involved a patient without capacity
- Physical assault, staff on patient - subsequently investigated by the Ward Manager, Matron & HR Manager.
- 2 staff received fractures – two members of staff have sustained fractures following assaults by patients within Q3:
- a patient grabbed staff members wrists and refused to release resulting in fractured wrist
- a patient became physically aggressive towards 2 members of staff, a HCA received a fracture to the arm
- both patients did not have capacity and investigations are being undertaken
- both incidents were reported to the HSE under RIDDOR requirements
- NB the reduction in reported incidents in Q1, was largely due to the reduced number of inpatients due to Covid-19

- NB ‘Inappropriate behavior incidents’ do not meet the criteria of verbal or physical abuse, but still require reporting. Incidents include circumstances where a patient, relative or indeed a staff member have acted inappropriately or used inappropriate language but did fit within the verbal or physical abuse categories

6.2. Quarterly Themes:

- a small number of patients responsible for significant amount of incidents
- the highest category of incidents continues to be physical assaults, patient on staff with 78 incidents reported, 77 of which relate to patients that did not have capacity
- the location with the highest number of violent or aggressive incidents reported was CRU with 36, followed by Cairns ward with 31 and Chavasse with 12, no other areas received any more than 7 incidents in Q3

6.3. Key actions to note:

- V&A MDT working group re-established and met on MS Teams in Q3. Quarterly meetings to be arranged moving forward
- LAST LAP (Looking After Staff That - Look After People) initiative launched via Walton Weekly and Team Brief. Review/audit of LAST LAP in Q4 20/21
- Personal safety training reviewed and updated (ward based training now being delivered for area’s with challenging patients)
- LSMS/Personal Safety Trainer continue to provide post incident support to ward/departmental managers
- Body worn cameras for security staff implemented in Q3
- provide input to inform the Trust specification for a replacement CCTV/Access control system within capital plan
- ensure V&A incidents are escalated to the daily safety huddle for onward management and monitoring
- undertake a thematic review and analysis of the previous year to look at the impact of V&A to establish a baseline trajectory
- Violence and prevention and reduction standard. A GAP analysis to be completed in Q4 on these new national standards (these will be incorporated into the 2021/22 NHS standard contract)

7. Complaints & Concerns

The Patient Experience Team (PET) receives a wealth of information surrounding the experience of our patients and their families. The Trust use the positive feedback to share and promote good practice and this information can be found in the table below. This section concentrates on the areas of concern raised by patients and their families. This information helps us to improve services and learn lessons to improve the care and service we provide to our patients. This section analyses the complaints and concerns raised with the Patient Experience Team.

TRUST WIDE	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21
Complaints					
Coroner statement requests	1	2	5	1	6
Police statement requests	6	9	12	10	11
Total Number of Concerns	157	152	75	145	151
Appointment arrangements	75	97	43	89	58
Approach and manner	14	18	7	16	16
Patient Care	10	13	8	16	10
Communication	34	45	24	72	51
Discharge Arrangements	8	5	3	4	5
Total Complaints received	37	25	14	25	16
Approach and Manner	11	14	6	10	7
Treatment	10	3	4	8	3
Appointment Arrangements	14	15	4	14	4
Patient Care	4	2	6	8	6
Communication	17	8	11	11	12
% Acknowledged within 3 working days	100%	100%	100%	100%	100%
% responded to within agreed timescale	100%	100%	100%	100%	100%
Neurosurgery complaints	15	12	6	18	9
Neurology complaints	19	12	5	7	7
Neurosurgery/Neurology complaints	2	1	3	0	0
Corporate	1	0	0	0	0
% signed responses scanned on system	100%	100%	100%	100%	100%
Complaints to Ombudsman	2	0	0	0	0

7.1. Concerns and Complaints:

- 16 complaints in Q3 compared to 25 in Q2
- 1 complaints from Q2 was re-opened as further clarity was sought
- 19 complaints were closed and 5 remain under investigation within the negotiated timeframe in Q3
- 100% of complaints were acknowledged and responded to within the negotiated timeframe
- A reduction was noted within Neurosurgery; 9 in Q3 compared to 18 in Q2, whilst Neurology remained the same with 7 complaints received in both Q2 and Q3.

Key themes for complaints include:

- Communication (12)
- Approach & Manner (7)
- Patient Care (6)

NB a complaint may include one or more subject/theme

7.2. Concerns:

- concerns received remained fairly static in numbers with 151 in Q3 compare to 145 in Q2
- although there has been a marked decrease in numbers, themes still include appointment arrangements (58 from 89) and communication (51 from 72)
- 34 enquiries were received, themes relating to the referral process and general hospital enquiries

7.3. Protected Characteristics:

In Q3, 2 concerns were raised in relation to:

- **Disabilities - Mental health** – Between WCFT and hospital transport services patient felt discriminated against - *Under review*
- **Physical disability/condition** – comment made by staff Outcome – *Closed, apology provided*

In Q3, 1 complaint was raised in relation to:

- **Nationality and age** - Patient unhappy with diagnosis and queried why further investigations not performed and if this was due to being Polish and over 50 years of age. – *Closed, noted this would not alter the level of service received and that all patients are treated with equality*

7.4. Compliments:

A noted increase in the number of compliments with 53 in Q3 compared to 45 in Q2.

7.5. Police/Coronial Requests:

Number of police request remains fairly static with 11 in Q3 from 10 in Q2 for police statements/case notes, while there was an increase in coroner requests with 6 in Q3 from 1 in Q2.

7.6. Volunteers:

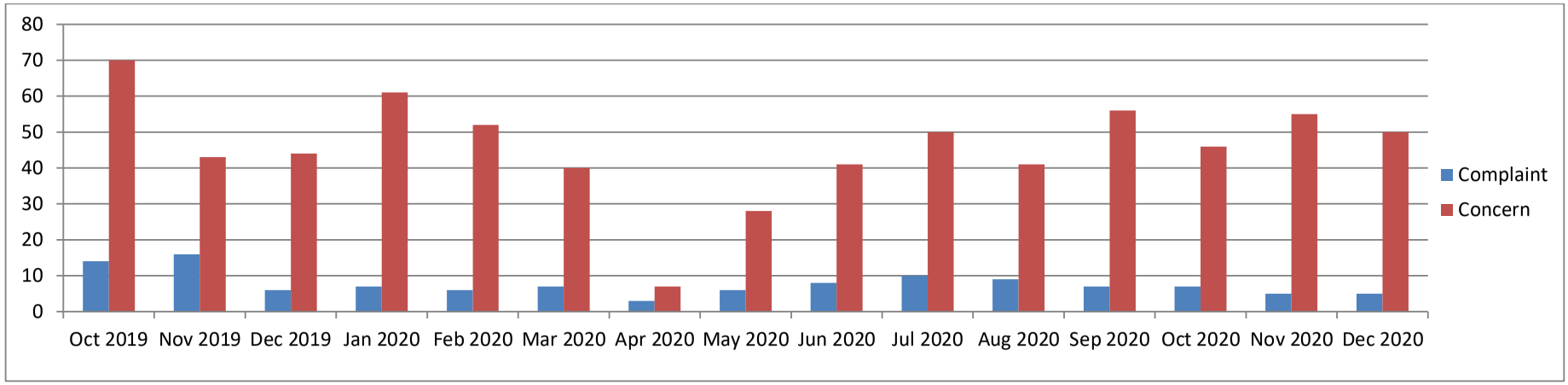
There was no volunteer activity within Q3 as volunteers have not been re-introduced into the Trust; regular communication is maintained with all volunteers.

7.7. Summary:

Our complaints and concerns remains in line with expected levels. It is encouraging to see that the number of formal complaints has reduced in Q3 while concerns has slightly increased showing that our teams are working together to swiftly resolve issues informally.

In Q3, 19 formal complaints were closed, 157 concerns were resolved and 34 enquiries received and responded to. This demonstrates excellent collaborative working between PET and Divisions.

Numbers of Complaints/Concerns by Month.



8. Claims / Legal

TRUST WIDE	Q3 19/20	Q4 19/20	Q1 20/21	Q2 20/21	Q3 20/21
Claims					
Total new claims received	9	6	5	9	9
Neurosurgery claims	4	4	5	6	5
Neurology claims	4	1	0	1	2
Corporate claims	1	1	0	2	2
Total number of pre-action protocols in quarter	10	11	13	7	7
Number of closed claims in quarter	7	10	4	5	3
Value of closed claims - Public liability	£0	N/A	£0	£0.00	£0.00
Value of closed claims - Employer liability	£0	N/A	£0	£0.00	£0.00
Value of closed claims - Clinical Negligence	£155,194	£485,936.22	£2,715,964.73	£3,203,388.52	£209,929.13

All staff involved in claims/coronial reviews or inquests receive full support throughout the process.

8.1. Re-opened claim

(222) Neurosurgery

- In July 2017 the claimant had spinal surgery and in March 2018 had revision L5 decompression. The claimant suffered with a dual tear and developed an epidural haematoma and an emergency washout was performed then further developed fluid collection due to CSF leak and underwent further surgery in March 2018. The claimant went on to have further problems including infection and following discharge was referred to the pain team.
- The claimant continues to suffer with bowels problems, has to self-catheterise daily, suffers gynaecological numbness and takes morphine for constant pain.
- Allegations refer to the consent process on 21/06/17 and 21/03/18. Performance of surgery 21/07/17 and 21/03/18 and the failure to do neurological examination on 21/03/18 and 22/03/18.
- Letter of Notification (LON) received and the Trust Letter of Response (LOR) was served in April 2020 denying all allegations. NHSR closed their file in July having received no response from the claimant. Letter of Claim (LOC) has now been received. Investigations are ongoing.

8.2. Lessons Learned:

The following lessons have been learned from on-going claims. Please note that lessons may have been learned following an RCA at the time of the incident over the last 5 years and not only following receipt of a formal Letter of Claim.

Treatment and documentation

- LW (192) - Claimant had SCS trial deemed successful. Allegations were that the permanent SCS lead tip was placed in the wrong position at level T12 on 13/10/12 instead of level T8. This failed to cover lower back pain. The claimant had a limited period of pain relief until a new SCS was fitted on 9 March 2015. This claim has now been settled.
- Lessons have been learned regarding changes in practice and documentation. We have made further enquiries to determine if any further lessons can be learned and are currently awaiting feedback.

Themes - documentation

- There is an ongoing theme of poor documentation which runs through many of the claims that the Trust receives. This is always highlighted in medical mandatory training sessions and junior doctor's induction.

Informed Consent

- Informed consent allegations are being highlighted in the CNST claims that we are receiving. We highlight the importance of informed consent at medical training to consultants and junior doctors.

8.3. CNST Trials:

The Trust has 4 clinical negligence trials coming up over the next 5 months. It is possible that some of these may be settled before trial start dates. Divisional and Clinical Management have been made aware of these cases so that they, along with the claims team can offer support to staff during this difficult time. The Claims Manager will attend the trials with the staff to provide ongoing support.

8.4. Coroners Inquests:

JB Neurology

A 28 year old male with a long standing history of seizures was admitted on 19/02/18 for monitoring of epilepsy with an aim to adjust treatment in order to improve seizure control. The patient's condition deteriorated despite maximal efforts and following admission ITU, he suffered a cardiac arrest on 08/04/18. Despite input from a consultant cardiologist, the patient suffered a further cardiac arrest which was futile and sadly died at 20:03.

Following a formal complaint from the family regarding care, treatment and the cause of death, the family have met with the Trust on two occasions and referred their concerns to the CQC and Coroner.

As part of the complaint an independent review was undertaken by the Royal College of Physicians (RCP). Recommendations have been included in an action plan which is under review by the CQC. Directions were received from the Coroner and the Trust attended a first pre inquest review (PIR) on 28/07/20 with legal representation. The family also has legal representation. Direction timeframe has been met. The PIR took place on 11/11/20.

The Coroner's Inquest has been adjourned awaiting outcome of the CQC investigation.

JH Neurology

Patient was admitted to Hyper acute Specialist Rehab on 06/11/2019 following a cardiac arrest on 16/09/2020 and a period on intensive care at Aintree University Hospital. He was transferred to Oakvale Gardens on 06/04/2020 and sadly died on 08/05/2020.

A Pre Inquest Review (PIR) took place on 22/09/2020. The next PIR is scheduled to take place on 22/01/2021. At present we do not feel legal representation is required for the Inquest, however, this will be kept under review.

AJ Neurosurgery

Patient transferred from IOM to WCFT on 30/08/2020 following a spontaneous intracerebral bleed. Surgery performed on 30/08/2020 and required post-op ICU care. Patient was due to be repatriated on 23/09/2020. On 22/09/2020 his tracheostomy dislodged out of hours on HITU whilst being turned resulting in hypoxic cardiac arrest and patient death.

The Coroner was informed and investigations have begun. An initial rapid review report was provided to the Coroner and a RCA has also now been provided.

The Trust is still awaiting a copy of the PM report which was due with the Coroner on or before 31/12/2020. To date this has not been received yet. The Coroner will let us have a copy as soon as this is received. The next PIR is scheduled to take place on 15/01/2021. At present we do not feel legal representation is required for the Inquest. However, this will be kept under review.

Staff Education and support:

- training is now provided to to all junior doctors at induction

9. Safety Section

Health & Safety - key points to note:

9.1. RIDDOR – Staff incidents resulting in 7 day absence:

There were 2 staff related incidents RIDDOR reported in Q3:

- A member of staff was attending to a confused patient, whose behaviour was having an impact on the patients safety. The member of staff attempted to assist the patient to a safe position and in doing so the patient tightly grabbed both wrists of the member of staff causing some swelling to the right wrist. This was later confirmed as a fracture. The patient was fully risk assessed at the time and staff had received all the relevant training.
- Member of staff was assisting a confused patient who became aggressive. The patient pushed forcefully the member of staff onto a chair causing injury to their neck & shoulder, resulting in pain & stiffness and an absence from work of over seven days.

9.2. Fit testing

Fit testing continues as a priority:

- the Governance Team is supporting fit testing of clinical staff on day and night shifts
- drop-in sessions have been arranged for staff to attend face mask fitting
- all drop in sessions communicated through Trust news & daily safety huddle
- 677 members of staff have been trained in the correct use of FFP3 respiratory protection masks, 359 of these staff have been trained and issued with re-usable masks
- joint working with procurement on provision of FFP3 stock and identify any future risks
- continue maintain a fit test database available to all ward managers

9.3. Fire Safety - key points to note:

- The Trust experienced 4 fire alarm actuations in Q3, one required the attendance of Merseyside Fire & Rescue Service (MFRS). A new member of staff using an e-cigarette in the staff room on Caton Ward was the cause of one alarm. The Ward Manager reinforced Trust policy with the member and emphasised the implications for the Trust around MFRS attendance
- compartmentation works:
    - are complete for the bulk of the Trust site; however there is one area around the Pharmacy which is incomplete
    - are the subject of discussion between the Trust's Estates Manager and the contractor Kier who failed to complete works to a satisfactory standard.
    - the outstanding works will be completed by the current on site contractor

- Training is ongoing, we are still utilising both face to face and virtual delivery methods:
  - unfortunately the Trust is only 84% compliant at present; this figure reflects the measures being adopted to control the Covid risk
  - the ability to deliver 'ward based' training has been reduced due to Covid 19
- review of elements of the Automatic Fire Alarm System (Walton Site):
  - is being reviewed and proposed changes discussed
  - a risk exists whereby the link between WCFT main and Aintree has failed on 2 occasions; this is a substantial risk and is being reviewed with a view to breaking away from Aintree
  - this has been added to the Trust risk register. (Risk No. 802)

Fire alarms unwanted fire signals (UwFS)

Month	Smoking Material/ Vape	Actual Fire	Call Point	Steam/ Dust	Toaster	Microwave	Fogging	Nebuliser/ aerosol	Smell smoke	System fault	FRS Attendance
Oct 20	1	0	0	0	0	0	0	0	0	0	0
Nov 20	0	0	0	1	0	0	0	1	0	0	1
Dec 20	0	0	0	0	0	0	0	1	0	0	0
Total:	**1**	**0**	**0**	**1**	**0**	**0**	**0**	**2**	**0**	**0**	**1**

Key Actions:

- review and action risk register entry 802
- fire risk assessments continue to be reviewed, findings discussed with all relevant parties
- ensure these findings (works identified/required by the fire risk assessments) are actioned by the Estates Department and/or Department staff
- the Fire Safety Advisor continues to work closely with Estates and Facilities Department to ensure suitable and sufficient solutions to problems are dealt with and remedied as early as possible
- continue to work with MFRS to ensure compliance with Fire Safety legislation and guidance

9.4. Moving and Handling - key points to note:

- classroom training sessions continues in line with current Trust agreed precautions and onsite training utilising appropriate PPE
- support with complex needs patients with appropriate PPE for the ward and patient status
- equipment regulatory inspection/service and maintenance – Lifting Operations and Lifting Equipment Regulations (LOLER) inspections are now complete and all relevant equipment is in date
- Datix reports a total of 2 incidents relating to Moving and Handling have been reported within Q3
- a total of six assessments were completed in order to support staff in practice in Q2, it is noted that 3 of these are non patient facing staff members

REPORT TO Trust Board
Date 4th February 2021

The Walton Centre NHS Foundation Trust

Title	Morbidity & Mortality Report 2020-2021 Quarter 3 (Q3)
Sponsoring Director	Name: Dr A Nicolson Title: Medical Director
Author (s)	Name: Patricia Crofton Title: Clinical Quality Lead
Previously considered by:	• Committee (please specify) ____Quality Committee_____
Executive Summary This report is Q3 of the quarterly review of Morbidity & Mortality within The Walton Centre. The rate of readmission within 28 days of discharge remains low at 4.3%. Surgical site infection rate was also low at 1.31%. There were 27 deaths during Q3, 22 in neurosurgery and 5 in neurology. 18 of the deaths occurred on the Critical Care Unit. Following review all deaths were considered unavoidable, but due to the complexity a more detailed structured judgement review has been recommended in three cases.	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do.
Risks associated with this paper	None
Related Assurance Framework entries	N/A
Equality Impact Assessment completed	• Yes – (please specify) ____N/A_____ • No – (please specify) _____
Any associated legal implications / regulatory requirements?	Compliance with National guidance on Learning , candour and accountability (A review of the way NHS trusts review and investigate the deaths of patients in England)
Action required by the Board	The Board is requested to: • Discuss and note the position

Quarter 3 (Q3) Morbidity & Mortality Report 2020-2021

Executive Summary

This report is a quarterly review of Morbidity & Mortality within The Walton Centre NHS Foundation Trust. Unless stated, figures relate to both Neurosurgery & Neurology combined.
Section 1, Morbidity, details information relating to, admission and readmission rates, surgical site infections.
Section 2 Mortality, provides information relating to inpatient deaths in Q3 (October 1 December 2020). As with previous reports in 20/21 the report includes CHKS data which is also included in the Integrated Performance Report. Although CHKS date does not include full Q3 data it shows how we compare with our peers.

There were 27 in patient deaths during Q3.18 patient deaths have been presented at the Neurosurgical mortality meetings. There are 4 outstanding there are 5 patient deaths awaiting presentation at the Quarterly Neurology mortality meeting. (There was no meeting in December due to MS teams' connection difficulties.), however the initial reviews have not identified any concerns.

Update from Q2.

AS detailed in the Q2 mortality report there had been an unexpected death within critical care. There has been a full Serious Incident review which has been sent to the Coroner and the Specialist Commissioners. This report together with the post mortem report has been shared with the patients' family. The critical care team together with the Patient Experience team are providing support for the patients relatives and will arrange a meeting at a suitable time for the family. This will need to be via an electronic platform as the patient lived on the Isle of Man.
In Q2 there was a death of a patient with Learning disability, this has been reported via the LEDER process and will be subject to an external review.

COVID-19 restrictions continue to provide challenges in caring for patients and supporting their family and friends at the end of life. There have been 1 patient's deaths where the patient had developed COVID 19 after presenting with complex conditions and significant co-morbidities. The Patient Experience Team continue to provide essential support for patients, their families and staff involved in caring for patients at end of life. A common concern raised by patient's families is in relation to the restrictions with visiting during this difficult time. The Trust guidance is focused on supporting compassionate visiting arrangements for those receiving care at the end of life.
Review of patient deaths over Q3 has identified a theme where patients have been transferred to the WCFT with Neurological conditions where as part of the presentation the patient had acute hydrocephalus requiring insertion of an External Ventricular Drain (EVD). This is a neurosurgical emergency and any delay may prove life threatening.
The EVD will relieve the initial hydrocephalus; however this may not be sufficient to change the poor outcome for the patient. To fully explain the need for an EVD the report contains a "Focus" on External Ventricular drains. (Appendix 1) The case histories relate to those patients who have required insertion of a drain and whether this procedure had an influence on the patients' outcome.

SECTION 1 Morbidity

1 Admission data 1st October 2020-31 December 2020

The Neurosurgical & Neurological admissions and re-admissions are detailed below. Admissions in Q3 have increased due to changes related to COVID 19 restrictions. Understandably elective activity remains lower than 19-20.

Table 1
Admission and readmission for Q3, October- December 2020

Q3 2020-21	Oct-20	Nov-20	Dec-20	Total
Admissions	352	324	344	1020
Re-admissions	12	14	18	44
%	3.4	4.3	5.2	4.3

Table 2
Admissions and readmissions Q1 19- Q3 2021

Q	Q1 19-20	Q2 19-20	Q3 19-20	Q4 19-20	Q1 20-21	Q2 20-21	Q3 20-21
A	1331	1290	1242	1198	601	987	1020
R	74	63	56	52	22	53	44
%	5.6	4.9	4.5	4.3	3.7	5.4	4.3

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CHKS Data Readmissions:

The table below shows the readmission rate for Walton Centre for the reporting period. 86% of readmissions are recorded within the specialty of neurosurgery.
The trust has a readmission rate of 2.01% and **is in the best performing quartile** in comparison to the selected peer. Both elective and non-elective readmissions are in the best performing quartile.

	Readmitted Spells	Total Spells	Readmission Rate	25th Percentile	Peer Value	75th Percentile
Readmissions within 28 days; Age >16	166	8514	1.95%	6.95%	8.21%	9.16%
1 - Elective	75	6495	1.15%	3.61%	4.09%	4.93%
2 - Non-elective	91	2019	4.51%	11.19%	12.57%	13.08%

Table 3 Readmissions by admission type November 2019 to October 2020

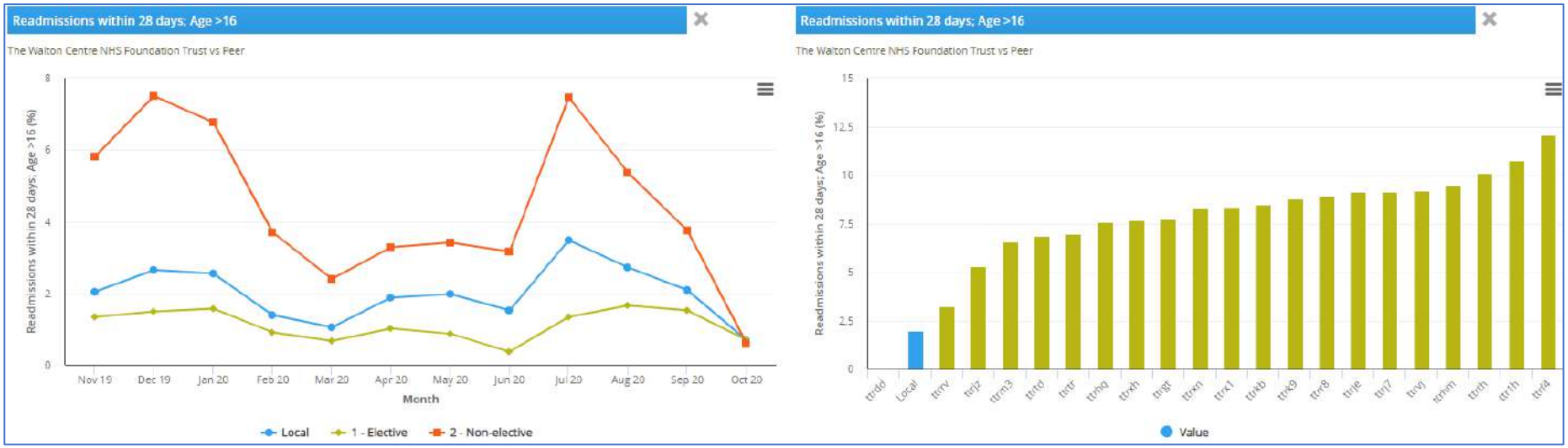


Chart 1 Readmission time series chart and peer distribution November 2019 to October 2020.

2 Surgical Site Infection (SSI) data-

	Elective	Infec	%	Urgent	Infec	%	Immediate	Infec	%	Expedited	Infec	%	Not record	Infec	%	Total ops	Total Infec	% Infec Rate
Q2 20/21	318	3	0.9	149	1	0.7	56	0	0.0	108	4	3.7	10	0	0.0	**641**	**8**	**1.25**
Q3 20/21	553	6	1.1	187	2	1.1	48	0	0.0	124	4	3.2	4	0	0	**916**	**12**	**1.31**

Section 2 Mortality Q3 2020.

There have been 27 deaths in Q3, 12 deaths in October 20, 10 in November 20 and 5 in December 20. This number is an increase of 4 in relation to Q2. There were 22 deaths in Neurosurgery, 5 deaths in Neurology; three patients were under the care of the rehabilitation team. 18 of the patient deaths occurred in critical Care.
Following initial mortality review, all deaths (27) were considered definitely not avoidable according to National Guidance. At initial review there were 3 patients where the deaths were considered unavoidable however given the complexity of the cases a further review using the recommended SJR methodology were requested.
1 has been suggested as a joint review between Neurosurgery and Haematology.

There have been 27 deaths requiring initial reviews, there are 7 outstanding reviews. All other deaths have been given an avoidability score of 6, (definitely not avoidable).

3:1 Quarterly Analysis – Neurosurgery and Neurology

Deaths by Admission Day of Week- There was no significance identified in relation to day of the week of admission

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 19/20	2	5	3	4	2	0	1	17	
Q2 19/20	0	2	3	2	4	2	0	13	
Q3 19/20	7	3	9	7	3	3	5	37	
Q4 19/20	1	2	4	3	6	7	2	25	**92**
Q1 20/21	8	7	2	7	2	3	6	35	
Q2 20/21	5	3	3	2	4	2	4	23	
Q3 20/21	4	2	3	5	3	5	5	27	**85**

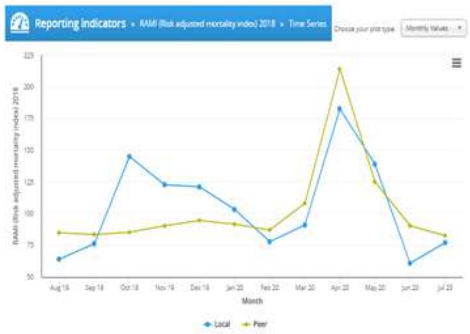
Deaths by Day of Week- There were no significance identified in relation to day of the week of the patient's death.

Q3 M&M Report 2020-2021

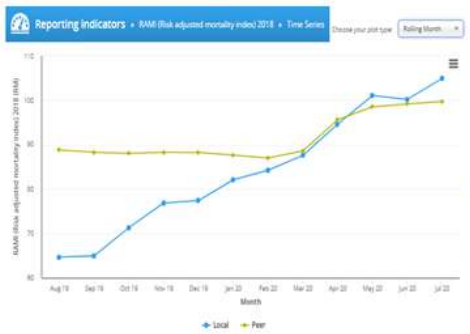
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Quarterly Total	Annual Total
Q1 19/20	2	6	2	1	3	1	2	17	
Q2 19/20	1	2	1	2	2	3	2	13	
Q3 19/20	2	3	8	1	9	10	4	37	
Q4 19/20	3	2	8	3	1	5	3	25	**92**
Q1 20/21	4	3	6	6	10	4	2	35	
Q2 20/21	0	5	7	4	1	2	4	23	
Q3 20/21	4	5	5	4	4	4	1	27	**85**

4: CHKS Mortality Data,

RAMI18 by month



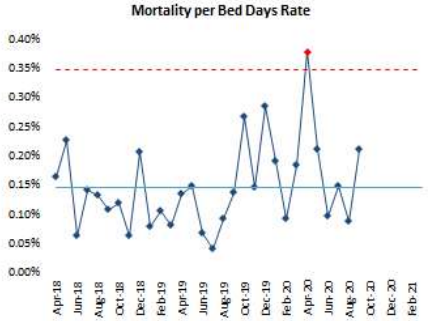
RAMI18 Rolling 12 month



During July 2020 there were eight deaths and in the RAMI18 model there were 10.36 expected deaths giving a RAMI18 position of 77.20 for the month. In July there was a reduced number of monthly deaths as it was seen in June, when compared to April and May 2020 with none of the eight deaths coded with COVID-19.

In the period between August 2019 to July 2020 there have been 117 observed deaths with the number of expected deaths from the model of 111.55 resulting in a RAMI18 figure of 104.89. This is 5.69 points above the peer average and places the trust towards to the upper quartile in the peer distribution. The monthly time series chart below show an increase in RAMI for Walton Centre in April and May 2020 and the Trust's RAMI noted to be above the peer average for five months in the last year. The rolling month chart (on right) shows the increase, in both the trust RAMI and the peer RAMI in the last five months, however the trust has moved from being below the peer to being slightly above the peer rate.

Mortality per Bed Days Rate



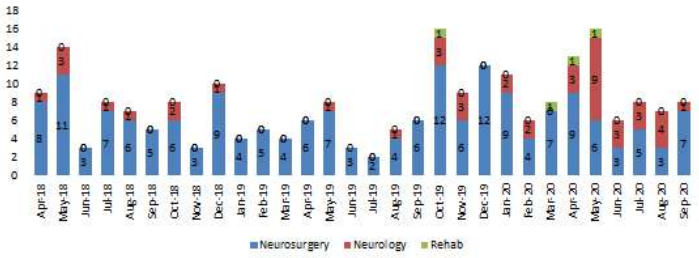
RAMI18 for HSMR condition groups July 2020

Description	Observed Deaths	Expected Deaths	RAMI18 Index	25th Percentile	Peer Value	75th Percentile
July 2020 RAMI (for HSMR conditions)	8	8.07	99.18	67.06	78.54	86.19
109 - Acute cerebrovascular disease	6	6.05	99.24	80.09	95.47	117.46
233 - Intracranial injury	2	1.17	170.63	47.95	86.25	102.96

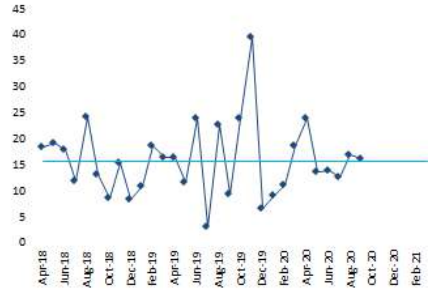
RAMI18 for HSMR condition groups August 2019 to July 2020

Description	Observed Deaths	Expected Deaths	Aug 19- July 20 RAMI18 Index	25th Percentile	Peer Value	75th Percentile
HSMR Conditions	85	89.21	95.28	82.3	89.89	98.66
109 - Acute cerebrovascular disease	45	53.79	83.66	82.49	94.81	103.32
233 - Intracranial injury	28	19.95	140.34	83.1	109.17	126.97
231 - Other fractures	6	1.36	440.02	97.29	111.62	131.76
42 - Secondary malignancies	3	7.03	42.7	48.12	71.84	82.61
38 - Non-Hodgkin's lymphoma	2	1.44	138.73	58.55	85.19	92.26
134 - Other upper respiratory disease	1	0.04	2733.76	60.03	114.66	143.79

Crude Mortality



Mortality Average Length of Stay



During August 2019 to July 2020 there were 85 observed deaths and 89.21 expected deaths giving a RAMI18 index of 95.28 this is above the peer average. The above table shows the six condition groups with observed deaths during the period compared to the peer.

One of the condition groups had a RAMI18 index below the peer average and in the best performing quartile of the peer.
The intracranial injury group is within the worst performing quartile of the peer. The charts below show this was due to a spike in April 2020, when there were four deaths (slightly higher than average), however the expected deaths were 0.79. All of the deaths followed an emergency admission.

REPORT TO TRUST BOARD

Date 04/02/2021

Title	Integrated Performance Report
Sponsoring Director	Name: Jan Ross Title: Deputy Chief Executive
Author (s)	Name: Mark Foy Title: Head of Information & Business Intelligence
Previously considered by:	• Committee – None • Group - None • Other - None

Executive Summary

This report provides assurance on all Integrated Performance Report measures aligned to the Business & Performance and Quality Committee. Measures have been grouped into three categories to highlight high performing measures, measures with opportunity for improvement and those measures currently under performing. Performance is based on four aspects; performance in month, trend/variation, whether the target is within variation and external benchmarking.

The ongoing COVID-19 situation has impacted the performance of a number of measures. Reduction in elective, outpatient and diagnostic activity during the first wave of Covid-19initially led to an increase in waiting times for overall RTT Pathways and for our 6 week wait diagnostic tests. Activity has now increased and has resulted in a reduction in overall RTT waiting times although still currently above trajectory and the 6 week wait target for diagnostics has been for achieved for two consecutive months. Cancer Performance has remained above targets as the Trust has continued to prioritise this activity. Healthcare Acquired Infections and Harms have remained within expected low levels.

Key Performance Indicators – Caring

Opportunity for Improvement Measures

Complaints – Due to COVID-19 all complainants were written to and advised there may be a delay in response. The divisions and patient experience team are now working closely together to respond to complaints.

Key Performance Indicators – Well Led

High Performing Measures

Agency Spend

Staff Friends & Family Test

Opportunity for Improvement Measures

Nursing Turnover

Sickness/Absence

Key Performance Indicators – Safe

Opportunity for Improvement Measures

Infection Control – local performance is on plan with the exception of MSSA which has passed its year end trajectory. The Trust is generally in line with national benchmark average, also with the exception of MSSA in which incidences have increased in 20/21.

Key Performance Indicators – Responsive

High Performing Measures

Cancer Standards – Two Week Wait

Cancer Standards – 31 Day First Definitive Treatment

Cancer Standards – 31 Day Subsequent Treatment

Cancer Standards – 28 Day Faster Diagnosis

6 Week Diagnostic Waits – A recovery plan was produced and performance against this standard has improved over last five months and has achieved the target for the last two months. Infection prevention and controls measures have resulted in activity being limited to 90% of normal levels.

Underperforming Measures

Referral to Treatment – Welsh RTT performance continues to recover, but is still below the 95% target.

Key Performance Indicators – Effective

Opportunity for Improvement Measures

Activity – During December 20; Daycase, Non Elective and Follow Up Outpatients all performed above our target for % of recovered activity of 19/20. Elective and New Outpatients were below the target. Activity levels particularly elective will be impacted due to the 3rd wave of COVID.

Related Trust Ambitions	Delete as appropriate: • Be financially strong • Research, education and innovation • Advanced technology and treatments • Be recognised as excellent in all we do
Risks associated with this paper	
Related Assurance Framework entries	
Equality Impact Assessment completed	• Yes – (please specify) _____ • No – (please specify)

	_____
Any associated legal implications / regulatory requirements?	• Yes – (please specify) _____ • No – (please specify) _____
Action required by the Board	Delete as Appropriate • To consider and note

The Walton Centre
NHS Foundation Trust

Board KPI Report
February 2021

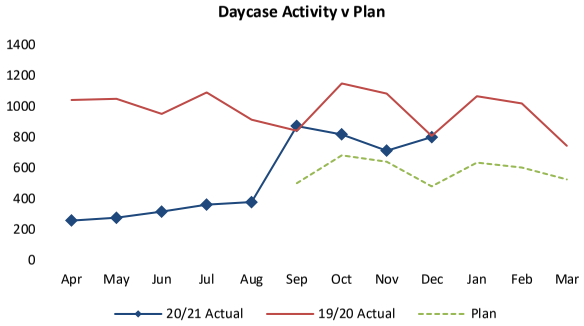
Data for December 2020 unless indicated

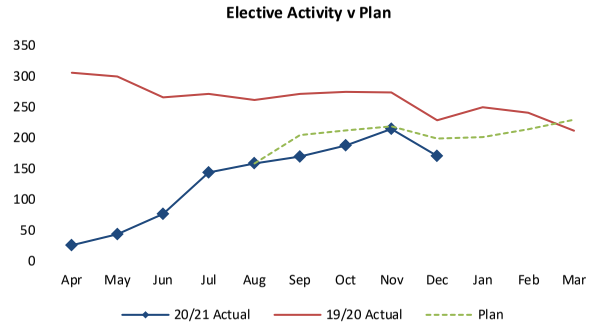
Excellence in Neuroscience

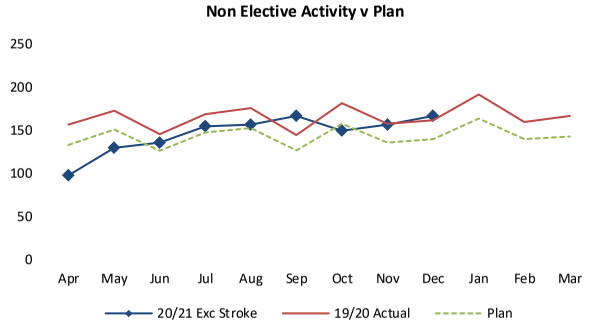
Operational

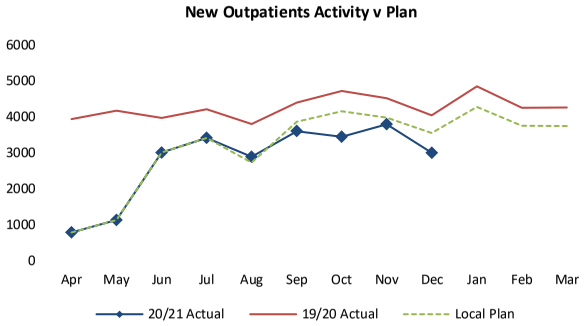
Effective - Activity Recovery Plan

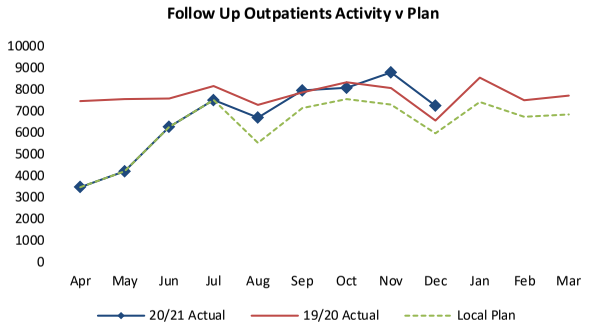
The Walton Centre
NHS Foundation Trust











December 20 Activity Performance

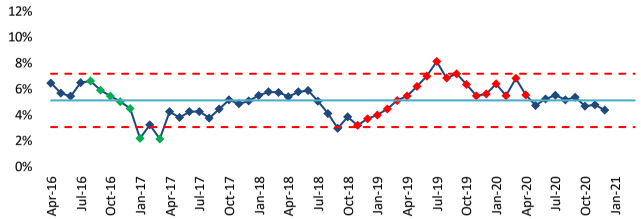
POD	Actual (% of 19/20)	Target (% of 19/20)
Daycase	99.01%	59.48%
Elective	74.67%	87.12%
Non Elective	103.09%	85%
New Outpatients	74.28%	87.94%
Follow Up Outpatients	110.55%	91.03%

Quality of Care

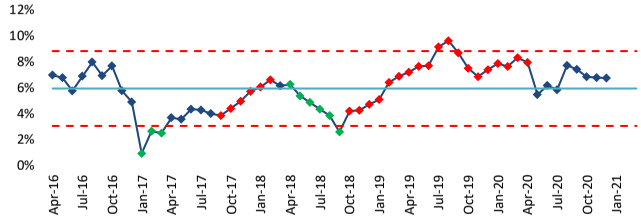
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

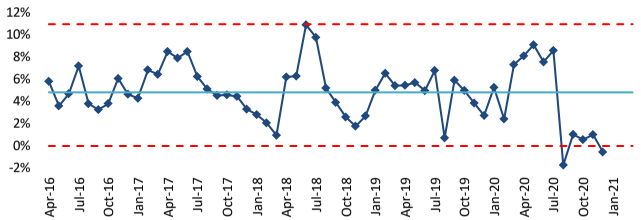
Overall Vacancy Level %



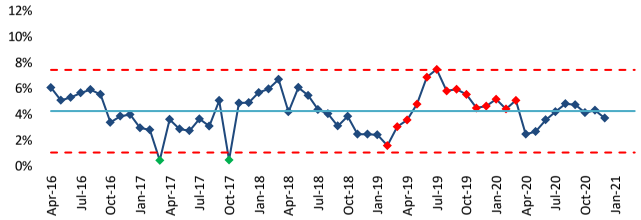
Nursing Vacancy Level %



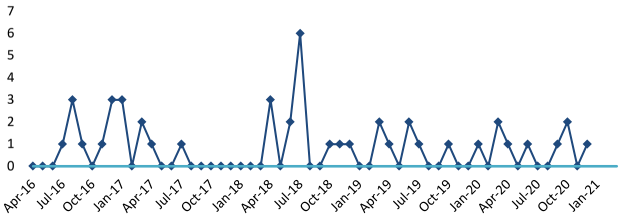
Medical Vacancy Level %



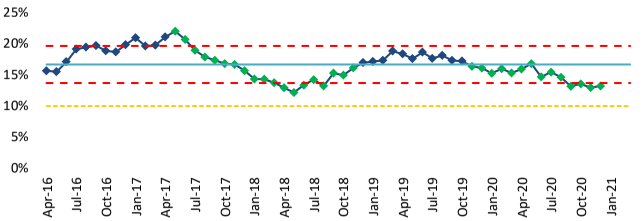
Other Staff Vacancy Level %



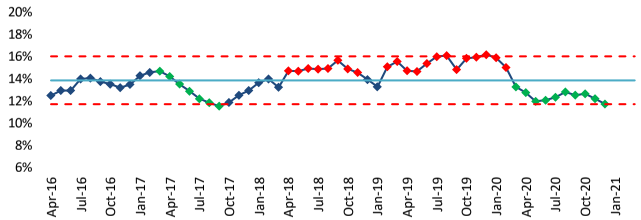
Medical Leavers



Nursing Turnover (Rolling 12 months)



Other Staff Turnover (Rolling 12 months)



Vacancy Levels

After a period of special cause variation Overall vacancy levels are within normalvariation. This is also the case when broken down to staff group for nursing and other staff. Medical vacancies are inside expected limits.

Nursing Turnover

Nursing turnover has significantly improved over the last year and is within special cause variation. At division level, the target is also outside of the control limit for neurology and neurosurgery, however Neurosurgery experienced special cause variation in Dec 20 and is below the target.

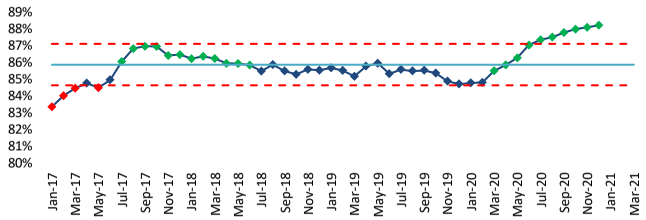
Sickness/Absence

Sickness/Absence is within expected levels for all types, however long term sickness has significantly increased over the last year.

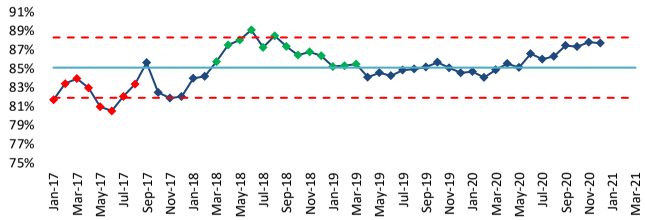
Staff Stability

Staff stability index for all staff has significant improved since March 20, this looks driven by more nursing staff remaining in post for 12 months.

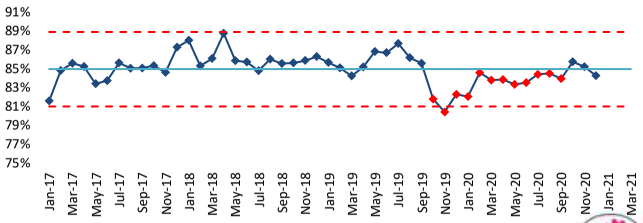
Staff Stability Index - All Staff



Staff Stability Index - Nursing



Staff Stability Index - Medical



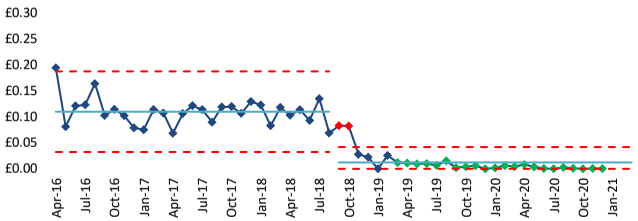
Excellence in Neuroscience

Quality of Care

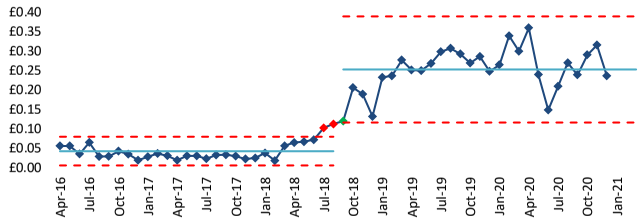
Well Led - Workforce KPIs

The Walton Centre NHS Foundation Trust

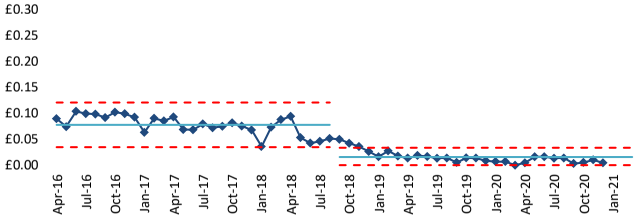
Nursing & HCA Agency Spend (£m)



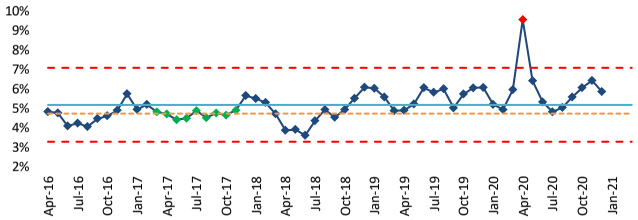
Nursing & HCA Bank Spend (£m)



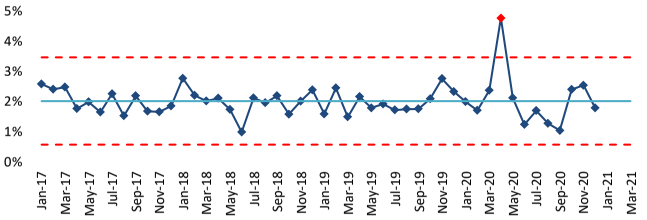
Nursing & HCA Overtime Spend (£m)



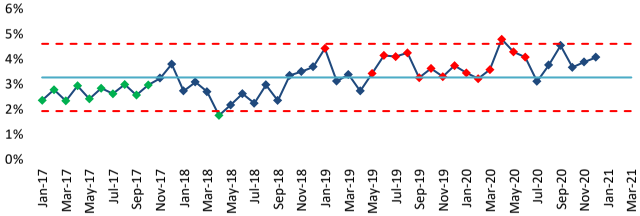
Sickness/Absence (Monthly)



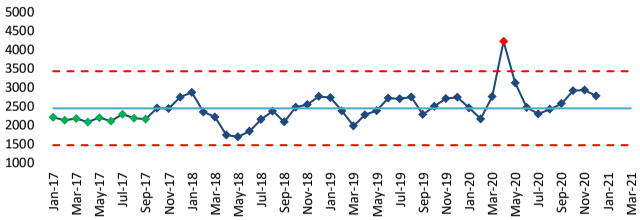
Short Term Sickness/Absence (Monthly)



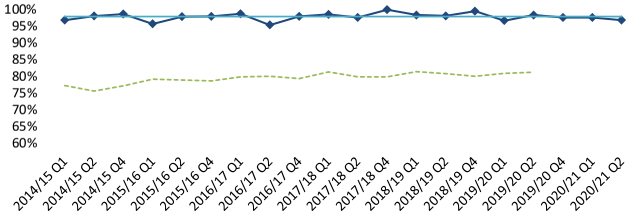
Long Term Sickness/Absence (Monthly)



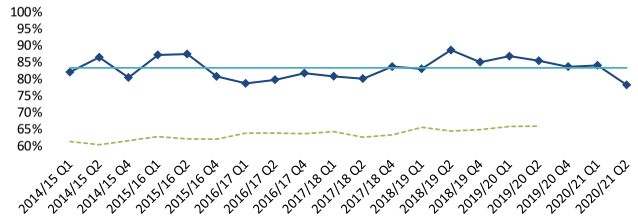
Lost Days due to Sickness/Absense (Monthly)



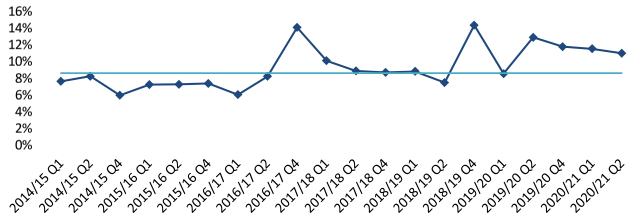
Staff FFT - % Recommend as Place of Care



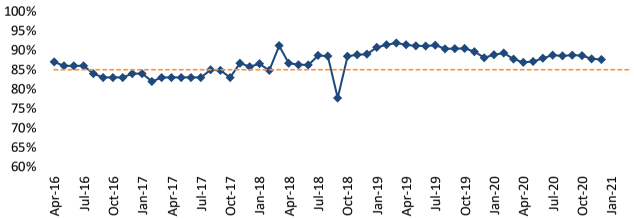
Staff FFT - % Recommend as Place of Work



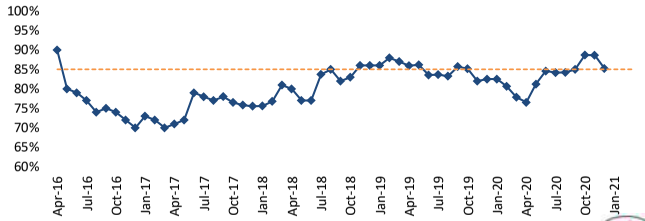
Staff FFT - % of Organisation Staff Responded



Mandatory Training Compliance (Rolling 12 months)



Appraisal Compliance (Rolling 12 months)



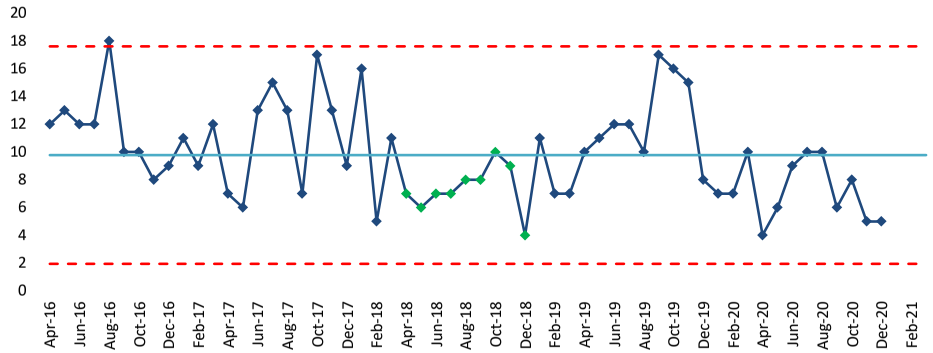
Excellence in Neuroscience

Quality of Care

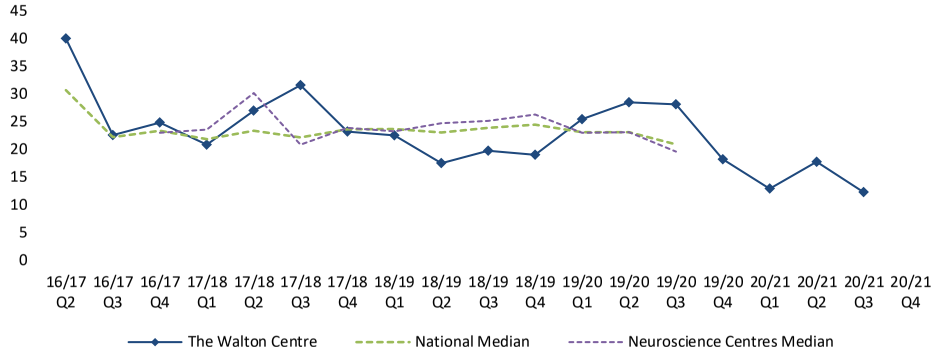
Caring - Complaints

The Walton Centre NHS Foundation Trust

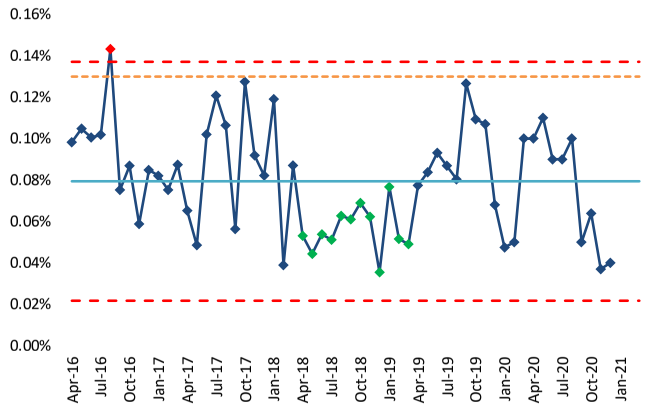
Total Complaints Received in month



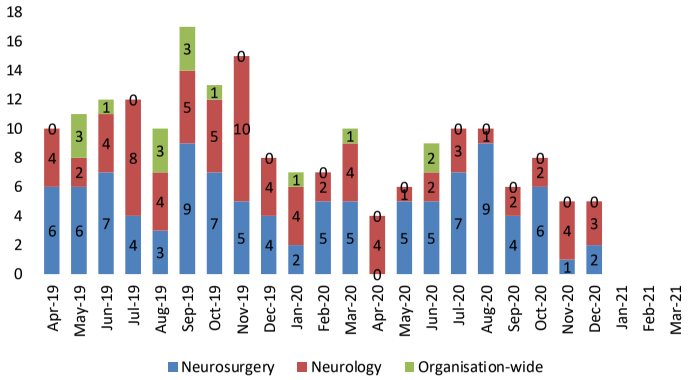
Quarterly Complaints per 1000 WTE



% Complaints Received against Activity



Total Complaints Received



Narrative

In December 2020 the Trust received 5 complaints. 3 Neurology (1 Reopened) and 2 Surgery.

The number of complaints the Trust receives has a wide variation range meaning the expected numbers range from 2 to 18 at an average of 10 per month. When balanced against patient contacts the number received is within normal variation. However when compared externally the number of complaints received per 1000 WTE is above both the national average and other Organisations with a large neurosciences service. Local data shows a reduction in Q4 and Q1. Publication of national data has been suspended due to COVID-19.

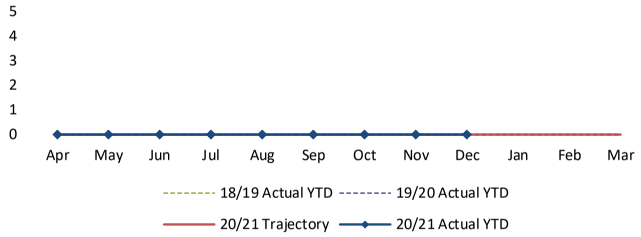
Excellence in Neuroscience

Quality of Care

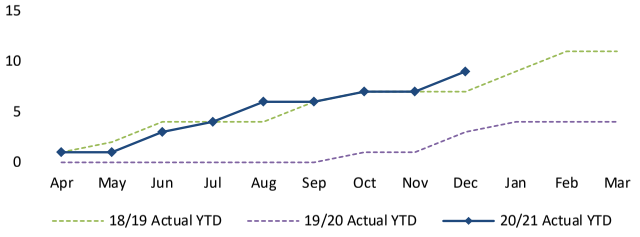
Safe - Infection Control

The Walton Centre NHS Foundation Trust

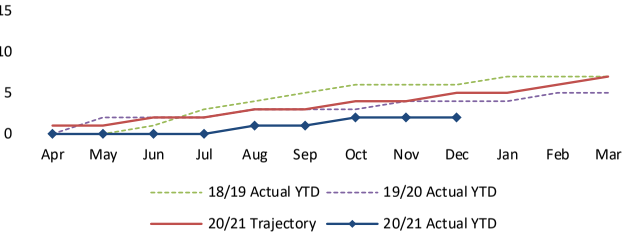
MRSA Bacteraemia



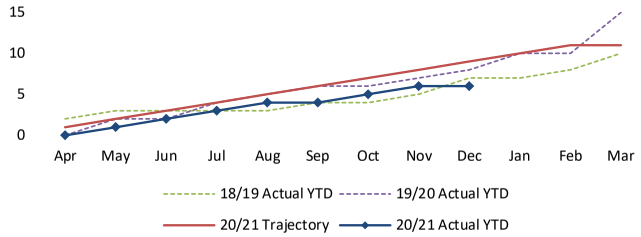
CPE



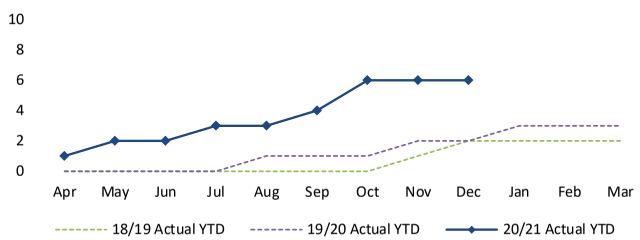
C.Diff



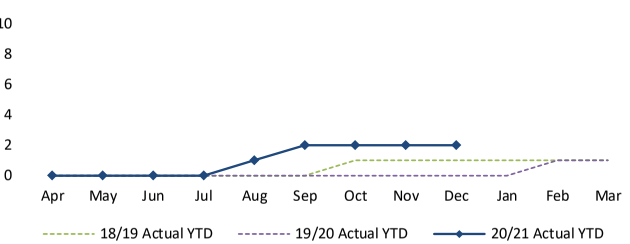
E.Coli



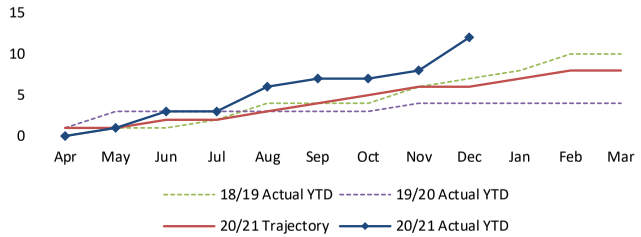
Klebsiella Bacteraemia



Pseudomonas Bacteraemia



MSSA



Total Healthcare Acquired Infections 20/21

	MRSA B	CPE	C.Diff	E.Coli	KB	PB	MSSA	Total
Cairns		2	1				1	**4**
Caton		1					2	**3**
Chavasse				1		1	1	**3**
CRU		1			1			**2**
Dott		4		1	2		1	**8**
Horsley		1	1	3	2	1	7	**15**
Lipton				1				**1**
Sherrington					1			**1**
Total	**0**	**9**	**2**	**6**	**6**	**2**	**12**	**37**

December Breakdown

2x CPE - Dott, CRU

4x MSSA - 3x Horsley, 1x Chavasse

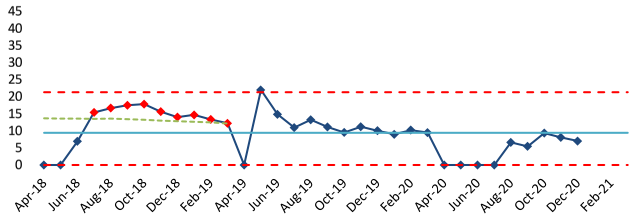
Excellence in Neuroscience

Quality of Care

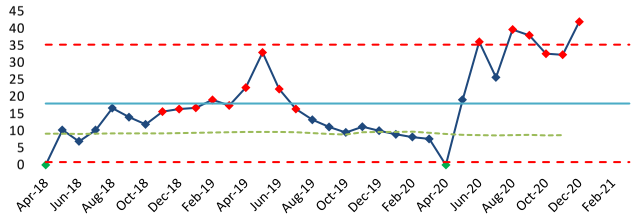
Safe - Infection Control

The Walton Centre NHS Foundation Trust

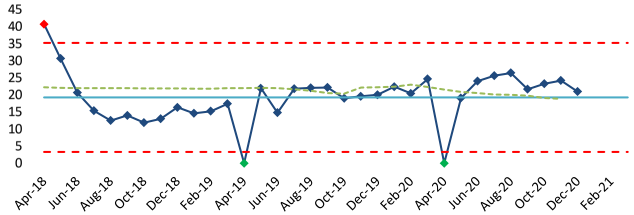
C.Diff Rate per 100,000 Bed Days YTD



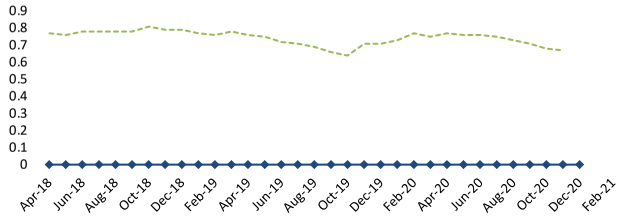
MSSA Rate per 100,000 Bed Days YTD



E.Coli Rate per 100,000 Bed Days YTD



MRSA Rate per 100,000 Bed Days YTD



Narrative

All infection types are within their YTD trajectory level for 20/21 during December 20 with the exception of MSSA in which there has been twelve recorded instances against a year end trajectory of eight.

MSSA rates per 100,000 bed days are significant above expected levels and the national average.

E.Coli rates have typically been better or inline with the average, while MRSA has been consistently better.

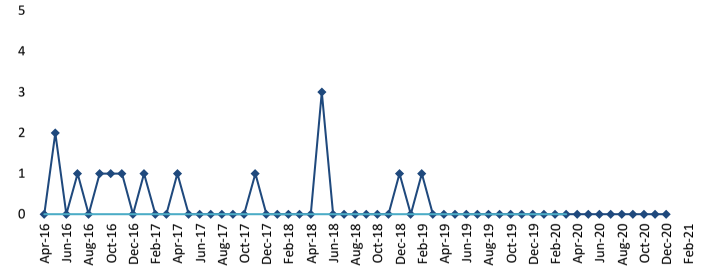
As of March 19 the C.Diff hospital acquired rate is no longer published.

Quality of Care

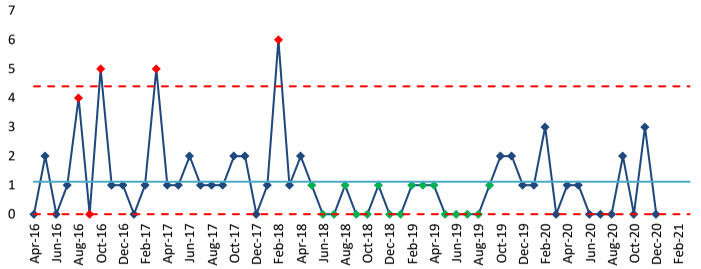
Safe - Harm Free Care

The Walton Centre NHS Foundation Trust

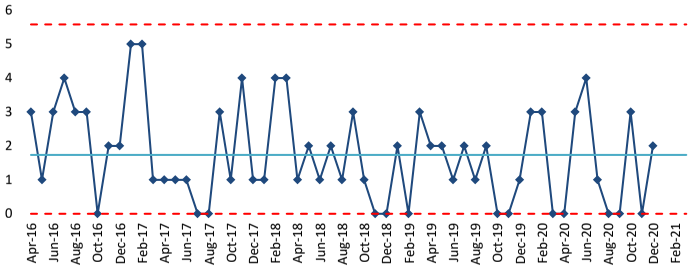
Total Moderate or Above Harm Patient Falls



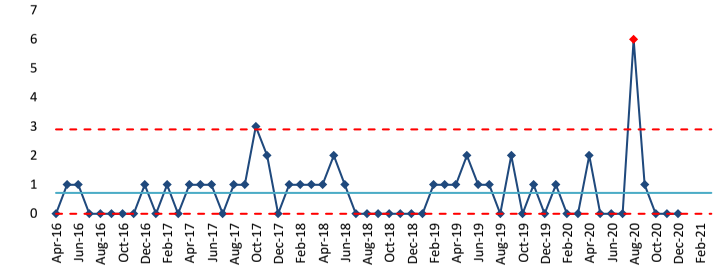
Total Hospital Acquired Pressure Ulcers (Category 2, 3, 4 & Unstageable)



CAUTI Incidences



VTE Incidences



Narrative

There were no falls which resulted in moderate or above harm in December 20.

There were no Hospital Acquired Pressure Ulcers in Deember 20

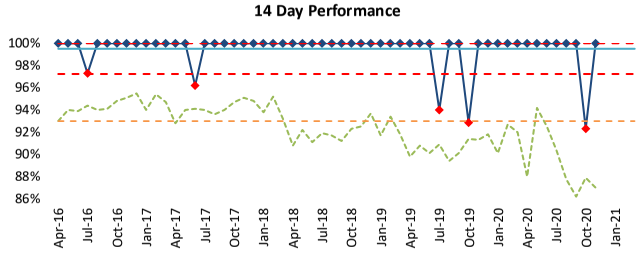
There were two CAUTI incidences in December 20

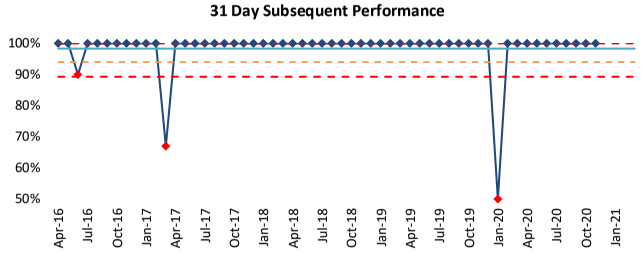
There were no VTE incidence in December 20.

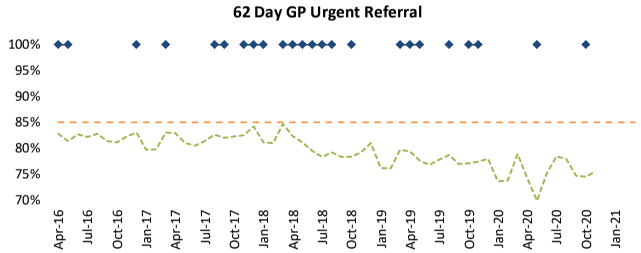
All harm measures are within normal variation.

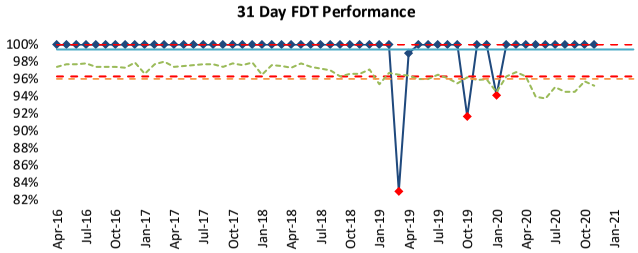
Operational
Responsive - Cancer

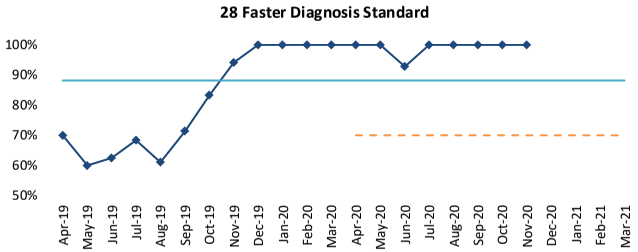
The Walton Centre NHS Foundation Trust











Narrative

All Cancer Access Standards have been met in the latest reporting period of November 2020.

The Trust has continued to see and treat all cancer patients throughout April as these patients were urgent, therefore the impact of covid-19 is minimal.

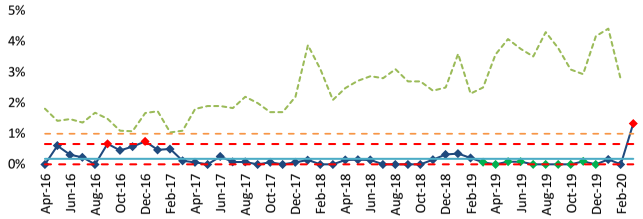
From April 2020 the new 28 Day faster diagnosis standard begins following a period of shadow monitoring. The target has been set nationally at 70%. The Trust has consistently met this target since its introduction.

Operational

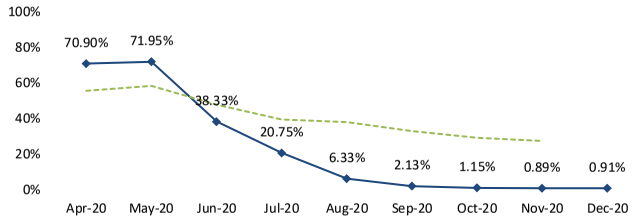
Responsive - Diagnostics

The Walton Centre NHS Foundation Trust

6 Week Diagnostic Performance (16/17 - 19/20)



6 Week Diagnostic Performance (20/21)

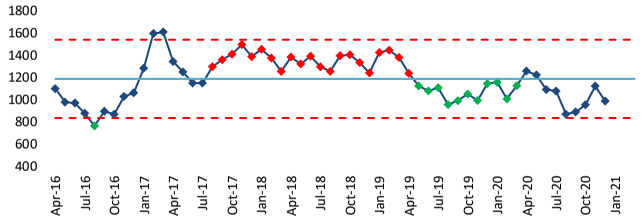


Narrative

Diagnostic performance in December 20 was 0.91%.

Performance has improved since May, however due to Infection Prevention and Control measures Radiology will be running at 90% capacity which remains a risk to performance.

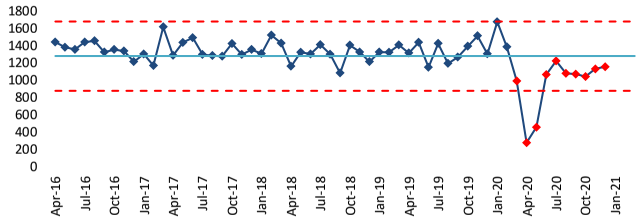
Total Diagnostic Waits at Month End



There were 9 six week diagnostic breaches at the end of December20.

MR - 8
CT - 1

Total Diagnostic Activity in Month



THE WALTON CENTRE NHS FOUNDATION TRUST
SUMMARY FINANCIAL INFORMATION

Trust I&E	In month			Year to Date			Forecast		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Main Contract	8,992	9,258	266	78,045	78,640	595	105,022	105,993	971
Exclusions	1,786	1,746	(40)	16,070	15,821	(249)	21,427	21,178	(249)
Private Patient	1	5	4	26	49	23	29	65	36
Other Operating	428	637	209	4,118	4,403	285	5,402	5,861	459
Total Operating Income	**11,207**	**11,646**	**439**	**98,259**	**98,913**	**654**	**131,880**	**133,097**	**1,217**
Pay	(6,111)	(6,025)	86	(54,229)	(54,202)	27	(72,565)	(72,324)	241
Non-Pay	(2,523)	(2,842)	(319)	(21,870)	(22,656)	(786)	(29,168)	(30,362)	(1,194)
Exclusions	(1,785)	(1,928)	(143)	(13,378)	(13,069)	309	(18,736)	(18,425)	311
COVID / Reserves	(599)	(115)	484	(4,683)	(3,977)	706	(6,408)	(6,009)	399
Total Operating Expenditure	**(11,018)**	**(10,910)**	**108**	**(94,160)**	**(93,904)**	**256**	**(126,877)**	**(127,120)**	**(243)**
EBITDA	**189**	**736**	**547**	**4,099**	**5,009**	**910**	**5,003**	**5,977**	**974**
Depreciation	(403)	(406)	(3)	(3,626)	(3,631)	(5)	(4,834)	(4,842)	(8)
Profit / Loss On Disp Of Asset	0	0	0	2	3	1	2	3	1
Interest Receivable	0	0	0	5	5	0	5	5	0
Financing Costs	(52)	(51)	1	(465)	(462)	3	(620)	(615)	5
Dividends on PDC	(92)	(101)	(9)	(825)	(835)	(10)	(1,102)	(1,138)	(36)
I & E Surplus / (Deficit)	**(358)**	**178**	**536**	**(810)**	**89**	**899**	**(1,546)**	**(610)**	**936**
Capital donations I&E impact	**19**	**12**	**(7)**	**159**	**42**	**(117)**	**216**	**106**	**(110)**
I & E Surplus / (Deficit)	**(339)**	**190**	**529**	**(651)**	**131**	**782**	**(1,330)**	**(504)**	**826**

In response to the COVID-19 pandemic, the financial regime has now moved into another phase, with the trust now being monitored against the year-end forecast of £1.1m deficit submitted in December (based on expected forecast at that time). The HCP latest forecast is close to being finalised now with the Trust's position being a £1.1m deficit within this control total.

From October (Month 7), the key changes from reporting in April – September (Month 1-6) are:
- 'Block' funding received for COVID related costs & growth (based on fair share of sector funding) for M7-12 rather than being reimbursed directly via retrospective top-up;
- No retrospective monthly top-up funding will be received to bring Trust to breakeven.

At month 9, the Trust reported a £190k surplus position. This is a £529k improvement on the planned position.

The in-month position includes £0.1m spend incurred as a result of COVID-19.

The Trust is forecasting a year end deficit position of £0.5m (after the impact of donations), which is an improvement of £0.8m against the planned year end position (and a £0.6m improvement against the previous forecast). This is due to one off benefits received in month 9.

STATEMENT OF FINANCIAL POSITION - 2020/21	Mar-20	Dec-20	Movement
	£'000	£'000	£'000
Intangible Assets	49	36	(13)
Tangible Assets	82,591	80,440	(2,151)
TOTAL NON CURRENT ASSETS	**82,640**	**80,476**	**(2,164)**
Inventories	1,232	1,170	(62)
Receivables	9,287	6,990	(2,297)
Cash at bank and in hand	26,673	40,921	14,248
TOTAL CURRENT ASSETS	**37,192**	**49,081**	**11,889**
Payables	(18,088)	(29,030)	(10,942)
Provisions	(226)	(226)	0
Finance Lease	(52)	(52)	0
Loans	(1,396)	(1,396)	0
TOTAL CURRENT LIABILITIES	**(19,762)**	**(30,704)**	**(10,942)**
NET CURRENT ASSETS/(LIABILITIES)	**17,430**	**18,377**	**947**
Provisions	(639)	(621)	18
Finance Lease	(115)	(81)	34
Loans	(25,031)	(23,635)	1,396
TOTAL ASSETS EMPLOYED	**74,285**	**74,516**	**231**
Public Dividend Capital	27,554	27,696	142
Revaluation Reserve	2,544	2,544	0
Income and Expenditure Reserve	44,187	44,276	89
TOTAL TAXPAYERS EQUITY AND RESERVES	**74,285**	**74,516**	**231**

STATEMENT OF CASH FLOW - 2019/20	December-20 Plan	December-20 Actual	Variance
	£'000	£'000	£'000
SURPLUS/(DEFICIT) AFTER TAX	**(810)**	**89**	**899**
Non-Cash Flows In Operating Surplus/(Deficit)	4,910	4,926	16
OPERATING CASH FLOWS BEFORE MOVEMENTS IN WORKING CAPITAL	**4,100**	**5,015**	**915**
Increase/(Decrease) In Working Capital	14,116	15,310	1,194
Increase/(Decrease) In Non-Current Provisions	(23)	(19)	4
Net Cash Inflow/(Outflow) From Investing Activities	(5,692)	(3,631)	2,061
NET CASH INFLOW/(OUTFLOW) FROM INVESTING ACTIVITIES	**12,501**	**16,675**	**4,174**
Net Cash Inflow/(Outflow) From Financing Activities	(2,146)	(2,427)	(281)
NET INCREASE/(DECREASE) IN CASH	**10,355**	**14,248**	**3,893**
OPENING CASH	**26,673**	**26,673**	**0**
CLOSING CASH *	**37,028**	**40,921**	**3,893**

*Cash flow inclusive of an additional month of commissioner payments due to providers having to deal swiftly with the Covid-19 outbreak. This is likely to reverse in March unless national policy changes

COVID-19 expenditure:

YTD £2.3m expenditure has been incurred on COVID-19 (and is included within the reported financial position).

In month (December) spend was £148k.

COVID-19 costs are subject to independent audit if requested through NHS Improvement.

COVID -19 Expenditure	Apr-20 Actual £'000	May-20 Actual £'000	Jun-20 Actual £'000	Jul-20 Actual £'000	Aug-20 Actual £'000	Sep-20 Actual £'000	Oct-20 Actual £'000	Nov-20 Actual £'000	Dec-20 Actual £'000	YTD Actual £'000
Pay cost (incl. additional shifts, on-call, etc)	99	254	191	118	96	49	91	97	35	1,030
Annual leave provision	287	(287)	52	0	0	0	0	0	0	52
PPE	62	148	259	63	10	94	0	17	(5)	648
Decontamination	9	8	(2)	6	(3)	9	4	0	0	31
Agile working	21	(19)	1	92	0	3	97	30	58	283
ITU	5	2	(3)	0	2	0	(2)	0	38	42
Other	37	24	18	23	18	33	32	19	22	226
TOTAL	**520**	**130**	**516**	**302**	**123**	**188**	**222**	**163**	**148**	**2,312**

Other spend includes providing free car parking for staff, increasing the number of staff uniforms for staff and a contribution towards storage costs at the Liverpool arena for PPE.

Capital

In month variance - £68k below plan.

Year to date variance - £2,391k below plan

The full year plan includes additional non-recurrent funding of £1.091m allocated by NHSI for critical infrastructure costs.

With the increase in capital funding finance have been working closely with divisions to identify deferred schemes which can be delivered by 31st March 21 to ensure that the plan is delivered.

The Trust has been allocated £0.5m from DHSC for an additional CT scanner which will be utilised by the Trust and to provide additional diagnostic capacity for the local system.

The detailed capital forecast is being monitored and reviewed weekly by Director of Finance and Director of Ops and Strategy.

CAPITAL

	Annual Plan £'000	In month Plan £'000	In month Actual £'000	In month Var £'000	Year to Date Plan £'000	Year to Date Actual £'000	Year to Date Var £'000
Division							
Heating & Pipework	978	49	33	16	978	521	457
Estates	368	31	7	24	276	133	143
IM&T	1,283	107	25	82	962	252	710
Neurology	2,122	43	28	15	1,992	36	1,956
Neurosurgery	1,702	142	80	62	1,277	286	991
Corporate	150	0	0	0	0	0	0
Capital Slippage	(2,099)	(131)	0	(131)	(1,627)	0	(1,627)
TOTAL (excl. COVID-19)	**4,504**	**241**	**173**	**68**	**3,858**	**1,228**	**2,630**
COVID-19	0	0	0	0	0	239	(239)
TOTAL	**4,504**	**241**	**173**	**68**	**3,858**	**1,467**	**2,391**

Capital spend in month is £173k.

There is £33k capital spend on phase 3 heating/pipework scheme.

There has been £25k of IM&T spend on staffing for projects, £7k on estates schemes, £20k spend for the new scanner in Neurology and £80k on a Allen spinal frame and CRW frame in Neurosurgery.

The plan reflects the final submission to Cheshire and Merseyside Health Care Partnership as part of the 20/21 phase 3 planning process.

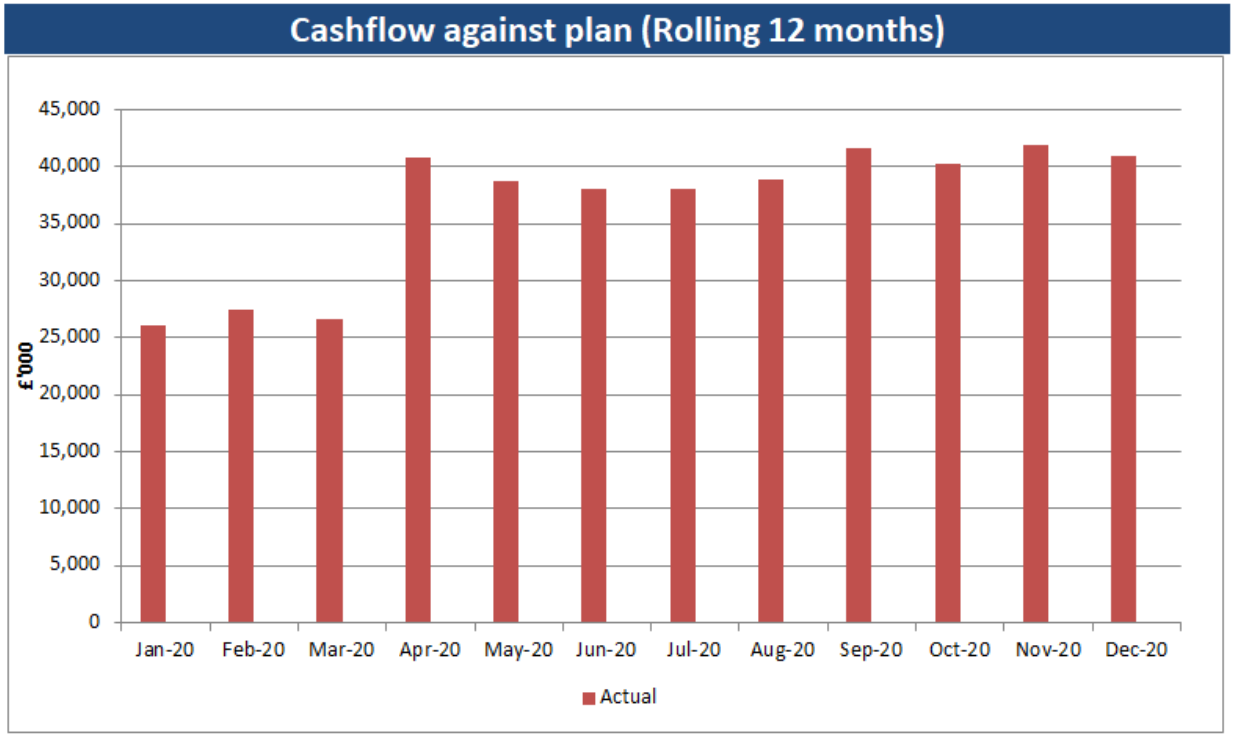
NHS I/E are in regular contact to monitor spending.

Although year to date spend is below plan, it is anticipated that it will be in line with the plan by the end of the year. This is primarily due to the installation of the CT scanner.

As of the end of December:

Actual Cash Balance: £40.9m

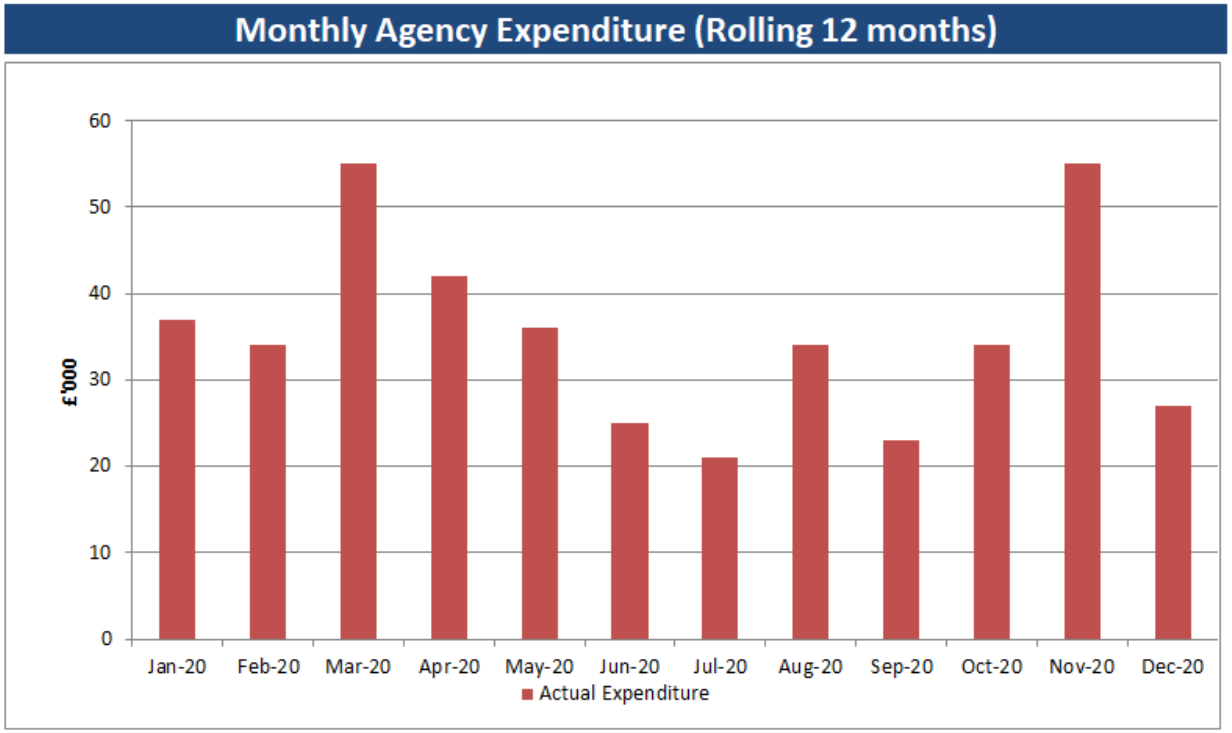
Number of days operating expenses = 118 days



The Trust cash balance at the end of December was £40.9m. This is a decrease of £1.0m from the end of November.

The cash position includes an additional month of block payment received in December relating to January for the new financial arrangements to cover the COVID-19 pandemic.

Notification has been received that the block payment will not be made in March to bring contract payments back in line, so the level of cash will reduce. However it is not known whether this will now happen due to the 3rd wave of COVID.

Agency Expenditure: In month Actual: £27k YTD Actual: £297k		Agency spend incurred in December was £27k, a decrease of £28k compared to November. At the end of December, £50k agency expenditure relates to COVID-19 (and is included within the COVID-19 expenditure analysis).

Key Risks and Actions for 2020/21

As a result of the COVID-19 pandemic financial regulations have changed for 2020/21, with the main changes being:

- Suspension of 2020/21 business planning;
- Payment by Results (PbR) being suspended for the year and income being based on block values determined nationally (based on 2019/20 expenditure between November 2019 and January 2020). To note that income has not been reduced for the national efficiency target;
- 'Top-up' payments from national block being made to cover additional costs incurred in relation to responding to reasonable COVID-19 and other known cost increases from 2019/20 (e.g. CNST contributions). This was the position for M1-6 with a block element of funding being allocated for COVID-19 and growth to C&M HCP for M7-12 which is to be distributed to all organisations;
- The trust is currently being monitored against the year-end forecast of £1.1m deficit submitted to NHS I/E and C&M HCP in December;
- An Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity (M6-M12). If the Trust over-performs against this target then the Trust will be financially rewarded for doing so, but if it under-performs then will receive a retrospective financial penalty. This will not be applied in September and October given the impact of Covid patients in the C&M system however we are awaiting further guidance on whether this will be applied in the following months;
- 2020/21 capital levels to be set at a Health & Care Partnership level and agreed across the C&M footprint. Note, this allocation does not include any phase 2 COVID-19 capital requirements or additional PDC allocated for specialist capital projects;
- Financial governance and regulations remain in place and any financial management will be addressed in the same way it would regardless of the pandemic.

As a result of the 3rd wave of COVID further guidance has been received around 2021/22:

- 21/22 business planning deferred for at least first 3 months of 21/22;
- Current financial regime is to continue for at least the first 3 months of 21/22 (and possibly the next 3 months dependant on levels of COVID);
- Exercise looking at 'exit run rates' for 19/20 and 20/21 is being undertaken by NHSE/I to determine potential level of contract funding for 1st quarter of 21/22;
- System level targets will continue.

Further feedback will be provided to committee/ board members on the future financial framework once information is received from NHSE/I.

Even though the NHS and Trust are responding to the pandemic, there are a number of potential risks in 20/21 and 21/22 that may impact in the delivery of the financial plan in the future;

RISK	COMMENT/ ACTIONS
Wales/ IOM expectations	Block payments for English commissioners planned income are based on average levels of income and spend for months 8-10 in 2019/20 plus 2.8% inflation. Assumed income for Welsh commissioners is consistent with this approach (per guidance released M7-12), although high cost exclusions are now based on a pass through cost and volume basis. As part of this guidance, if activity has reduced by more than 25% below the block contract payment it will be adjusted by 10% in value increasing to a maximum reduction of 20% in value if activity reduces by more than 50%. Given that the Trust has had to cancel elective activity in January to support the regional COVID response there is a risk that Welsh activity will be at least 25% less than prior year activity which would mean that the contract penalties would be applied. This could result in a £700k reduction in income. National discussions are taking place around this but remain a material risk to the Trust. IOM are only paying for actual activity that has been delivered (which is reflected within the financial position), again resulting in an under payment compared to centrally assumed levels of income in line with 19/20 outturn. Although there was an increase in activity between M6-M9, this is not expected to continue at these levels.
Current/ Future NHS Financial Framework	For the remainder of the year block funding will remain in place but COVID-19 will not be retrospectively reimbursed, with central funding allocated to the HCP for the rest of the year. C&M HCP is expected to achieve a breakeven position by the end of the financial year. STP's were required to submit phase 3 recovery plans for activity (and associated financial implications) on 1st September with final plans being submitted on 21st September. As part of this process the Trust has been completing phase 3 forecasts based on anticipated levels of activity to

	understand the financial implications for the Trust which have been submitted to the C&M Healthcare Partnership with final submissions submitted in late October. The trust is now being monitored against a year-end forecast of £1.1m deficit. This was taken from a revised submission in December. The level of forecast financial deficit across C&M has reduced to c. £11m and this is currently being accepted as the final position for C&M. However, discussions will continue to be held with NHSE/I about future expectations in light of the 3rd wave of COVID. As a result of the current national position with COVID notification has been received that 21/22 financial planning has been deferred for at least 3 months. In addition to this, it has been confirmed that current financial arrangements will remain in place for at the 1st 3 months of 2021/22. However it is still to be confirmed as to the value of the plan/ block funding for the Trust for Q1 in 21/22. An exit run rate exercise is being carried out across the NHS which is likely to determine these allocations.
Elective Incentive Scheme	The Elective Incentive Scheme came into effect in M6 in which the Trust is required to meet a set percentage of 2019/20 activity for outpatient, inpatient day-case and elective activity. The Trust has under-performed against this target in M6 – M9 (mainly in relation to the levels of elective activity) and as such the Trust may have received a retrospective financial penalty (if applied to individual organisations). However during this period, the system has had greater than 15% of beds filled with COVID related patients, and as such the Trust is not expecting a retrospective financial penalty for this period. NHSE/I have confirmed that the EIS will not be applied to C&M for at M6 and M7. Any potential financial impact of the Elective Incentive Scheme is currently outside the reported forecast position as requested by the HCP.
Efficiency requirements going forwards	Due to the current uncertainty around the financial framework, it is not clear what the efficiency requirements of the Trust will be and as such planning to deliver recurrent savings is difficult. However, this is likely to be greater than 1.1% given the additional NHS investments 2020/21. Clearly the delay in 21/22 business planning may impact on national

	efficiency requirements but it is currently not clear what internal efficiencies may need to be delivered to meet expected financial plans.
Future delivery of clinical services whilst still managing COVID-19	Organisations have to plan on how to deliver safe services whilst still managing COVID-19. The delivery of services will have to fundamentally change to take account of social distancing requirements, PPE availability, willingness of patients to come into hospital and availability of staff to deliver services. This is likely to cause a cost pressure to the Trust in order to implement the required measures to provide safe services. However there is also likely to be an impact on the size of waiting lists and how quickly patients can be treated (as fewer patients will be able to be seen given the additional PPE/ social distancing requirements). It should be noted that it has been agreed by C&M HCP that Trust elective activity will be cancelled for at least 4 weeks to be able to support the regional response to COVID. This will both have a financial impact but also will impact on waiting times and future recovery of activity.

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 04/02/2021

Title	**Quality Account Amendments Report**
Sponsoring Director	Name: Lindsey Vlasman Title: Acting Director of Nursing and Governance
Author (s)	Name: Lindsey Vlasman Title: Acting Director of Nursing and Governance
Previously considered by:	• Committee (please specify) _____ • Group (please specify) _____ • Other (please specify) _____
Executive Summary **Towards the end of each financial year, the Trust works closely with various stakeholders to identify areas of focus for quality improvements for the forthcoming year. At this time it also allows the Trust to reflect on the year's previous performance against the identified quality improvement priorities. The delivery of the quality improvement priorities are monitored through meetings of the Quality Committee, chaired by a Non-Executive Director, with sub groups focussing on the 3 domains of quality: patient safety, clinical effectiveness and patient experience. The Director of Nursing and Governance is the Executive Lead responsible for delivering the plan and designates duties to operational leads for each of the priorities** **The full 2019/20 Quality Accounts were last reviewed at the Trust Board in July 2020. Since this time there have been some amendments as shared in this report prior to publication. The report has been managed differently this year due to the COVID 19 pandemic and is out of line with the usual schedule.**	
Related Trust Ambitions	Delete as appropriate: • Best practice care • Be recognised as excellent in all we do
Risks associated with this paper	Risk to quality of care to patients and reputation
Related Assurance Framework entries	
Equality Impact Assessment completed	No – (please specify) _____
Any associated legal implications / regulatory requirements?	No – (please specify) _____
Action required by the Board	• Note both the amendments made to the Quality Account subsequent to Board review in July 2020 and the final version of the Quality Account 2019/20 included at Annex A.

Amendments to the Quality Account 2019/20

The full 2019/20 Quality Accounts were last reviewed at Trust Board in July 2020. Since this time there have been some amendments as per below:

- Section 2.3.9 (Page 31 onwards)

Slight amendment to paragraphs from:

The Information Governance Toolkit was replaced in April 2018 by the Data Security and Protection Toolkit (DSPT). The new toolkit was designed by NHS Digital to encompass the National Data Guardian reviews and the 10 data security standards and supports the key requirements under the General Data Protection Regulation (GDPR) and new Data Protection laws. The DSPT does not include levels in the same way as it did in previous years; instead it requires compliance with 40 assertions and the entire mandatory evidence items.

The Trust is on target to provide evidence for 100% of the mandatory evidence items in addition to completing and meeting 40 of the 40 assertions by the extension deadline of 30th September 2020 due to Covid19.

Slight amendment to paragraphs to:

This year was the second year of the new Data Security and Protection Toolkit. The focus is now on the security of data, and incorporating the Network and Information Systems Regulation 2018 (NIS) and the 10 Data Security Standards and is very different to the old IG Toolkit. Within the Toolkit there are 44 assertions and 116 mandatory evidence items.

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

The Trust has met all 44 assertions, mandatory evidence items and achieved standards met for the Data Security and Protection Toolkit, which was submitted to NHS Digital on 27th July 2020.

- Section 2.3.9 (Page 32 – Table: The Walton Centre Internal Clinical Coding Audit 2019/20)

Percentage column read *TBC* and has been amended to read *suspended due to COVID.*

- Section 11 (Page 49)

Table providing data on VTEs has been amended from *awaiting publication* on the national average figures for Q4 19/20 to *suspended due to COVID.*

- Annex 1 (page 53 onwards)

Commentary from the following stakeholders have been included in the Quality Account:
Healthwatch Liverpool
Healthwatch Sefton
Healthwatch St Helens

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

The Walton Centre
NHS Foundation Trust

Quality Account

2019 – 2020

Part 1 Statement on Quality from the Chief Executive

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

Improvement Priorities

2.1 How well have we done in 2019-20?

2.1.1 Patient Safety
2.1.2 Clinical Effectiveness
2.1.3 Patient Experience

2.2 What are our priorities for 2020-21?

2.2.1 Patient Safety
2.2.2 Clinical Effectiveness
2.2.3 Patient Experience

2.3 Statements of Assurance from the Board

2.3.1 Data Quality
2.3.2 Participation in Clinical Audit and National Confidential Enquiries
2.3.3 National Audits
2.3.4 National Confidential Enquiries
2.3.5 Participation in Local Clinical Audits
2.3.6 Participation in Clinical Research and Development
2.3.7 CQUIN Framework & Performance
2.3.8 Care Quality Commission (CQC) Registration
2.3.9 Trust Data Quality
2.3.10 Learning from Deaths
2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services
2.3.12 Speaking Up

Part 3 Trust Overview of Quality 2019/20

3.1 Complaints
3.2 Local Engagement – Quality Account
3.3 Quality Governance
3.4 Top Industry Award
3.5 International Engage Award (ShinyMind App)
3.6 International Engage Lifetime Contribution Award
3.7 BBC Two Hospital Episode
3.8 Director of Clinical Academic Development – October 2019 (University of Liverpool)
3.9 Applied Research Collaboration North West (ARC NW)
3.10 CQC Inspection
3.11 Launch of Childrens Book
3.12 Official Opening of Garden Room
3.13 Surgical Spine Centre of Excellence (SSCoE)
3.14 Roy Ferguson Compassion Award
3.15 Centre of Clinical Excellence Award
3.16 Joined Rainbow Badge Initiative (ED&I)
3.17 Overview of Performance in 2019/20 against National Priorities from the Department of Health's Operating Framework
3.18 Overview of Performance in 2019/20 against NHS Outcomes Framework
3.19 Indicators

Annex 1 Statements from Commissioners and Local Healthwatch Organisations

Glossary of Terms

Part 1 Statement on Quality from the Chief Executive

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

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

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

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

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

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

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

In addition, this year we have achieved:

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

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

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

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

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

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

Hayley Citrine, Chief Executive

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

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

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

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

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

2.1 Update for Improvement Priorities for 2019–2020

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

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

2.1.1 Patient Safety

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

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

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

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

Priority 2: Implement Aseptic Non Touch Technique

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

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

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

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

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

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

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

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

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

2.2.2 Clinical Effectiveness

Priority 1: Introduce In-house Masters Neurosciences Training Module

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

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

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

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

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

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

Priority 3: Introduce the A3 methodology for Quality Improvement

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

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

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

2.2.3 Patient Experience

Priority 1: Introduce Patient and Family Centred Champions

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

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

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

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

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

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

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

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

Outcome: Achieved

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

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

Reason for Prioritising:

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

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

Outcome: Achieved

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

2.2 What are our priorities for 2020 – 2021?

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

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

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

How progress to achieve these priorities will be reported:

Updates are presented to the Quality Committee and Patient Experience Group which report to Trust Board. Merseyside Internal Audit Agency (MIAA) will be fully involved providing regular reviews and assurance via the Audit Committee. Quarterly quality meetings are held with the commissioners to review quality assurance and provide external scrutiny and performance management.

2.2.1 Patient Safety

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

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

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

Priority: FOCUS – Free of Criticism for Universal Safety

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

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

Priority: Introduction of MITEL System

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

Outcome Required:

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

2.2.2 Clinical Effectiveness

Priority: Introduce Multitom Rax 3D Imaging

Reason for Prioritising:

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

Outcome Required:

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

Priority: HCA Apprenticeship Training

Reason for Prioritising:

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

Outcome Required:

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

Priority: Bespoke Spinal Module

Reason for Prioritising:

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

Outcome Required:

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

2.2.3 Patient Experience

Priority: Introduce the Road to Recovery

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

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

Priority: LASTLAP – Looking After Staff That Look After People

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

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

Priority: Outsourcing Mail

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

Outcome Required:

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

2.3 Statements of Assurance from the Board

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

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation

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

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

2.3.1 Data Quality

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

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

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

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

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

2.3.2 Participation in Clinical Audit and National Confidential Enquiries

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

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

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

2.3.3 National Audits

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

2.3.4 National Confidential Enquiries

- Dysphagia in Parkinson's Disease

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

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

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

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

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

2.3.5 Participation in Local Clinical Audits

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

Neurology Clinical Audits & Service Evaluations

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

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

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

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

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

Neurosurgery Clinical Audits & Service Evaluations

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

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

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

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

Trust wide Clinical Audits & Service Evaluations

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

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

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

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

2.3.6 Participation in Clinical Research and Development

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

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

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

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

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

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

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

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

2.3.7 CQUIN Framework & Performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2019/20 was conditional on achieving quality improvement and innovation goals agreed between The Walton Centre and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at enquiries@thewaltoncentre.nhs.uk

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

The CQUINS agreed for 2020/21 are the following:

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

2.3.8 Care Quality Commission (CQC) Registration

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

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

Ratings for The Walton Centre

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

2.3.9 Trust Data Quality

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

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

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

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

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

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

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

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

Regulation 2018 (NIS) and the 10 Data Security Standards and is very different to the old IG Toolkit. Within the Toolkit there are 44 assertions and 116 mandatory evidence items.

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

The Trust has met all 44 assertions, mandatory evidence items and achieved standards met for the Data Security and Protection Toolkit, which was submitted to NHS Digital on 27th July 2020.

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

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

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

The Walton Centre Internal Clinical Coding Audit 2019/20

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

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

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

2.3.10 Learning from Deaths

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

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

17 in the first quarter

13 in the second quarter

37 in the third quarter

25 in the fourth quarter

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

In 0 cases a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

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

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

In relation to each quarter, this consisted of:

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

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

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

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

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

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

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

2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services

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

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

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

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

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

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

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

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

Trust policy 'Operational Guidelines for the Surgical and Medical Acute Response Team (SMART)'.

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

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

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

2.3.12 Speaking Up

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

Part 3 Trust Overview of Quality 2019/20

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

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

Patient Safety Indicators

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

Clinical Effectiveness Indicators

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

Patient Experience Indicators

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

3.1 Complaints

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

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

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

3.1.2 Complaints Management and Lessons Learnt

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

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

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

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

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

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

3.1.3 Complaints Activity

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

Complaints received 01 April 2019 – 31 March 2020

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

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

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

3.1.4 Duty of Candour

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

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

3.2 Local Engagement – Quality Account

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

3.3 Quality Governance

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

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

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

- Deliver
- Invest
- Adopt
- Provide

- Lead
- Recognise

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

3.4 Top Industry Award – Nov 2019

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

3.5 International Engage Award (ShinyMind App)

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

3.6 International Engage Lifetime Contribution Award

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

3.7 BBC Two Hospital Episode

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

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

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

3.9 Applied Research Collaboration North West (ARC NW)

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

3.10 CQC Inspection

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

3.11 Launch of children's book

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

3.12 Official opening of the garden room

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

3.13 Surgical Spine Centre of Excellence (SSCoE)

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

3.14 Roy Ferguson Award

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

3.15 Centre of Clinical Excellence Award

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

3.16 Joined Rainbow Badge Initiative (ED&I)

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

3.17 Overview of Performance in 2019/20 against National Priorities from the Department of Health's Operating Framework

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

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

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

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

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

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

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

- Our performance against these indicators
- The national average

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

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

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

3.19 Indicators

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

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

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

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

Rationale: The Trust does not provide mental health services

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

Rationale: The Trust is not an ambulance trust

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

Rationale: The Trust is not an ambulance trust

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

Rationale: The Trust does not provide mental health services

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

Rationale: The Trust does not perform these procedures

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

Response:

	No. of readmissions	% of Inpatient Discharges Readmitted
2018/19	266	5.00%
2019/20	244	4.82%
Change	-22	-0.18%

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

Actions to be taken

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

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

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

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

Response:

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

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

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

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

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

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

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

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

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

APPLICABLE

Response:

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

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

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

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

Some Key Highlights are as follows:

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

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

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

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

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

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

Key staff survey questions:

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

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

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

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

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

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

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

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

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

- The Trust intends to continue to work with staff side and staff through various engagement sessions to increase the response rates and percentage scores for the 2020 survey. A Trust action plan and Divisional action plans covering all 11 themes will be formulated and approved by Board.

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

Rationale: The Trust does not provide mental health services

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

Response: * To be updated once National data published

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

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

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

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

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

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

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

Response:

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

WCFT Clostridium difficile infections per 100,000 bed days:

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

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

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

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

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

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

13. Rate of patient safety incidents per 100 admissions

Response:

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

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

- Increased patient acuity
- Increase in capacity and activity

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

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

The Trust will continue to:

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

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

Annex 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Walton Centre NHS Foundation Trust

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

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

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

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

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

An impressive account of clinical effectiveness and safety.

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

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

Quality Account Statement – The Walton Centre NHS Foundation Trust.

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

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

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

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

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

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

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

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

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

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

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

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

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

South Sefton and Southport & Formby CCGs
Signed

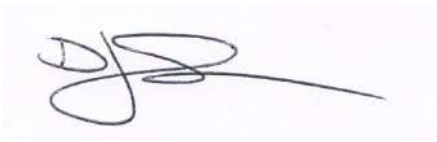
Fiona Taylor, Chief Officer Date: 20 November 2020

Liverpool CCG

Signed Date: 24 November 2020

Chief Officer

Knowsley CCG



Chief Executive Date: 24 November 2020

Specialised Commissioning (North West)

Signed  Date: 20 November 2020

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

Glossary of Terms

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

The Walton Centre NHS Foundation Trust

REPORT TO THE TRUST BOARD
Date 4th February 2021

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

1.0 Matters for the Board's attention

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

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Internal Audit Progress Report Q3

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

b) Internal Audit Recommendations Report

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

c) MIAA External Quality Assessment Report

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

d) Counter Fraud Progress Update

The Committee received the MIAA counter fraud progress report covering the period from July 2020 to January 2021 and noted that 29 local fraud alerts and 6 national fraud alerts had been published

during the reporting period. One fraud report had been closed with no further action appropriate and no additional reports had been received. NHSCFA had launched a Fraud Prevention Guidance Impact Assessment in October 2020 and an overview of the guidance within the assessment was provided.

e) External Audit Progress Report

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

f) External Audit Plan and Fees

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

g) Financial Systems Benchmarking Challenge Questions

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

h) Tender Waivers

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

i) Losses and Special Payments Report

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

j) 2020/21 Financial Accounts Timetable

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

k) Review of Committee Terms of Reference

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

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

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

m) Committee Cycle of Business 2021-22

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

n) Committee Effectiveness Review

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

3.0 Progress against the Committee's annual work plan

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

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

4.0 Recommendations

The Board of Directors is recommended to:

- Receive and note the Summary Report and approve the Audit Committee Terms of Reference included at Annex A.

AUDIT COMMITTEE
Terms of Reference

1 AUTHORITY

1.1 The WCFT's Audit Committee is constituted as a standing committee of the Board of Directors. Its constitution and terms of reference shall be as set out below, subject to any future amendment(s) by the Board of Directors.

1.2 The Audit Committee is authorised by the Board of Directors to act within its terms of reference. All members of staff are directed to co-operate with any request made by the Audit Committee.

1.3 The Audit Committee is authorised by the Board of Directors to instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for, or expedient to, the exercise of its function.

1.4 The Audit Committee is authorised to obtain such internal information as is necessary and expedient to the fulfilment of its functions

2. PURPOSE

2.1 The Audit Committee provides an independent and objective view of the system of internal control.

3. DUTIES AND REPSONSIBILITIES

3.1 The duties of the Committee can be categorised as follows:

Governance, Risk Management and Internal Control

3.2 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that support the achievement of the Trust's objectives.

3.3 In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the Annual Governance Statement and declarations of compliance with the CQC outcomes) together with any accompanying Head of Internal Audit Statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board;

- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

3.4 In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.5 This will be evidenced through the Committee's use of the Board Assurance Framework to effectively guide its work and that of the audit and assurance functions that report to it.

Internal Audit

3.6 The Committee will ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.

This will be achieved by:

- consideration of the provision of the Internal Audit service, the cost of the audit and any questions of resignation and dismissal;

- review and approval of the Internal Audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the Trust as identified in the Board Assurance Framework;

- consideration of the major findings of internal audit work (and management's response) and ensure co-ordination between Internal and External Auditors to optimise audit resources;

- ensuring that the Internal Audit function is adequately resourced and has appropriate standing within the Trust, and

- an annual review of the effectiveness of internal audit.

External Audit

3.7 The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular the Committee will review the work and findings of the external auditors and consider the implications and management's response to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors as far as the rules governing the appointment permit (and make recommendations to the Council of Governors when appropriate)

- discussing and agreeing with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan ensuring coordination, as appropriate, with other External Auditors in the local health economy;

- discussing with the External Auditors of their local evaluation of audit risks and assessment of the Trust and associated impact on the audit fee;

- reviewing all External Audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.

- review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements.

- The Council of Governors should take the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. To support them in the task, the Audit Committee should:

    - Provide information on the external auditor's performance, including details such as the quality and value of the work, the timeliness of reporting and fees;

    - Make recommendations to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor and related fees as applicable. To the extent that a recommendation is not adopted by the Council of Governors, this shall be included in the annual report, along with the reasons that the recommendation was not adopted.

- Ensure the Trust has effective arrangements for avoiding potential conflict of interest through the supply of non-audit services, by taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

Other Assurance Functions

3.8 The Audit Committee shall review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications to the governance of the Trust. These will include, but will not be limited to reviews and reports by, Department of Health, NHS England, CQC

etc and professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies).

3.9 In addition, the Committee will review the work of other committees within the Trust that can provide relevant assurance to the Audit Committee's own scope of work. With regard to clinical governance and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the Trust's clinical audit system.

Counter Fraud and Whistleblowing

3.10 The Audit Committee will approve the appointment of the Local Counter Fraud Specialist and receive assurance that counter fraud polices are being developed within the Trust.

3.11 The Committee shall satisfy itself that the Trust has adequate arrangements in place countering fraud and shall review the outcomes of counter fraud work.

3.12 The Audit Committee shall review arrangements by which staff of the Trust and other individuals where relevant, may, in confidence, raise concerns about possible improprieties in matters of financial reporting or other matters.

Management

3.13 The Committee shall request and review reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

3.14 The Committee may also request specific reports from individual functions within the Trust (e.g. clinical audit, information governance) as they may be appropriate to the overall arrangements.

Financial Reporting

3.15 The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance reviewing significant financial reporting judgements contained in them.

3.16 The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

3.17 The Audit Committee shall review the Annual Report (including the Quality Account) and Annual Financial Statements before submission to the Board, focusing particularly on:

- the wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;
- changes in, and compliance with, accounting policies and practices and estimation;
- unadjusted mis-statements in the financial statements;
- significant judgmental areas in the preparation of the financial statements;
- significant adjustments resulting from the audit;
- Letter of Representation, and
- Qualitative aspects of financial reporting.

4. MEMBERSHIP AND ATTENDANCE

4.1 The Committee will be appointed by the Board of Directors and shall comprise the following members:

- Chair – a Non-executive director who should have a financial qualification or recent and relevant financial experience (in the absence of the Chair another Non-executive director who is a member of the Committee will preside as chair).
- At least two other Non-executive directors.

4.2**. Attendees**

The following will be in attendance at each meeting:

- Director of Finance
- Director of Nursing and Governance
- A representative from Internal Audit
- A representative from External Audit
  - Chief Executive as required. As a minimum this should be when the Committee considers the draft internal audit plan and the annual accounts and, at least annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.3 All members are expected to attend a minimum of 75% of the meetings during the financial year. ~~and where they are unable to attend send a nominated deputy.~~ ***Management attendees may send a suitably informed nominated deputy where they are unable to attend meetings.***

4.4 Other members of the Executive Team, Senior Management Team and or Professional Leads will be invited to attend by the Chair as appropriate to the Agenda.

4.5 **Quoracy**
The meeting will be deemed quorate if at least two members are in attendance.

5. RELATIONSHIP WITH THE BOARD OF DIRECTORS, COMMITTEES & OTHER GROUPS

5.1 The Committee Chair shall report in writing to the Board after each meeting through a Chair's assurance report which will incorporate matters for escalation to the Board where appropriate, or require executive action, a summary of the business transacted and the basis for any recommendations made.

5.2 The Committee will report to the Board annually on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the assurance framework, the completeness and embeddedness of risk management in the organisation, the integration of governance arrangements and the appropriateness of the self-assessment for the production of the Trust's Quality Account

5.3 The Audit Committee will report to the Council of Governors, where it has identified any matters which it considers that action or improvement is needed and make recommendations as to the steps to be taken.

6.0 PROCEDURAL ISSUES

6.1 **Frequency of meetings**

Meetings will be held at least four times a year, with additional meetings as required. Any member of the Committee, External Audit or Head of Internal Audit may request an extra ordinary meeting if they consider that one is necessary.

6.2 At least once a year the Committee will meet privately with the Internal and External Auditors.

6.3 **Minutes**

The minutes shall be formally recorded by ***a member of the Corporate PA Team nominated by the Corporate Secretary,*** ~~the Corporate Secretariat,~~ checked by the Chair and submitted for agreement at the next meeting.

6.4 **Annual Work Programme**

The Committee will agree an Annual Work Programme/Cycle of Business which will be reviewed at each meeting to ensure that the Committee is meeting its duties.

7. EQUALITY AND DIVERSITY

Ensure that equality and diversity and due consideration to the Human Rights Act are regarded in all aspects of the Audit Committee's work.

8. REVIEW

8.1 The Committee will evaluate its own membership and review the effectiveness and performance of the Committee on an annual basis. The Committee must review its terms of reference annually and make any changes to the Board of Directors for approval.

8.2 Compliance with the Terms of Reference will be monitored on an ongoing basis. In addition the Committee's effectiveness review will include a summary on compliance with the Terms of Reference.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
04/02/21

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

1.0 Matters for the Board's attention

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

2.0 Items for the Board's information and assurance

The Committee received the following updates:-

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

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

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

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

e) Quality Committee Effectiveness review

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

3.0 Progress against the Committee's annual work plan

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

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD

04/02/21

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

1.0 Matters for the Board's attention

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

2.0 Items for the Board's information and assurance

The Committee received the following updates:-

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 February 2021

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

1.0 Matters for the Board's attention

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

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

2.0 Items for the Board's information and assurance

The Committee received the following updates:

a) Integrated Performance Report

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

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

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

Capital spend was £173k (£256 YTD) in M9 with no further in-month Covid capital spend. Excluding Covid spend (which would be refunded as per NHSI/E guidance) capital spend was

£2,630k underspent. Part of the underspend was due to the plan being profiled in 12ths when a large proportion of spend will be incurred later in the year. The largest element of spend the Bi-plane scanner was due to be on site in March. It was noted that this payment would be secured in March and the Trust's cash flow would reduce accordingly. The Trust had also reduced additional funding in relation to critical infrastructure, a CT Scanner, E-roster monies and was awaiting the outcome of a digital aspirant bid with NHS Digital.

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

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

b) CQUIN Quarterly Update

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

c) Quality Improvement Programme Update

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

d) Trustwide Risk Register (scores 12 and above)

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

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

e) E Rostering Update and Business Case

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

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

f) Mass Spectrometer Business Case

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

g) Anaesthetic Ventilators Business Case

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

h) IT Case Note Scanning Business Case

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

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

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

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

i) Synertec Business Case

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

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

j) Items presented under Consent Agenda

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

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

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

Update in Private Section of the Chair's Report.

3.0 Progress against the Committee's annual work plan

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

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 February 2021

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

1.0 Matters for the Board's Attention

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

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

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

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

- BRC Walton roadshows are also to be reinstated.

2.0 Items for the Board's Information and Assurance

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

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

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

3.0 Progress Against the Committee's Annual Work Plan

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

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 February 2020

Report Title	**Chair's Assurance Report – Neuroscience Programme Board Meeting held 17 December 2020**
Sponsoring Director	Mike Burns Director of Finance and IT
Author (s)	Mike Burns
Purpose of Paper:	
The paper provides an update on the main points discussed at the meeting held on 17 December 2020.	
Recommendations	The Board is requested to: • Note the summary report

1.0 Matters for the Board's attention

2.0 Items for the Board's information and assurance

The Programme Board received the following updates:

a) Rapid Access Neurology Assessment Pilot (RANA)
The Board received a presentation providing information on the proposed pilot for a RANA service. Neurological conditions, excluding stroke, account for 10-20% of emergency department attendances in District General Hospitals (DGH's) resulting in a substantial number of secondary care admissions (approximately 600 per year). The vast majority of acute inpatient referral requests and calls to the Neurological on-call teams for urgent advice comprises of common neurological disorders and these patients are often admitted to DGHs whilst patients have (often) inappropriate or unnecessary investigations followed by a wait for a visiting neurologist to attend the hospital. The proposed pilot was to implement a RANA service held on the Trust site Monday to Friday 9am – 5pm. RANA would provide direct access to a RANA Neurological Registrar to discuss patients presenting to LUFT EDs with Neurological signs or symptoms.

Additional costings, risks and challenges were discussed. The pilot was expected to last for six months and service requirements were outlined. Discussions were ongoing to identify a potential site. A planned Acute Neurology Review assessment of the Acute Neurology service would include alternative models. A paper had been produced by members of the Neurology Division outlining the benefits and costings of the scheme and this would be presented to the Neuroscience Programme Board and Commissioners at a future meeting.

b) Optimum MS Pathway
The Board were updated on a virtual workshop that had taken place to discuss the Specialist Service Review for an optimum MS pathway devised by NHS England who wanted to see how to localise it across Cheshire & Mersey. There was good participation by CCGs, stakeholders, patients and clinicians. The key message was that the Walton Centre is providing a good service in relation to MS and acute cases of MS but patients feel additional support is required in terms of physiotherapy, emotional and psychological support. Addressing these concerns could provide a cross system benefit in the reduction of admissions and GP attendance. An action plan would be devised and brought back to the meeting in March 2021.

c) Major Trauma Centre Collaborative Service Review
The Board were updated that C&M Major Trauma Operational Delivery Network (CMMTN) carried out a service review in September 2020 as part of the network accreditation process for Major Trauma Centre Collaborative status for acute trusts across C&M. Following the assessment LUFT and WCFT had achieved the required standard for network accreditation as a Major Trauma Centre Collaborative (MTCC) for the period 2019-20. The next review would take place in 2021. The

MTCC were congratulated on the continued excellent service and care given to major trauma patients and for compliance with the CMMTN, Major Trauma Clinical Standards. The Board were informed of the areas of good practice and significant achievements attributed to the Walton Centre.

An action plan was being devised with key delivery timescales to the recommendations that came out of the review including a completion of the pilot system for electronic referrals – Orion Cloud.

d) Spinal Network Progress

Dr Nicolson updated on the progress made over the past three years to modify spinal services configuration across Cheshire & Mersey. Getting It Right First Time (GIRFT which is a national programme), NHSE and Commissioners had agreed a region wide clinical model for complex spinal surgery based wholly at the Walton Centre and established an on-call rota which included LUFT spinal surgeons. The Spinal Steering Group had agreed to the transfer of services as of April 2021 but there were still some issues to address including how to manage patients presenting at The Royal Liverpool site not requiring intervention or input from the Walton Centre and agreement as to how the funds for the service would be determined.

e) Hot Topics from other hospitals

Due to the number of apologies item deferred.

f) Terms of Reference

It was agreed that a revised Terms of Reference would be drawn up and presented at a forthcoming meeting for approval (due to the existing Terms of Reference having been devised through the Cheshire & Mersey Partnership Health Care Partnership).

g) Mr Stockdale from NW Specialised Commissioning Team updated the Board on the implications for commissioning following the proposed establishment of Integrated Care Systems (ICS) from April 2022. It was expected that specialist commissioning in future will be done on an ICS level leaving some of the more rare conditions being nationally commissioned once again. The proposals were still going through consultation.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 February 2021

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

1.0 Matters for the Board's attention

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

2.0 Items for the Board's information and assurance

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

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

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

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

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

e) Summary Investment Reports:

a. CCLA - The Investment Manager from CCLA joined the meeting and gave a presentation of the performance of the investments including market information, fund holdings and transactions and ethical responsibility. The CCLA portfolio was valued at £580,894 at 31

December 2020 which was an increase of £21,103 from the previous position (Q3) reported in the November meeting.

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

f) Finance Report as at 31 December 2020

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

g) Fundraising Activity Report

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

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

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

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

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

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

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

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

i) Application for Neuropathology Specimen Imaging (Neuroscience Laboratories)

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

The equipment would greatly enhance the effectiveness training in tissue dissection and the image library would be available as a teaching resource.

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

j) Staff Appreciation Gift (Amazon gift cards)

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

k) Staff Appreciation Gift (presentation gift)

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

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

l) Preparation of the Financial Statements 2020/21

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

m) Home from Home Annual Report

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

n) Review of Charitable Projects Process

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

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

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

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

o) Report on longer term commitments to the Charity

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

p) Update on Risk Management Policy

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

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

3.0 Progress against the Committee's annual work plan

The Committee continues to follow its annual work plan.

The Walton Centre NHS Foundation Trust

REPORT TO TRUST BOARD
4 February 2021

Title	**Quarterly Summary to Trust Board from Strategic BAME (Black, Asian and Minority Ethnicity) Advisory Committee (SBAC)**
Sponsoring Director	Hayley Citrine CEO
Author (s)	Name: Hayley Citrine Title: CEO
Previously considered by:	n/a

Executive Summary

Following the agreement in July's Trust Board to support the establishment of the Strategic BAME Advisory Committee (SBAC) that will report into Trust Board quarterly; attached is the first quarterly summary.

- The Committee has met twice
- Terms of reference agreed and approved (Trust Board in December)
- Reviewed data and intelligence for both BAME staff and patients, requested further information with a view to agreeing final suite of metrics for measuring Trust's progress next committee meeting.
- Approved sub groups prioritisation of national and regional Board recommendations for the Trust board (see appendix a)
- Agreed improvement ambitions to measure where we are now, what good looks like, what great looks like for Board to ratify (see appendix b)
- Received presentation 'underneath the skin' research from Edna Boampong (C&M, HCP) the impact of COVID-19 on BAME communities – agreed Trust support and involvement.
- Sampled BAME staff COVID risk assessments mitigation themes
- Responded to NW SBAC Assembly's request for the NHS in the NW to be clearly and unashamedly anti-racist on behalf of the Trust.

Related Trust Ambitions	• Deliver best practice • Lead research, education and innovation • Be recognised as excellent
Risks associated with this paper	• Failure to agree Trusts approach to regional and national recommendations of best practice for addressing inequalities has the risk of widening inequalities further and not addressing the current inequalities
Related Assurance Framework entries	• Several BAF risks are associated with the strategic ambitions and in particular new ways of working during pandemic – the committee provides direction in this year's approach to help mitigate some of those risks further.
Equality Impact Assessment completed	• Yes, disadvantages white and non BAME staff and patients, as focus exclusively on BAME staff and patients due to the inequalities they face e.g. with COVID -19
Any associated legal implications / regulatory requirements?	• Good practice rather than legal implications. It is anticipated new CQC inspections will focus on equality, diversity and inclusion particularly BAME challenges
Action required by the Board	• To receive and note the quarterly summary. • To approve approach for Trust Ambitions – Good to Great • To approve Board Recommendations review and for these to be monitored by SBAC.

Appendix a) Review and Prioritisation of Expert BAME Board Recommendations

The Trust Board accepted the recommendation to review National and Regional expert recommendations to Boards on BAME inclusion and agreeing a Walton Centre approach with milestones and timelines.

A working group drawn from the Strategic BAME Advisory Committee (SBAC) was set up and recommendations made. For each of the individual papers and recommendations, examples of how the Trust currently meets each one or what steps the Trust needs to take in order to meet or improve its approach were captured and discussed at SBAC. It was agreed to review progress on these after 6 months. This appendix summarises the papers and overall sub groups' opinion rather than the level of detail discussed at SBAC.

Several expert papers and views were reviewed including:

- Roger Kline 10 suggestions for Boards and ICS leaders, following his 'Beyond the Speeches; what now for NHS staff race discrimination?'', follow up to 'the Snowy White Peaks'.
- Issues raised by our BAME healthcare workers, our data and our patients
- Actions required on Walton's WRES latest results (already in place)
- 'Beyond the data; Understanding the impact of COVID-19 on BAME groups' Public Health England
- Recent WRES briefing for boards and COVID-19 EPRR membership in the NHS (publication approval reference 001559 – How Boards and COVID-19 EPRR structures can improve representation in decision making – steps to make changes)
- Chartered Institute of Personnel and Development (CIPD) 'six principles to develop a robust anti-racism strategy'
- Allyship – the 7 A's of Authentic Allyship – Dame Yvonne Coghill

Roger Kline 10 suggestions for Boards and ICS leaders, following his 'Beyond the Speeches; what now for NHS staff race discrimination?'', this was a follow up to 'the Snowy White Peaks' by Roger Kline - a Research Fellow at Middlesex University Business School, which led to introduction of the Workforce Race Equality Standard (WRES) in the NHS. In June 2020, Kline asked 'what now for NHS staff race discriminations' and articulated the need to move from words to actions with 10 suggestions for Boards and ICS leaders to consider particularly following the COVID-19 impact on BME staff and Black Lives Matter.

Sub Group Review.

Recommended Trust and Board accept all with the exception of 'Boards should stop signing off action plans unless those proposing them can demonstrate why they are likely to work' – this was felt counter intuitive to the PDSA approach and stretch action plans but agreed action plans must be part of a wider approach, not just training and SMART.

Beyond the data; Understanding the impact of COVID-19 on BAME groups Public Health England (PHE) 2020

PHE were commissioned by the Chief Medical Officer for England to understand the extent that ethnicity impacts upon COVID-19 risk and outcomes. The PHE review of disparities in the risk and outcomes of COVID-19 shows that there is an association between belonging to some ethnic groups and the likelihood of testing positive and dying with COVID-19.

Throughout the stakeholder engagement exercise, it was clearly and consistently expressed that without explicit consideration of ethnicity, racism and structural disadvantage in our responses to COVID-19 and tackling health inequalities there is a risk of partial understanding of the processes producing poor health outcomes and ineffective intervention.

The recommendations arise from a range of requests for action from stakeholders and point to the areas where commitment, focus, and delivery at scale could make a significant difference in improving the lives and experiences of BAME communities.

Sub Group Review. -

Recommended Trust and Board accept all.

WRES briefing for boards and COVID-19 EPRR membership in the NHS

The briefing notes that the NHS is at its best when it has diversity of representation and thought at its heart, across its workforce, leadership and processes of decision-making as important in the day-to-day running of an organisation as it is at times of emergency.

It suggests steps that help NHS boards and COVID-19 EPRR structures to improve representation in decision-making and to review those structures already in place to ensure that the diversity of the organisation at large, and across specialisms, is reflected in the EPRR composition.

Sub Group Review.

Recommended Trust and Board accept all.

The Chartered Institute of Personnel and Development (CIPD) promote six principles to help employers develop a robust anti-racism strategy, following engagement with the BAME Network and WRES Experts.

And The 7 A's of Authentic Allyship, Developed by Yvonne Coghill CBE, Director of Race Equality for NHSEI developed an approach known as 'The 7 A's of Authentic Allyship' - this is a prerequisite for tackling racism and developing accountability; it drives normalisation of conversations around race and the way that racism manifests.

Sub Group Review.

Considered both approaches have value – CIPD in methodology and 7 'A's in addressing culture; a further option of developing the Trusts own was also discussed. It was agreed to revisit these following the Trust Board Development Session with Globis on 'civility and unconscious inclusion' and Trust wide approach.

Appendix b) Strategic BAME Advisory Committee Ambitions

BAME Measurement for Improvement Ambitions		
Current	**Good**	**Great**
2.33% of *BAME leaders* & managers at band 7 and above	Increase the representation of BAME leaders and managers by 2021	Double the representation of BAME leaders and managers by the end of 2022, moving from 2.33% to 4.66%, and then to 10% by 2025.
BAME staff engagement/inclusion The Trust has established an effective mechanism for BAME staff networking	Develop BAME staff network into an effective inclusion and consultation mechanism with established high profile BAME staff network leadership within the Trust.	BAME staff network leadership represented at relevant Trust committees and structures across the Trust. High levels of general staff understanding of the value of the network, and a high percentage of BAME staff and non-BAME staff allies signed up as members of the BAME staff network
Reverse mentoring and NHS leadership programme opportunity but no targeted *BAME development and talent management* internal process	Reverse mentoring and NHS leadership programme opportunity. Scope out and pilot targeted BAME development and talent management internal programme	Reverse mentoring extended. More applicants ready for NHS leadership programme opportunity. Staff from BAME talent programme successfully applying and securing leadership roles / promotion
Only partnered with organisations to help us reach *talent from BAME* ethnic backgrounds for non-executive appointments	Encourage diverse shortlists for all leadership roles band 6 and above. And we'll partner with organisations that will help us to reach talent from BAME ethnic backgrounds.	Require diverse shortlists for all leadership roles – no exceptions. And we'll partner with organisations that will help us to reach talent from BAME backgrounds.
Under utilising our *apprenticeship levy* and not proactively seeking to utilise for BAME candidates	Utilise our apprenticeship levy and seek partnerships and opportunities which focus on benefitting Black, Asian and ethnic minority candidates.	Maximise the use of our apprenticeship levy and seek partnerships and opportunities which focus on benefitting Black, Asian and ethnic minority candidates.
Data collated but not utilised and *tracked* to reduce inequalities within the Trust, other than annually for WRES e.g. shortlisting, accessing non-mandatory training, turnover	Collect data which enables us to track progress and reduce inequalities within our internal systems and processes when it comes to promotion, opportunities and patient access and outcomes	Actively collect and monitor data which enables us to track progress and reduce inequalities within our internal systems and processes when it comes to promotion, opportunities and patient access and outcomes, to track & discuss at SBAC
No requirement for leaders to have *PDR objectives* to play their part in delivering our commitment to racial equality	Encourage all of our leaders to have objectives that ensure they are playing their part in delivering to our commitments to racial equality for our patients and our staff.	Require all of our leaders to have objectives that ensure they are playing their part in delivering to our commitments to racial equality from 2021 for patients and staff.
Starting to consider *partnering* and investing with suppliers that demonstrate adding social value in their own businesses/ community	Be mindful to partner and invest more with suppliers that demonstrate inclusion and equality and add social value in their own businesses/ community.	Change our procurement process so that we partner and invest more with suppliers that demonstrate inclusion and equality and add value in their own businesses/community
Commenced growing our ambition as an *anchor institute.* ED&I lead has good working relationship with BAME community groups.	As part of our AI ambition & ED&I work start partnering with BAME groups and targeting population areas with high % of BAME for works with our schools and employment work	Established key partnerships with BAME groups, populations with high % of BAME & seeing increased BAME applicants for roles in the Trust.
WRES data demonstrates reduction in 5 out of 9 indicators year on year	WRES data demonstrates improvement year on year	WRES data reflects the good practice in the Trust and is in the top quartile for all 9 indicators
Trust Board agreed to Strategic BAME Advisory Committee reporting into TB to tackle BAME inequalities and	Culture of zero tolerance to racism throughout the Trust, clear evidence that inequality metrics have improved year on year.	Culture of unconscious inclusion throughout the Trust, equality evident for patients and staff for all ethnicities.

commence active anti-racism approach and *culture.*		
Varied Trust programme to ensure good *health and wellbeing* for all staff	Health and wellbeing programme is desegregated to champion needs for equality, diversity and inclusion of protected characteristic groups	Health and wellbeing programme has a suite of ED&I offers led by diverse leaders from BAME staff (and other protected characteristics groups)
Awareness of increased risk for BAME staff and patients related to *COVID-19* and risk assessments commenced	Risk assessments reviewed timely and actions taken to reduce risks. BAME champions on tactical command for COVID team.	Risk assessments reviewed timely and actions taken to reduce risks. Staff feel confident with actions. BAME champions on tactical command for COVID team and influencing approach.
To recognise need to develop knowledge and understanding for all staff, to support ambition of having a *culture of unconscious inclusion*. To develop the approach with BAME staff, patients and experts.	Knowledge and understanding approach is in place, there are several sessions for staff to attend in a year and there is a commitment to measuring its impact on cultural change.	The majority of staff have attended sessions; there is a clear positive impact on cultural change and a beginning to unconscious inclusion.