The Walton Centre
NHS Foundation Trust

Excellence in Neuroscience

Quality Account 2023/24

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Introduction to The Walton Centre

In 1992, The Walton Centre was established as an NHS Trust and was subsequently authorised as an NHS Foundation Trust in 2009.

The Walton Centre is the only specialist hospital trust in the UK dedicated to providing comprehensive neurology, neurosurgery, spinal and pain management services.

Specialist staff provide a world-class service in diagnosing and treating and providing comprehensive neurology, neurosurgery, spinal and pain management services as well as injuries and illnesses affecting the brain, spine and peripheral nerves and muscles, and in supporting people suffering from a wide range of long-term neurological conditions.

The Walton Centre NHS Foundation Trust has become the newest member of the University Hospital Association. University hospitals are specialty trusts with significant involvement in research and education. Their research puts them at the forefront of developments in care and connections with industry, while their work in education makes them central to providing the future workforce.

The Trust serves a catchment area of circa 3.5 million people across Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man, North Wales and beyond. While the main hospital site is situated in Fazakerley, Liverpool, services are also delivered through clinics at 19 hospitals and health centres in the region through service partnerships with 12 NHS Trusts and through the Cheshire and Merseyside Major Trauma Centre Collaborative and Cheshire and Merseyside Rehabilitation Network.

With around 1,550 staff, The Walton Centre treats more than 141,000 outpatients and 16,931 inpatients each year with conditions including:

- Head and spinal trauma injuries
- Tumours of the central nervous system, both cranial and spinal
- Neurovascular diseases
- Epilepsy (including a full surgical programme)
- Movement disorders (including the provision of a deep brain stimulation service)
- Pain, with a particular focus on trigeminal neuralgia
- Multiple sclerosis and motor neurone disease
- Chronic neuropathic pain, facial pain, headache and migraine

Our Neurosurgery Division is one of the biggest and busiest in the UK, performing around 2,618 elective surgical cases, 1,455 emergency surgical cases and 1,619 day case procedures each year.

The Neurology service is delivered by a multi-skilled professional team and sees over 83,122 new and follow-up patients as well as treating 5,612 inpatients.

We have a dedicated Neuroscience Research Centre which runs a range of research studies, linking with partners in industry, academia and the NHS.

Our Pain Management Programme is regarded as a model of best practice for helping patients with severe and chronic pain.

Our Neuroradiology service is the most comprehensive in the UK, with five MRI scanners; two CT scanners and two biplane intervention rooms available.

Underpinning all our work is a learning culture that empowers staff to believe they can make and lead change, be curious and seek continuous improvement. Our Walton way values – dignity, respect, caring, pride, and openness - are at the heart of this culture.

Vision
Excellence in Neuroscience

Mission
To provide a high quality of treatment, care and patient experience in the most appropriate place for the needs of our patients.

The Walton Way
Our Walton Way values were developed through staff engagement and are values that underpin everything we do at our Trust.

The five Walton Way values are:
- Caring - Caring enough to put the needs of others first
- Dignity - Passionate about delivering dignity for all
- Openness - Open and honest in all we do
- Pride - Proud to be part of one big team
- Respect - Courtesy and professionalism – it's all about respect

The five strategic ambitions are:
- Education, training and learning
- Research and innovation
- Leadership
- Collaboration
- Social responsibility

Part 1 Statement on quality from the Chief Executive

I am pleased to share the Quality Account for 2023/24 which demonstrates our continual drive and commitment to delivering excellent standards of quality care to our patients and their families. It details our performance over the last year whilst also highlighting our key priorities for 2024/25.

As Chief Executive, and former nurse, I know how important it is to deliver the very best treatment and care to our patients, and their families and friends.

There is incredible work going on across The Walton Centre by both our clinical and non-clinical teams which makes a real difference to patients from across the north west and North Wales.

It's been another busy year, but with some important changes and incredible milestones and where we have continued to support our colleagues and patients across the region through a number of collaborative initiatives.

Some of the highlights over the past year include:

- In early 2024 we carried out the 100th spinal surgery procedure using the spinal robot – the most of any NHS Trust.

- Increased numbers of patients have been seen through the Rapid Access to Neurology Assessment (RANA) service, providing direct access to an expert neurologist to discuss patients presenting to emergency departments with neurological signs or symptoms. During 2023 we seen 511 patients compared to 169 in the previous year.

- We shared our work with a wider audience via a Channel 5 documentary 'Trauma Room One' which focused on trauma and neurosurgical cases and received very positive feedback from the public.

- We celebrated our work in pain management and rehabilitation, who marked milestones of 40 year and 10 years respectively.

- Improvements in the percentage of staff who would recommend the Trust as both a place to work and a place to receive treatment which are above the national average.

- The Trust participated in the annual NHS Patient Led Assessment of the Care Environment (PLACE). We saw a significant scoring increase bringing the Trust's performance above the national average for all PLACE domains.

- The Trust achieved Silver under the Ministry of Defence Employer Recognition Scheme for our commitment and support to Defence and the wider Armed Forces community.

- We were assessed for our Investors in People standards (Investors in People and Investors in Wellbeing) and retained our reaccreditation of Gold.

- We were awarded the National Preceptorship Quality Mark following an assessment.

We cannot do any of this without our dedicated and talented staff. They are the heart of The Walton Centre and their commitment, resilience and compassion is demonstrated on a daily basis. No matter what their role is, their contribution is felt and appreciated by our patients and their families every day.

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

Jan Ross, Chief Executive

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

Towards the end of every financial year, the Trust work closely with stakeholders to identify areas of improvement for the forthcoming year. This 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 is monitored through meetings of the Quality Committee, chaired by a Non-Executive Director, with subgroups focusing on the three domains of quality: patient safety, clinical effectiveness and patient experience. The Chief Nurse is the Executive Lead responsible for delivering the plan and designates duties to operational leads for each of the priorities.

All the priorities were identified following a review by Trust Board on the domains of quality reported in 2022/23. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing our priorities for 2023/24.

The Trust is committed to embracing improvement across a wide range of issues to achieve excellence in all areas of care. The following section includes a report on progress against the three priority improvement areas for 2023/24.

2.1 Update on improvement priorities for 2023/24

In December 2023 the Council of Governors and Board of Directors undertook a full review of quality priorities used by the Trust for the previous financial year and acknowledged the work implemented to ensure each priority was on target. Quality priorities were also identified and agreed for 2024/25. The improvement priorities contained specific indicators which have been monitored over the last 12 months to provide evidence of sustainable improvement.

Performance has been managed through subcommittees, to Trust Board. Operational groups within the Trust are responsible for the implementation of the quality priorities and reporting to committees as required.

2.1.1 Patient safety

- **20% reduction in hospital acquired pressure ulcers: Not Achieved**

The Trust's goal of achieving a 20% reduction in hospital-acquired pressure ulcers (HAPU) was not achieved in the 2023/24 reporting period. At year end, there were a total of 34 hospital acquired pressure ulcers, including category 2, deep tissue injury, mucosal, and device-related pressure ulcers. This figure for the previous year was 33.

Despite not meeting the reduction target, improvements have been noted since the introduction of new nasogastric (NG) transparent NG fixators, with no further incidents related to mucosal nasal pressure ulcers. Additionally, a successful ward based/bedside education programme on Lipton Ward has resulted in 859 days pressure ulcer free.

- **At least a 20% reduction in catheter-acquired urinary tract infections (CAUTIs): Not Achieved**

The Trust did not achieve the goal of a 20% reduction in catheter acquired urinary tract infections (CAUTIs) in the 2023/24 reporting period. There was a total of 27 hospital acquired urinary tract infections compared to 31 at the end of 2022/23.

The overall reduction at year was 13% and despite not meeting the 20% target, extensive training was provided throughout the year, monthly audits were conducted, and feedback was given on the care and maintenance of catheters. New fixation devices were introduced and trialled in the last quarter of 2023/24. To support effective management, the existing digital catheter diary was reviewed and simplified, and is in the final stages of development.

- **100% of patient facing staff trained in aseptic non-touch technique (ANTT): Not Achieved**

ANTT is a practice and theory framework to safely manage the risk of healthcare associated infection by reducing variation in practice when undertaking interventions such as wound care, insertion of invasive devices etc.

The Trust did not achieve the priority within the reporting period with an overall outcome of 68% of patient facing staff having completed the training. Discussions are ongoing with the Divisional Clinical Directors and the Training and Development Team as to how medical staff can be further supported to complete the ANTT training via the implementation of an e-learning package and competency assessments.

All clinical staff employed by the Trust including, bank and agency staff, locums, trainees and students who undertake ANTT as part of their role will attend ANTT training and be compliant with the competency. Compliance is monitored via divisional risk and governance meetings.

Information relating to ANTT is available on the Trust Intranet which includes the ANTT policy.

- **Introduce low stimulation room on Chavasse Ward: Not Achieved**

The introduction of a low stimulation room on Chavasse Ward was partially achieved in the 2023/24 reporting period. Unfortunately, the identified room was impacted by the theatre refurbishment programme, preventing full implementation of this priority. Patient complaints regarding noise from the ongoing theatre work also led to the decision to temporarily pause the use of the room, as it would not provide the intended benefit under current circumstances. However, the necessary equipment for the room has been made available, and a Standard Operating Procedure (SOP) for its use has been developed. Additionally, a risk assessment to determine suitable patients for the room has also been established.

2.1.2 Clinical effectiveness

- **Introduce the use of lung ultrasound as a diagnostic tool into the physiotherapy critical care service: Achieved**

The goal of introducing lung ultrasound as a diagnostic tool into the physiotherapy critical care service was successfully achieved. Lung ultrasound is now regularly utilised within Horsely Intensive Care Unit by both the physio team and the advanced critical care practitioners. This has enabled effective time prioritisation, targeted treatments based on underlying pathology, supported weaning from ventilation, facilitated early use of positive pressure treatments, and has assisted staff in adjusting treatment and ventilation settings as needed.

- **Introduce electronic quality boards on each of the wards: Achieved**

The objective of introducing electronic quality boards on each of the wards was also achieved. The boards are now operational on all wards, providing leadership teams with accurate and relevant data for decision making.

- **Increase the number of MR scans performed daily by 10%: Not Achieved**

The Trust did not achieve the priority within the reporting period with an overall outcome of 0.73% of MR scans being performed daily. We are however, scheduling an additional patient each day on an MR scanner fitted with the software update.

2.1.3 Patient experience

- **Increase of 10% patient discharges before 12 midday: Achieved**

The Trust successfully achieved the goal of increasing patient discharges before 12 midday by 10% in the 2023/24 reporting period. This was accomplished through regular audits and increased collaboration with the multidisciplinary team, including the senior nursing team, SHO, and bed management team. A poster campaign was launched to highlight the importance of timely discharge medication, also known as to take out (TTO), and the use of the discharge lounge was reinstated. Discussions on discharge suitability are held daily at the 10am handover meetings, for patients due for discharge.

- **Introduce the SWAN model (end-of-life and bereavement care) to the Trust: Achieved**

The introduction of the SWAN model for end-of-life and bereavement care was successfully implemented across the Trust. Communication about the SWAN model was shared through Team Brief and the Walton Weekly. Wards now refer to the SWAN Team, who liaise with the Medical Examiner's office and provide support to families following the death of a relative.

- **Trial magnetic resonance (MR) guided laser treatment for epilepsy patients who have not been suitable for other forms of surgical intervention: Achieved**

The Trust achieved the goal of trailing magnetic resonance (MR) guided laser treatment for epilepsy patients who were not suitable for other forms of surgical intervention. We have been awarded a national NHS contract for this procedure.

During the past year, we have made significant strides toward our quality improvement priorities. While not all goals were fully achieved by year end, the progress made has laid a solid foundation for continued efforts. We remain committed to monitoring and advancing these priorities throughout 2024/25.

2.2 What are our priorities for 2024/25?

In November 2023 Heads of Departments submitted proposed improvement priorities, considering various factors such as increased infections, audit findings, or a rise in complaints. These proposals were then reviewed and discussed by key stakeholders including the Executive Team, Patient Experience Group, Health Watch, Specialist Commissioners, Council of Governors, and the Quality Committee.

The Council of Governors, representing the interests of the Trust’s stakeholders, had the opportunity to review and vote on the proposed priorities, providing their input and perspective. This process ensures that the improvement priorities are aligned with the expectations and needs of the community served by the Trust.

Monitoring and measurement of progress:

Each priority has designated leads responsible for overseeing progress and achieving agreed-upon milestones throughout the year. Regular monthly meetings are held to review progress, provide support as needed, and ensure that efforts are on track.

How progress to achieve these priorities will be reported:

Progress towards achieving these priorities is reported through various channels. Updates are presented to the Quality Committee and Patient Experience Group, which report to the Trust Board. Additionally, quarterly quality meetings are held with commissioners to review quality assurance, provide external scrutiny, and manage performance effectively.

By engaging stakeholders and establishing clear processes for monitoring and reporting, the Trust can effectively track progress towards its quality improvement goals and make informed decisions to drive positive outcomes for patients and the organisation

2.2.1 Patient safety

❖ **Reduce the number of patients who 'Did Not Attend' (DNA) by 20%**

Implementing text reminders for patient appointments and introducing a patient engagement portal are excellent strategies for reducing the number of patients who 'Did Not Attend' (DNA) appointments.

Below are the steps we will take to help achieve our goal of reducing DNAs by 20%:

- **Text Reminders:** Sending text reminders to patients about their upcoming appointments serves as a gentle reminder. Many patients appreciate this convenience and are less likely to forget or miss their appointments.
- **Patient Engagement Portal:** Providing patients with access to a digital platform where they can view their appointments and request changes adds flexibility and convenience. Patients can reschedule or cancel appointments as needed, reducing the likelihood of missed appointments. This engagement also empowers patients to take an active role in managing their healthcare, which can lead to better attendance rates.
- **Maximising Clinic Slot Utilisation:** Optimising clinic schedules and maximising slot utilisation, ensures that appointments are efficiently utilised. This not only helps in accommodating more patients but also minimises the impact of missed appointments on clinic productivity and revenue. By filling unused appointment slots promptly, we can reduce waiting lists and improve access to care for patients.

Overall, these strategies will improve patient attendance, enhance clinic efficiency, and mitigate the financial impact of missed appointments. Regular monitoring and evaluation of the effectiveness of these measures will be crucial for achieving and sustaining the targeted reduction in DNAs.

2.2.2 Clinical effectiveness

❖ **Redesign the sepsis pathway to improve education and achieve a consistent compliance of 90% or above**

There will be a concerted effort to redesign the sepsis pathway and enhance education among clinical staff. Achieving a consistent compliance rate of 90% or above is crucial for improving patient outcomes and reducing the impact of sepsis.
Outlined below are the strategies we will put in place to help contribute to achieving this goal:

- **Collaborative Approach**: Collaboration with various teams such as the SMART Team, IT, Business Intelligence, and Communications and Marketing Team ensures a holistic approach to addressing sepsis management. Each team brings unique expertise and resources to the table, facilitating comprehensive solutions.
- **Education Initiatives**: Conducting drop-in education sessions and developing eLearning training packages are effective ways to disseminate knowledge about sepsis among clinical staff. These initiatives ensure that staff members are equipped with the necessary information and skills to identify and manage sepsis promptly and effectively.
- **Audits and Monitoring**: Weekly audits help track compliance with the sepsis pathway and identify areas for improvement. Making the sepsis pathway form a mandatory requirement on the e-observation system ensures that it is consistently followed whenever patients trigger, promoting adherence to best practices in sepsis management.
- **Continuous Improvement**: Developing a sepsis dashboard allows for real time monitoring of key metrics related to sepsis management, facilitating continuous improvement efforts. This dashboard provides actionable insights that enable timely interventions and adjustments to protocols as needed.
- **Communication and Awareness**: Displaying posters throughout the Trust and targeting clinical staff helps raise awareness about sepsis and the importance of adherence to the redesigned pathway. Effective communication channels ensure that staff members are informed and engaged in the initiative.

Implementing these strategies in a coordinated manner, we can improve education, increase compliance with the sepsis pathway, and ultimately enhance patient outcomes in the management of sepsis.

❖ **Establish one-stop bloods pathway**

Collaborating with various departments such as pre-op nurses, OPD staff, pharmacists, and neurosurgical secretaries is a proactive approach to improving the pre-operative experience for patients.

The information below are the proposed changes which will enhance the process and benefit patients:

- **Streamlined Process**: Conducting simple pre-op checks, including blood tests, during the initial clinician consultation saves patients time and eliminates the need for additional visits to the hospital. This streamlines the pre-op journey, making it more convenient and efficient for patients.

- **Enhanced Patient Experience**: By reducing the number of visits to the hospital and minimising unnecessary appointments, patients will experience less disruption to their daily lives and have a smoother pre-operative experience. This approach demonstrates a commitment to patient-centred care and prioritises patient convenience and comfort.
- **Improved Preparedness for Surgery**: Completing pre-op checks early on ensures that patients are adequately prepared for surgery. This proactive approach helps identify any potential issues or concerns beforehand, allowing clinicians to address them promptly and optimize patient safety and outcomes.
- **Efficient Resource Utilization**: Optimising the pre-op process reduces the strain on hospital resources by minimising unnecessary appointments and streamlining workflows. This allows staff to focus their time and resources more effectively, potentially increasing capacity and improving overall efficiency within the healthcare system.
- **Accelerated Pre-op Journey**: By eliminating the need for follow-up appointments for low-risk patients, the pre-operative journey is accelerated, leading to shorter waiting times and faster access to surgical care. This benefits patients by reducing anxiety and uncertainty associated with prolonged waiting periods.

Overall, these improvements contribute to a more patient centred, efficient, and streamlined pre-operative experience, ultimately enhancing patient satisfaction and outcomes. Collaboration among different departments ensures a coordinated approach and maximises the effectiveness of the proposed changes.

2.2.3 Patient experience

❖ **Introduce a lived experience panel**

Incorporating patient representatives and forming partnerships with patient groups are excellent initiatives for ensuring that healthcare services are truly patient centred and responsive to the needs of service users and their loved ones.

The information below shows how this priority will enhance the quality improvement (QI) process:

- **Patient Centred Design**: By involving patient representatives and forming relationships with patient groups, healthcare providers can gain valuable insights into the lived experiences of patients and their loved ones. This firsthand perspective is crucial for understanding the unique challenges and preferences of service users and tailoring services to meet their needs effectively.
- **Partnerships with AQUA and Patient Groups**: Collaborating with organisations like AQUA and patient groups provides additional support and resources for implementing quality improvement projects. These partnerships create opportunities for knowledge sharing, peer support, and access to best practices, enhancing the success and sustainability of QI initiatives.
- **Lived Experience Panel**: Engaging patient representatives in QI projects, such as the DNA project, as part of a lived experience panel enables healthcare providers to incorporate diverse perspectives and priorities into project planning and implementation. This ensures

that interventions are meaningful, relevant, and sensitive to the needs of patients and their families.

- **Co-Design Approach**: Adopting a co-design approach, where services are developed in collaboration with service users and their loved ones, promotes transparency, inclusivity, and shared decision-making. This approach fosters a sense of ownership and empowerment among patients and caregivers, leading to more meaningful engagement and better outcomes.
- **Ongoing Feedback and Improvement**: Seeking advice and guidance from patient representatives throughout the QI process facilitates continuous learning and improvement. By soliciting feedback, healthcare providers can identify areas for enhancement, address concerns, and make adjustments to services in real time, ensuring that they remain responsive to the evolving needs of patients and their families.

In summary, involving patient representatives, forming partnerships with patient groups, and adopting a co-design approach are integral to achieving patient-centred care and driving meaningful quality improvement in healthcare services. These strategies promote collaboration, empathy, and accountability, ultimately leading to better outcomes and experiences for patients and their loved ones.

2.3 Statements of Assurance from the Board

During 2023/24, The Walton Centre provided and/or sub-contracted six relevant health services:

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

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

The income generated by the relevant health services reviewed in 2023/24 represents 95.2% of the total income generated from the provision of the relevant health services by The Walton Centre for 2023/24.

2.3.1 Data quality

The Walton Centre is taking proactive steps to ensure the accuracy and reliability of their data across various dimensions of quality. Focusing on patient safety, clinical effectiveness, and patient experience, we are covering crucial aspects of healthcare delivery.

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

- Continue to develop internal data collection systems ensures the data used for decision making is as accurate as possible.
- We continuously review the internal processes related to measurement and reporting which is essential for maintaining data quality standards.

This approach aligns well with best practices in healthcare quality management, where data integrity is fundamental in making informed decisions and driving improvements in patient care.

We consistently collect nursing quality indicator data and have done so over the past decade. This long-term data collection provides a valuable historical perspective on the hospital's performance in delivering quality care and improving patient experience.

This data will also support progress against the quality improvement priorities and incorporating additional nursing metrics for internal assurance, the hospital demonstrates a comprehensive approach to monitoring and improving healthcare delivery. This allows us to have a clear focus on areas for improvement, ensuring that patient experience and the quality of care remain top priorities. This information supports the Trust in building year-on-year metrics to show progress against important aspects of the patient journey.

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

Implementing the Tendable App offers a comprehensive solution for conducting audits and inspections within clinical areas. Its ability to score questions, collect free text comments, and capture photographic evidence is extremely useful for ensuring thorough evaluations. One of the advantages of using electronic tools like Tendable is the real time nature of data collection and analysis.

Using this system enables us to aggregate data and identify themes and trends across the Trust. This functionality can provide valuable insights into areas of strength and areas needing improvement, ultimately contributing to enhanced quality assurance and patient safety.

2.3.2 Participation in clinical audit and national confidential

During 2023/24, seven national clinical audits and one national confidential enquiry covered relevant health services that The Walton Centre provides.

During that period The Walton Centre participated in 100% national clinical audits and 100% 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 2023/24 are as follows:

2.3.3 National audits

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

2.3.4 National confidential enquiries

- End of Life Care

The above national confidential enquiry is to identify and explore areas for improvement in the end of life care of patients aged 18 and over with advance illness, focusing on the last 6 months of life.

The national clinical audits and national confidential enquiries that The Walton Centre participated in, and for which data collection was completed during 2023/24, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit or enquiry.

National Audit	Participation	% Cases submitted
Acute care		
Adult Critical Care (ICNARC / Case Mix Programme)	Yes	Awaiting final figure
Severe Trauma (Trauma Audit and Research Network)	Yes	Submissions suspended
National Emergency Laparotomy audit (NELA)	N/A	No eligible cases
The Sentinel Stroke National Audit Programme	Yes	97.5%
National Audit of Care at the End of Life (NACEL)	Yes	Awaiting final figure Commenced Jan 2024
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100% (HES Data)
Older people		
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	Yes	100%
National Confidential Enquiry into Patient Outcome and Death		
End of Life Care	Yes	Awaiting final figure

The reports of three national clinical audits were reviewed by the provider in 2023/24 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)	Intensive Care National Audit and Research Centre (ICNARC). The Case Mix Programme is an audit of patient outcomes from adult critical care units. A data analysis report identifies trends over time showing how we compare with other critical care units. **Key Successes:**

	• Time invested to train outcome team staff how to collect and enter the data, this has helped with long term sickness and reducing backlog - previously only 1 member of staff in the Trust knew the process. • Report received from ICNARC has shown an increase in the number of patients who have died who had an estimated mortality risk of <20%. All cases in this sub-category were reviewed by clinical leads from ITU, neurology and neurosurgery with no concerns found regarding the current process or clinical practice. **Key Concerns:** • Staffing for data collection and input is less than GPICS recommendation. • Backlog is slightly reduced but still running roughly 8 weeks behind. **Key Opportunities:** • MELA introducing advanced analytics system – meeting scheduled to discuss benefits to unit and overall cost. Please see information below. • New quality indicators aligned with ICNARC v4/CCMDS datasets to give almost real-time insight into unit activity and performance, for all ICNARC auditing as well as ad-hoc requests. • Data can also be shared with the team via live dashboards and PowerPoint-style presentations, helping you make informed decisions and continuous quality improvements without delay. • The plan is to introduce the platform at critical care network level, so all hospitals within can benchmark their performance against each other to compare strategies for collaboration and improvement. **Key Actions:** • Explore feasibility of installing new analytics, to enhance the service and ensure WCFT is recognised for keeping up to date with latest developments. • Divisional manger to explore how to maximise staffing resource to support the development of the service.
Severe Trauma - Trauma Audit and Research Network (TARN)	• Due to an incident affecting Manchester University in June 2023 the decision was made to take the TARN system offline while a new system was built using the National Outcomes Registry. • Data collection continued within the Trust however analysis in line with TARN standards wasn't possible. • The new system the National Major Trauma Network is due to go live in April 2024 with reporting forecasted in the summer of 2024.
The Sentinel Stroke National Audit programme (SSNAP)	• WCFT thrombectomy cases and declined referrals are reviewed at the Regional Thrombectomy MDT group. The regional MDT group will continue to identify and discuss potential areas for improvement across the patient pathway. • At present the Walton Centre submits thrombectomy data on the records transferred to the Trust on the SSNAP registry. WCFT submit data following the record being transferred by the referring hospital as the patient record is started at the hospital the patient presents to first following the stroke.

	• Issues identified relating to data submission have been discussed with WCFT senior management. The Trust submitted 97.5% of applicable cases during 2023/24 and aim to submit remaining cases.

Participation in local clinical audits

The reports of 93 local clinical audits were reviewed by the Trust in 2023/24 and The Walton Centre intends to take the following actions to improve the quality of healthcare provided:

Neurology clinical audits and service evaluations

Audit title	Actions
Diagnosis and management of CVST (Central Venous Sinus Thrombosis)	**Summary of Actions:** • There is delay in diagnosing patients presenting with CVST in District General Hospitals 29.6% missed the diagnosis on the original scan. • 23% of patients had hematological disorders, other comorbidities include infection 9%, obesity 9% and pregnancy 1%. • Headache 70%, seizures 17% and visual problems are the most common presenting symptoms in CVST. • Major morbidity is common 48% and death is uncommon but significant 6%. • Involvement of other specialities ophthalmology 71%, neurosurgery 68%, haematology 34% others 12% • Delay in diagnosis of CVST lead to high morbidity and significant mortality. **Key Actions:** **Issue:** Raise awareness among medical practitioners about CVST. **Action:** Present example of severe cases in ground round. Organise headache teaching module.
Clinical and genetic characteristics of a cohort of 20 patients with confirmed biallelic pathogenic SPG7 mutations from the North West of England	**Summary of Findings:** • We identified 20 patients with confirmed biallelic mutations in the SPG7 gene under the care of the Walton Centre 49, range 20-77. • Only 40% had the typical 'HSP' phenotype with 40% having a complex phenotype including cerebellar ataxia and one having a novel phenotype of chronic progressive external ophthalmoplegia (CPEO). • 1/20 were identified using whole genome sequencing. • 11/20 patient identified via panel testing. • 50% had at least one genetic test or genetic panel sent prior to testing which confirmed responsible mutation. **No actions necessary.**
Provision and use of Lumbar Puncture leaflets to the patients in the Walton Centre undergoing Lumbar puncture	**Summary of findings:** • First cycle identified lack of staffs' knowledge about existing LP (Lumbar puncture) leaflet in the hospital. • Staff believed providing LP leaflets would benefit the patients in reducing the anxiety and making them well aware of the procedure.

	• Staff were aware about CSF (cerebral spinal fluid) biobank, but rarely discussed with patients and rarely taken samples for the biobank. **Key Actions:** **Issue**: Unavailability and usage of LP leaflet / Action: LP leaflet revised – to be approved and disseminated in the wards and clinics. **Issue:** Use of CSF Biobank for research / Action: Details of the CSF biobank research was attached in the LP leaflets in order to encourage patients to donate CSF sample for further research.
Audit of 2 week wait scans under the headache pathway	**Summary of Findings:** • 69 patients underwent brain imaging under the 2WW (week wait) protocol between January and June 2020. • Median time from referral to scan was 8 days, range 1-16. 3 patients exceeded 14 days. • Median time from referral to clinic appointment was 12.5 days, range 2-28 days. 21 patients exceeded 14 days. • 45/60 patients seen in clinic were discharged following their initial clinic appointment. • 42% of patients accepted under the 2WW headache criteria did not fulfil the 2WW criteria but were accepted. • There were 9% (6/69) of patients had a significant abnormality on scan. 3 of these patients were identified using the 2WW criteria. • Predictors of a significant scan finding were older age and headache with new onset visual disturbance. • Where a diagnosis was given (41 patients) 51% had a final diagnosis of migraine. • Predictors of a diagnosis of migraine were younger age and female gender. **Key Actions:** • Stricter adherence is needed of the 2WW criteria when triaging referrals. • Not all patients need a clinic appointment if low risk and normal scan. • GPs should be educated that can refer directly to scan. If the scan is normal the management of the patient can go back to primary care rather than continuing to a clinic appointment.
Monitoring and safety in prescription of corticosteroids – second audit cycle	**Key Success:** • Good consideration of gastric protection. • Improved mention of varicella zoster virus (VZV) status (although still only 8%). **Key Concern:** • Inadequate management of bone health (including use of FRAX) and checks for steroid cards. • Safety monitoring in general is poor. **Key Actions:** • Need for more awareness and discussion of steroid monitoring in outpatients - Discussion in audit meeting. • Discussed in Neurology grand round. • Steroid monitoring guidance available via the intranet and in clinic rooms. • Included in Risk bulletin.

Assessment of bone health in the neurology clinic	**Summary of Findings:** • Bone health infrequently discussed/assessed in frail patients (>75 yo) attending neuromuscular (NM), movement disorder or epilepsy clinics. • Discussion of bone health (looking back 5 yrs if long-term f/up) was recorded in 2/20 NM, 0/20 MD and 1/17 epilepsy patients meaning that no bone health assessment or advice for GP to do was provided in >90% of them. • One patient had a FRAX assessment in clinic (NM clinic) and none had advice recorded to see GP for this instead. • Ca and vitamin D levels were checked in 6/20 NM (4 of which were noted to be on a bisphosphonate), 0/20 MD and 1/17 epilepsy patients, indicating bone health was considered in almost a third of NM patients, even if FRAX assessment was not performed or recommended to GP in them (bar 1 patient who had FRAX assessment); one patient (NM clinic) was noted to be on a bisphosphonate who had not otherwise had a bone health discussion recorded or Ca/vitamin D tested. **Key Actions:** • Need for more awareness and discussion of bone health in frail neurology outpatients. • Discussed in Neurology grand round. • Bone health guidance available via the intranet and clinic rooms. • Included in Risk bulletin.
Sleep disorders in Parkinson's disease	**Key Success:** • Sleep disorders are very common (34-72%) in patients with Parkinson's Disease at WCFT. • We have improved at detection & treatment areas (Daytime sleepiness, restless legs syndrome). • We are consistently treating patients with rapid eye movement (REM) Sleep Behaviour Disorder in line with NICE guidance. **Key Concerns:** • Not all sleep disorders are asked about during the disease course of all patients audited. • We have regressed in documenting we ask about REM sleep behaviour disorder, nocturnal akinesia and recommendation of DVLA involvement. **Key Actions:** • Recommendations presented 29/11/2023 - Improve awareness to enquire of sleep disorders and other non-motor symptoms in patients with Parkinson's Disease · Improve and emphasise importance of language choice and documentation of quality measures to capture measurable clinical practice. **Issue:** Method to capture Parkinson's disease symptoms required. **Action:** Develop a proforma (paper or on EP2) to document relevant non-motor symptoms as one-off to go on patients record.
Optimising Early Spasticity Management in the Neuro ITU	**Key Success:** • Positive feedback from team re spasticity management MDT form created. **Key Concerns:** • Unable to optimise spasticity management due to staffing issues within this time frame. Highlights the requirement for a more

	structured and routine approach to make treatment more efficient and therefore more consistent particularly when under staffing pressures. • Minimal use of outcome measures. **Key Actions:** **Issue**: Introduce spasticity management protocol within therapy team on ITU. **Action:** To promote and engage the therapy team in optimal spasticity management on ITU. **Issue:** Collate data on use of outcome measures and spasticity management MDT forms. **Action:** Ensure data is collected "live" not in retrospect as difficult to gather all data from EP2.
'Get it on Time' Time critical medication in PD	**Key Success:** • Over 35% improvement to national average around time critical medication compliance. • In patient prescriptions accurately reflect the usual regime when appropriate. • Staff who administer time critical medication have education during preceptorship. • Policy to support self-medication is in place. • Each ward is covered by neuroscience pharmacists. • Electronic prescribing systems allow for bespoke medication timings. **Key Concerns:** • Not all patients are identified as being on time critical medication. • A list of time critical medications is not displayed in ward areas. • Due to time constraints and workload patients may not get medication on time even though policies and electronic systems allow for this. • Although the trust has policies who support self-medication the percentage of patients who self-medicate is low 4.25%. Some patients may not be appropriate but there also may be lack of education around use of the policy and current lockers are not patient friendly. • Education around the need for time critical medication could be improved. **Key Actions:** **Issue:** Quality Improvement project to be implemented. **Action:** Meeting planned to discuss findings of audit further and ways of implementing recommendations. Meeting planned for 27th March to develop project and hopefully have PDUK involvement for some resources.
Post Falls Audit of compliance with Trust Policy on Slips, Trips and Falls	**Key Concerns:** • 33% of falls were not referenced or acknowledged within patient records or files. • Next of Kin not always informed of fall. • 27% post fall risk assessments not completed. • Only 43% had lying and standing BP recorded 24 hours before the fall. **Key Actions:** **Issue:** Share findings.

	Action: Discuss at sharing and learning, falls prevention steering group, Ward Manager risk and governance and via email to Ward manager group. **Issue:** Education. **Action:** Reinforce post falls actions required at induction and mandatory training. **Issue:** Local monitoring of compliance. **Action:** DIF2 managers monitoring post falls actions locally, WM and Matron monitoring.
UTI Audit on antimicrobial prescribing	**Key Success:** • Of those patients started on intravenous (IV) antibiotics, 80% were stepped down to oral antibiotics. • 8 patients presented with unconvincing UTI symptoms; doctors requested cultures to be taken prior to initiating antibiotics. Only 1 of the 8 patient was included, as cultures were positive, and the doctor clarified for UTI symptoms. • All but one patient had mid-stream urine and catheter specimen urine sent. **Key Concerns:** • Inappropriate use of urine dipsticks. • Poor documentation/commencing treatment in asymptomatic patients. • Poor review rates at 48-72hrs. **Key Actions:** **Issue:** Poor documentation of symptoms. **Action:** Education to nursing staff. **Issue:** Inappropriate urine dipstick. **Action:** Education. **Issue:** Formulary choice. **Action:** Review epidemiology and update formulary.
To review if vetting was appropriate for imaging a patient with history of seizure(s). (Audit of Epilepsy Protocol)	**Summary of Findings:** • All patients (100%) were imaged as per an Epilepsy protocol. • 96% patients were scanned appropriately using either a screening protocol or a pre-surgical Epilepsy protocol. • All patients with history of seizure were scanned on an epilepsy protocol. • No significant concerns. Only 1 patient who had a normal scan about 8 years ago and with EEG findings possibly lateralising to the frontal lobe, could potentially have had the scan using the pre-surgical protocol. 1 patient (2%) who had a scan with the pre-surgical protocol could have the scan done on the screening protocol. **No actions necessary.**
Audit of the Recording of CT radiation doses and unsaved CT images 2022 data	**Summary of Findings:** • Overall, the audit has improved compared to last years with the biggest improvements being the TDC axial image (2.31%). • Missed dose on CRIS remains an issue as this audit demonstrated a 1.74% increase (from 2021) in staff not recording any dose for the CT examination performed. • Regarding images that were not sent to PACS this year demonstrated a few improvements.

	• 6.29% of TDC (time density curves) screen save images weren't sent to PACS in comparison to 2021. • Increase (1.74%) in the number of doses not recorded on CRIS from 2021. • 3 incorrect doses recorded the same as 2021. **Key Actions:** **Issue:** Highlight problematic themes. **Action:** Highlighted to staff. Included in monthly brief & QRG update. **Issue:** Education – highlight the need for TDC images to be sent. **Action:** Highlighted to staff. Included in monthly brief & QRG.
Upper limb stenting prior to neurovascular intervention in intracranial aneurysm patients with a nickel allergy	**Summary of Findings:** Our service evaluation highlights that in patients with a nickel allergy who require aneurysm treatment, undertaking stenting of an upper limb vessel prior to their subsequent intracranial aneurysm treatment is a viable therapeutic option. • Since inception of this practice within our centre, our service has remained 100% compliant with the proposed practice, with the procedure a safe method to manage their intracranial aneurysms. • The specific record detailing the allergen history of some patients was not available on the electronic system but rather only documentation from a clinic letter/hospital entry. **Key Actions:** **Issue:** Not all earlier patients in the study had an ultrasound examination of the periphery in addition to clinical examination. **Action:** This has been addressed in the latter group of patients but warrants reminder to the neurointerventional staff group to ensure follow-up ultrasound of the periphery is booked on the day the peripheral stent is implanted. **Issue:** Specific document detailing the breakdown of the patient's allergen history was not always available. **Action:** Ensure all future patients are referred to allergen specialist for dedicated allergen testing & records are uploaded to electronic system. This referral will take place via the consultant interventional neuroradiologist in their clinics.
Standards for reporting and interpretation of fluoroscopy guided Lumbar punctures	**Summary of Findings:** • No issues identified in advanced practitioner reports following double reporting by Consultant Radiologist. • No errors identified in reports. **Key Actions:** • Results disseminated – Directorate management meeting.

Audit to assess the suitability of line algorithm for visualisation of nasogastric tubes – re-audit	**Summary of Findings:** • 100% compliance for visualisation of NG (nasogastric) tube. • 76% demonstrated the NG tip 9 (74.5% 2022). • 90% demonstrated the Carina (98% 2022). • 93% were diaphragm centred (93% 2022). • 96% of examinations had both images on PACS (+/- line algorithm) (improvement compared with 89% previous audit). • 41% had ECG leads, lines etc, overlying the image. **Key Actions:** • Staff reminded to remove ECG leads and lines overlying the chest prior to exposure. • General and Theatre monthly brief. • ECG lines included as criteria for next audit.
Audit of groin complications in interventional neuroradiology	**Key Success:** • Compared to previous audits, compliance with ultrasound guided punctures has certainly improved, and those without ultrasound were all non-elective patients. • Significant groin complications requiring further intervention have improved since 2018 and remained stable since 2020. **Key Actions:** • No Major concerns identified - findings discussed at directorate management meeting.
Audit of multiple examinations in Radiology in line with Royal college of radiologists (RCR) guidelines	**Summary of Findings:** No radiology reports were found to be only partially reported.100% compliance with RCR requirements. **No action necessary** discussed at directorate management meeting.
Audit of Interventional Radiology radiation dose audit	**Key Success:** • Angiographic dose is consistent. • Changing to a variable frame rate when screening has allowed dose to remain the same. **Key Actions:** • No concerns identified - findings disseminated Radiology Directorate management meeting and staff meeting.
Audit of exam time taken from radiology examination to issue of report availability	**Key Success:** • For 2022 our same day Inpatient reporting is 87.16%. Up slightly 0.17% on last year's audit. • Average monthly activity for 2022 has increased on 2021. This equates to an increase of 95 extra reports per month. **Key Concerns:** • The over 14 day report turnaround time had increased significantly from 5.4% to 34.73%. • Reasons-reduced number of reporting radiologists due to thrombectomy provision activity going 24/7, One Cons Radiologist reduced by 1 PA, increased sickness absence due to Covid second wave, some radiologists involved in organising other clinical sessions MRFgus/reporting for research, annual leave of those radiologists left to cover with 4 weeks of family leave for an IVNR agreed by the Trust. **Key Actions:** **Issue:** Communication of results.

	Action: Communicate and distribute to all members of the directorate management team. Re-audit 12 months. **Issue:** a significant increase in the 14-day turnaround. **Action:** An 8th diagnostic reporting radiologist was recruited **Issue:** Utilise Waiting List Initiative to offer additional reporting sessions. **Action:** Planning of WLI reporting lists.
Audit of application of the primary progressive multiple sclerosis (PPMS) protocol and the rate of identifying inflammatory activity as indicated by NICE guidelines	**Key Success** • Gadolinium should be used in progressive MS for early assessment of activity in newly diagnosed PPMS and in patients with PPMS or SPMS with a heavy, confluent lesion load. • Subsequent screening for PPMS and in patients with SPMS with previous imaging < 2 years, Gadolinium is not required. This has allowed us to rationalise our use of gadolinium and change our protocol accordingly. • This audit has been accepted for a poster presentation at the BSNR ASM. **Key Concerns** • The progressive MS protocol is correctly applied in only 66% of patients. This likely relates to the simplicity of the protocol for post contrast brain imaging in MS patients but should ideally be reserved for patients with progressive MS (either PPMS or SPMS) who may be eligible for treatment change. **Key Actions:** **Issue:** Over-requesting of gadolinium for MS patients. **Action:** Modification to Walton MRI guidance for MS. **Issue:** In correct use of PPMS protocol. **Action:** Discussion with Walton Neuroradiologists regarding vetting scan requests.
Audit of Radiology urgent reports and fail-safe notifications	**Key Success:** 100% compliance by office staff in maintaining standard of communication of radiological reports and fail-safe notifications. **Key Actions:** No concerns identified. • Comms sent out to reiterate the importance noting consultant name and secretary name.
Comparison of current standard CT reconstruction algorithm with new AI based Iterative reconstruction algorithm in lesion conspicuity' aka AICE Algorithm	**Key Success:** • Departmental review of available deep learning algorithm on our CT scanner. • One third of cases demonstrated improved lesion conspicuity. **Key Concerns:** • The algorithm has the potential to exaggerate white matter changes and artefacts (metallic artefacts, posterior fossa beam hardening). • The algorithm may reduce sensitivity for detection of iso- to hyperattenuating subdural blood. • The algorithm may produce artefacts which we are not yet aware of or have not been published in the literature. **Key Actions:** **Issue:** The consultant body may not be aware of differences in contrast and signal to noise

	Action: a) introduce the AiCE algorithm alongside the standard protocol for a period of one month. b) Dissemination of presentation and results to all consultants prior to start of trial period. **Issue:** Reevaluate impact of the AiCE algorithm introduction across the consultant body. **Action:** Consultant meeting – if in agreement, to replace the existing protocol with AiCE algorithm. **Action outcome:** Discussed at CT protocols meeting - agreement is to continue the current practice of sending axial, coronal and sagittal images using AiCE protocol and standard axial imaging (old protocol) until further notice.
Audit of Consent to Treatment within Neuroradiology 2023	**Key Concerns:** • Form 4 patients capacity section was not always properly documented and filled in. **Key Actions:** **Issue:** Form 4 patient's capacity section was not always properly documented and filled in. **Action:** This audit will be distributed amongst interventional neuroradiology consultants and a notice be placed in angio suite control rooms. - Increase awareness amongst all healthcare professionals taking consent to ask patients and document whether they have received an information leaflet.
Middle Meningeal Artery Embolization as a treatment for non-acute subdural haematomas. A single site UK experience.	**Key Success:** • 21 males and 4 females, with ages ranging from 47–92 years. • All patients had a GCS between 13-15 at the time of embolization. • Total of 27 embolisation sessions were performed – 25 under general anaesthesia and 2 under conscious sedation (due to cardiac morbidity). • 6 patients had bilateral embolisation, with a total of 31 separate cSDHs having been embolised. • 29 cSDHs were embolised with polyvinyl alcohol (PVA) particles, and 2 cSDHs were embolised with liquid embolic agent (SQUID) • Radiological follow-up ranged from 1-15 months (mean 5.2 months) – 15 resolved completely [48.4%] (3 of which were adjuncts to surgical drainage), 13 decreased in size [41.9%] (1 of which was an adjunct to surgical drainage), and 3 reaccumulated needing surgery [9.7%]. • Clinical follow-up ranged from 1-13 months (mean 4.3 months) – 17 improved or became independent [68.0%], 2 had persistent cognitive and/or mobility issues [8.0%], 2 died [8%] (9 months and 2 months after the procedure), and 4 had no clinical follow-up (remained well with no concern on imaging). • No peri-operative morbidity or mortality. A single procedure was complicated by a superficial iatrogenic meningeal arteriovenous fistulation – this was occluded in the same session with no major concern. • Radiologically 15 resolved completely [48.4%] (3 of which were adjuncts to surgical drainage), 13 decreased in size [41.9%] (1 of which was an adjunct to surgical drainage), and 3 reaccumulated needing surgery [9.7%].

	• Clinically 17 improved or became independent [68.0%], 2 had persistent cognitive and/or mobility issues [8.0%], 2 died [8%] (9 months and 2 months after the procedure), and 4 had no clinical follow-up (remained well with no concern on imaging). **Key Concerns:** • No major concern. Overall good outcomes. **Key Actions:** • Ensure effective referral process from neurosurgery to INRs. • Presented to CESG.
Vessel wall imaging – do the current MR protocols satisfy the Expert consensus recommendations of American society of Neuroradiology	**Key Success:** • Good technique of 3d pre contrast vessel wall sequence. • Reasonable black blood on both pre and post gad. **Key Concern:** • No 2d black blood sequences. • Significant artefacts on T2 volume. • Post gad 3d T1 volume needs improvement in terms of SNR and also wall delineation. Flow artefacts and venous enhancement also impairing adequate assessment. **Key Actions:** **Issue:** No 2d post gad targeted sequences. **Action:** Develop and implement the sequence (This requires a significant input of work from a Medical Physicist hence the timeframe of 2 yrs for all actions). **Issue:** T2 volume CSF artefacts. **Action**: Work with physicist to optimise this. **Issue:** 3d T1 post gad SNR and wall delineation. **Action:** Work with colleagues and physicist to optimise this.
Comparison of shuntograms performed in Xray under IRMER regulations	**Key Success:** • Only one of the examinations had the incorrect code entered. • Majority of examinations entered onto CRIS matched the corresponding dose report. **Key Concern:** • 20% is still quite high for a dose discrepancy due to incorrect code. **Key Actions:** **Issue:** Dose input into CRIS not always correct and matching dose report. **Action:** Speak to individuals, disseminate in monthly brief and re-audit in 6 months.
Audit of standards for reporting and interpretation of ultrasound images in line with RCR and BMUS guidelines	**Summary of Findings:** • As per RCR recommendation 5% of reports were double reported. **Key Success:** • 100% full agreement. **Key Concern:** • N/A **Key Action:** • Results disseminated to staff meeting, Quality and Risk Group update, audit board, Directorate management meeting.
Audit of non-medical referrers for radiology	**Key Success:** • 53 non-medical referrers for Radiology 100% compliance.

under IRMER guidelines 2023 data	**Key Concerns:** N/A **Key Actions:** • Results disseminated to Director of Nursing, Radiology Directorate Management meeting and Staff Meeting Dec 2023.
Evaluation of recurrence rates for Woven EndoBridge (WEB) device in the treatment of intracranial aneurysms	**Key Success:** • WEB device aneurysm occlusion rates comparable to other studies. **Key Concern:** • WEB recurrence may be influenced by 2 factors – size of aneurysm and location (posterior circulation/basilar). **No actions necessary** - Results of the audit are similar to observations made by INR consultants and changes to daily practice already in place.
Evaluation of efficacy and safety for FRED X flow diverting stent device in the treatment of intracranial aneurysms	**Summary of Findings:** • High efficacy of the FRED X device in the treatment of intracranial aneurysms. Complete occlusion of aneurysm in 76.7%. • Neurologic complication rate is 13.3%; higher compared to other studies. However, the result may not reflect real-life practice as there is likely to be bias from small sample size and inclusion of complications which are not directly related to use of FRED X. • Mortality in this audit occurred in 1 patient (3.3%), a similar rate when compared to similar studies. **Key Success:** • High efficacy of the FRED X device in treatment of intracranial aneurysms. **Key Concern:** • Neurologic complications seemingly higher compared to similar studies. However difficult to draw accurate conclusion due to presence of bias as described above. **No actions necessary.**
Protocoling and adherence to MRI conditions of active implants	**Key Success:** • All scans were performed in a safe manner with adequate adherence to safety principles. **Key concerns:** • None **Key actions:** **Issue:** Documentation of repeat off label scanning. **Action:** Improve SOP and pro-forma for repeat off-label scanning.
Audit of double reporting in line with Royal college of Radiologists guidelines	**Key Success:** • Demonstrable robust system of checking other consultant report in line with RCR recommendations. • Action was taken for the 1 case which had impact patient, the original report was addended to highlight the issue and the clinician was made aware as it alters the diagnosis of the patient and may mean the clinician decides to stop the Parkinson's treatment, thus alters how the clinician may manage the patient. **Key Concerns:** • As per previous recommendation this has been used for Consultant to Consultant which has resulted in an increase in the percentage disagreement from 2% to 5%. The outcome last year

	of 2.1% included registrar reporting which was removed for data analysis for 2023 as these should not be included according to guidance. **Key Actions:** **Issue:** Communication of results. **Action:** Communication and distribute to all members of the directorate management team. Annual audit – on rolling programme for radiology.
Audit to monitor the compliance of recording medical exposure factors for rejected plain film radiography in accordance with IR(ME)R 2017 Regulations	**Key Concerns:** • It is a legal requirement to record all relevant dose information for each patient exposure in the Radiology Management System (CRIS). This audit is to monitor the compliance of Radiographers recording doses for rejected plain films. • 4% of rejected images were not sent to the recycle bin for reject analysis. **Key Actions:** **Issue:** 1) Doses for all rejected images to be recorded in CRIS correctly. 2) All rejected images to be sent to the Recycle Bin. **Action:** Staff reminded.
Audit of the Recording of CT radiation doses and unsaved CT images 2023 data	**Summary of Findings:** • 98% of the175 examinations were sent to PACS. compared to the previous audit of a 100%. • 88% compliant in sending TDC axial images to PACS – equivalent to previous audit. • 92.5% compliant in TDC screen save being sent to PACS – equivalent to previous audit. (3 of these screen saves not sent were due to not being able to achieve a peak and were done at a set time after discussion with a radiologist.) • 100% of CTV H-F MIPS were sent to PACS equivalent to previous audit. • 93.5% compliant in sending both CTA MIPS. This is a decrease in compliance compared to 98.7% on the previous audit. (Out of these 8 MIPS not being sent to PACS, 3 had comments on CRIS to say MIPS not available due to patient movement). • 100% compliant with CTA and CTV axial images being sent to PACS. • 100% compliant with the number of doses recorded on CRIS compared to 99.5% on the previous audit. • 97.7% compliant with doses recorded correctly. (User error/new staff). **Key Actions:** **Issue:** 1) Highlight problematic themes. 2) Education – highlight the need for Topo, TDC images and MIPS to be sent. Daily checks of completed actions. **Action:** Staff reminded.
Audit to monitor the reject analysis rate for rejected plain film radiography in accordance with IR(ME)R 2017 Regulations for 2024	**Summary of Findings:** Target - Reject rate of 4%. Overall upward trend for the reject rate during 2023 (average 7.25%). Common reasons for rejects: • Technique – Largely CSP examinations (fracture follow up patients are particularly challenging – age/ presentation). • Artefacts - Jewellery / clothing artefacts not removed.

	• Patient movement – largely due to the cohort of patients, particularly in the elderly for peg views in collars. • Exposure – almost negligible rejects. **Key Concerns:** • None identified as patient presentation is the biggest challenge and is out of our control. **Key Actions:** **Issue:** 1) Highlight problematic themes – artefacts. 2) Education. **Action:** Staff reminded.
Adherence to carpal tunnel syndrome (CTS) nerve conduction studies protocol	**Key Success:** • The adherence to standards 1, 4, 5 and 8 was exemplary, with all studies scoring 100%. For standards 6 and 7, there was only one study that missed out these standards, (understandably due to intolerance). **Key Concerns:** • Standard 3 0% recorded temperature. Barriers explored mainly related to availability of thermometers. **Key Actions:** **Issue:** Temperature recording. **Action:** Provision of thermometers and discuss with Natus the options of temperature probes/sensors. Addition of temperature field to patient data in EMG machines **Issue:** Documentation of name and professional status of the physiologist doing the test. **Action:** Make the physiologist's name field mandatory to enter in the key point EMG machines. **Issue:** Edit the current policy. **Action:** regarding the selection of sensitive tests (Guideline 1,2.3) to be in line with the British Society of Clinical Neurophysiology (BSCN). And current CTS grading scale. **Issue:** CTS grading accessibility. **Action:** Print A7 cards for the CTS grading.
Evaluation of service gap for tracheostomy service – is there a need for outreach community service to facilitate and re-assess tracheostomy discharges	**Key Concerns:** • Following significant delays and difficulties with establishing a care agency for a patient recently discharged home with a tracheostomy, and then concerns from staff with regards to insufficient training standards and provisions of this agency, there was a potential agreement around discharge directly from Lipton to home not being an option in future. However, this is not an agreement which has been finalised by the Trust or CMRN, and recent legal advice with regards to another potential tracheostomy discharge home has been that we are not in a position not to offer discharge home as an option. With this in mind more needs to be done to make this process more timely, to align expectations of carers and patients with what is available and improve pathways to discharge and more robust community care provisions. The latter of which is out of the hands of the MDT. **Key Actions:** **Issue:** Areas of particular delay in the process identified / Action: Discuss planning and processes with discharge co-ordinator.

	Issue: Service gap identified / /Action: Presentation of data to team and department lead. **Issue:** Learning points to be identified and disseminated to wider team. **Action:** Presentation of findings to associated MDT, Tracheostomy steering group - reach agreement as to how to escalate issues that fall outside the remit of the Lipton MDT.
Evaluation of SLT compliance with yellow sign and kitchen board documentation of eating and drinking recommendations	**Summary of Findings:** • Yellow signs are consistently in place on the acute wards and CRU for 100% of appropriate patients. Yellow signs are in place for 0% of patients on Lipton and Horsley. (All patients audited on Lipton and Horsley have a tracheostomy in situ). • Kitchen boards were found to be 66% accurate across the entire caseload, and 79% accurate on the acute wards. • Data showed that, on the acute wards, SLT documented 93% of the time that the kitchen board had been updated. However, only 79% of the time was the kitchen board found to be accurate. • The most frequent reason the kitchen board was not accurate was due to patient absence from the board, with other reasons being that there was the wrong bed/ bay number and recommendations were incorrect. • Yellow signs are consistently in place on the acute wards and CRU for 100% of appropriate patients. • The kitchen board on CRU is 100% accurate. • SLT documentation of the updating of the yellow signs and kitchen boards is high at 93% - the equivalent of only one set of notes not fully compliant based on this sample size. • Yellow signs are consistently absent for patients on Horsley and Lipton wards. • Kitchen board accuracy on the acute wards is low compared with yellow sign accuracy. • There is a discrepancy between the percentage of the time SLT have documented as kitchen board being updated and the percentage of the time that the kitchen board is accurate: indicating that kitchen boards are changed post-SLT intervention and become inaccurate as a result. • Yellow signs are consistently in place on the acute wards and CRU for 100% of appropriate patients. Yellow signs are in place for 0% of patients on Lipton and Horsley. (All patients audited on Lipton and Horsley have a tracheostomy in situ). **Key Actions:** **Issue:** Yellow signs are in place for 0% of patients on Lipton and Horsley. **Action:** Band 7 and Band 8 SLTs to consider whether yellow signs are appropriate in these environments given the uniqueness of the caseload and different ways of working on these wards **Issue:** Kitchen board accuracy is low compared with yellow sign accuracy. **Action:** SLT to feedback findings at Nutrition Steering Group, for discussion of whether it is appropriate for SLTs to continue to use kitchen boards.

	Issue: Findings indicate that kitchen boards on the acute wards are changed post-SLT intervention and become inaccurate as a result. **Action:** SLT to feedback findings at Nutrition Steering Group, for discussion of whether it is appropriate for SLTs to continue to use kitchen boards.
Is the unable to weigh form on Ep2 being used correctly	**Summary of Findings:** • 75 unable to weigh forms completed as part of the MUST (malnutrition universal screening tool) in the 6 months between June and November 2022. • 4% of these patients required a dietitian to estimate weight, 96% could safely be weighed at the point of dietetic assessment. • 11% of unable to weigh were completed in error. • 13% were due to user or IT error. • 64% were completed on admission. • Project has allowed the dietitian to identify training needs where MUST risk assessment is being completed incorrectly and resulting in unable to weigh form being generated. **Key Actions:** • Update dieticians in team meeting. • Inform nutrition steering committee. • Update MUST training.
Service Evaluation of nursing knowledge of refeeding syndrome identification and management	**Key Success** • Education was shown to increase those reporting moderate confidence by 62%, from 19% to 81%. • Confidence score (0-5) increased on average by 1.43 points. • 95% of participants reported it was not appropriate to provide additional supplementation post education, an extra 25% compared to pre-education. • 100% of participants knew where to find the trust's refeeding policy post education. **Key Concerns** • 67% of participants reported bowels not opened > 1 week as a risk for refeeding syndrome post education compared to 38% pre-education. • 0% of participants correctly listed all three electrolytes pre-education compared to 38% post education. **Key Actions:** **Issue:** Poor confidence surrounding management of refeeding syndrome. **Action**: Nutritional bulletin. Dietitians' week refeeding syndrome awareness. **Issue:** Further education required on identifying the main risk factors for refeeding syndrome Action: Nutritional bulletin. Dietitians' week refeeding syndrome awareness **Issue:** Only 38% of participants correctly listed the three electrolytes monitored in refeeding syndrome post education. **Action:** Nutritional bulletin. Dietitians' week refeeding syndrome awareness. To implement as part of nutrition training – discuss with Team Lead.

An evaluation of patients who are prescribed oral nutritional supplements on admission, during admission and on TTO's and referral to inpatient dietitians or community dietitians on the acute wards at the Walton Centre.	**Key Success:** • One positive finding was that 95% of patients who were prescribed oral nutritional supplement (ONS) at some point during their admission were referred to the inpatient dietitians for further assessment and monitoring. This is a high percentage which means very few patients who are prescribed ONS as an inpatient are being missed. Of the 5 that were not referred to the dietitians, 2 of which were an inpatient for 2 days or less which may have been a contributing factor. **Key Concerns:** • It was found that 30% were not referred to a follow up dietetic service but did have ONS on their TTO's. This has the potential for inappropriate community prescribing if patients are not receiving any dietetic support once discharged. **Key Actions:** **Issue:** No advice or standard note on JAC advising on TTO's when prescribing ensures. **Action:** Process to be revised and discussed regarding ONS on TTO's. **Issue:** No referral criteria advising to refer when supplements are prescribed. **Action:** Process to be revised and discussed regarding ONS on TTO's. **Issue:** No SOP/policy standardising when ONS is to be included on TTO's. **Action:** Process to be revised and discussed regarding ONS on TTO's.
Audit to identify sample of patients that are under the care of dietetics and accuracy of weights taken and the impact it has on efficiency of dietetic review time.	**Key Success** • Some staff are second screening / re-weighing patients (6% of total weights taken). **Key Concerns** • Delays to dietetic review time. • Majority of the patients where enterally fed and BMI indicates that 71% were overweight. • 11% of weights audited showed a percentage weight change of more than 10%, due to querying the accuracy of this delays making changes to dietetic plans, impacting on efficiency of dietetic review time. • Patients are not being re-weighed if there is a possible in-accurate weight taken (most likely due to staff not being aware of previous weight). **Key Actions:** **Issue:** Inaccurate weights taken by staff. **Action:** Education / MUST training to inform staff on new recommendations for re-weighing patients. Educational nutritional bulletin on importance of accurate weights and re-weighing. To be disseminated to Nursing / HCA's teams. **Issue:** Hoist scale / chair scale training. **Action:** Link in with Manual Handling trainer to add hoist / chair scale to mandatory training? **Issue:** Results of audit and actions. **Action:** Presentation to Dietetic Team of audit details and action.

Nasogastric tube size service evaluation	**Key Concerns:** All patients requiring a nasogastric tube should have a fine bore (10FR) NG tube. Patients may be transferred from referring hospitals with wider bore NG tubes (12 FR or greater), 12Fr NG tubes should be restricted to critical care. These tubes should be changed to fine bore as soon as possible; advice must be sought from the medical team - Note that the nasogastric feeding tube placing SOP recommendations does not match the practice on the ward. The most common cause for 12Fr insertion seemed to be this was the size of NG available on the ward. **Key Actions:** **Issue:** 12Fr NGT are available on ward and 10 Fr NGT are not available. **Action:** Discuss with matrons, instruct procurement to change order.
Gastrostomy placement: Are we meeting NICE guidelines?	**Key Success:** • 60% of patients had a referral made on the acute wards and increase of 10% from previous audit. **Key Concerns:** • Misinterpretation of NICE guidelines that recommend gastrostomy placement is considered if enteral feeding likely to be required for 4 weeks has not been received the previous 4 weeks. • No clear PEG pathway despite this being recommendation from previous audit. **Key Actions:** **Issue:** Highlight lack of formal Gastrostomy pathway to SLT and dietetic colleagues – clear justification as to why this has not been implicated following previous audit**.** **Action:** Present to dietetic and SLT team for discussion / Feedback to nutrition steering committee **Issue:** Education to teams re 4 week marker and this alone is not a clinical indication for gastrostomy. **Action:** Feedback in dietetic team meeting. **Issue:** Ensure clear documentation regarding when ng tube is no longer needed. **Action:** Feedback in dietic team meeting.
To determine if Renapro would be more cost effective and appropriate for use on ICU patients then Prosource TF which is the current practice	**Key Success:** • Prosource TF is beneficial to use a protein supplement in some cases one only ~ 11g protein in addition is the deficit. **Key Concerns:** • Renapro in some patient groups could potentially save money if used appropriately and was available, currently not available. **Key Actions:** **Issue:** New product nursing staff may not be aware **Action:** Liaise with ICU matron - education on product with staff. **Action:** Liaise with pharmacy to get regular stock renapro on Horsley ICU.
Effectiveness and efficiency of Video fluoroscopy Clinic	**Key Success:** • Successes appeared that the data suggested the video-fluoroscopy swallow study (VFSS) clinic was effective for supporting pt's understanding of their dysphagia/ quality of life

	measures and for commencing on oral intake (improvement in functional oral intake score). **Key Concerns:** • Concerns regarding the inefficiency of the clinic and inactive clinician time. **Key Actions:** **Issue:** VFSS clinic inefficiency identified of clinicians time. **Action:** changes planned for the VFSS clinic in 2024 e.g. changing room/ equipment therefore repeating the service evaluation would see if there was any change in the efficiency of the clinic. Repeat service evaluation – summer 2025.
Exploring MDT perspectives of the role of psychology on the CRU	**Key Success** • Joint working and facilitating holistic care and communication with patient and family. • Supporting emotional wellbeing of patients, families and staff. • Generally being really well-liked as people and as a profession. **Key Concerns:** • Training re: challenging behaviour and the role of psychology in general. • Facilitating connection and community among the wider team. • Making sure psychology are physically accessible on the ward. • Ward activities (priority for MDT as a whole). **Key Actions:** **Issue:** Psychology presence on ward (had to vacate CRU office during covid, currently occupy 2nd floor SWB plus original office). **Action:** Assistant Psychologists and Trainee Psychologists based full time in CRU office, qualified Psychologists split between CRU office/2nd floor SWB. **Issue:** Ensure Psychology presence at handover **Action:** Assistant Psychologists now attend CRU morning handovers. **Issue:** Challenging behaviour training/education. **Action:** Challenging behaviour working party has been set up on CRU, MDT members also attend Violence and Aggression Walton working party. Psychologist Dr Sophie Cochrane to represent Psychology.
Exploring staff perspective of the cognitive pathway within an inpatient neurorehabilitation team	**Key Success:** • Psychology and occupational therapy staff spoke positively of an interdisciplinary approach to the assessment and treatment of cognition. • Psychology and occupational therapy staff described working in a person-centred and holistic way to meet their patients' needs. **Key Actions:** • Cognitive pathway to be redeveloped by psychology and occupational therapy teams. Current practice and evidence should be reviewed prior to the redevelopment of the pathway, to ensure it is consistent with the most recent guidance and informed by staff expertise. The pathway should also capture the current practice on the ward to be informed by patient need.
An Evaluation of Patients' Needs Around Child Caregiving Within a	**Summary of Findings:** Four main themes were generated from the data collected (The child's involvement, visibility, access to support and family

Complex Specialist Rehabilitation Service	centred rehabilitation). • Patients felt generally well supported by the community team and wider network regarding their parenting/caregiving needs. • Patients felt their children were an active part of their rehabilitation. • This was facilitated and encouraged through a collaborative person centred approach. • Patients wanted more information/resources to facilitate conversations with their children about their illness/injury. • The findings highlighted some areas for further development (see recommendations). **Key Actions:** • Roll out of parenting resources. • Development of information session for staff to support roll out of resources. • Development of a child friendly information leaflet explaining role of community team. • Publication of service evaluation.
CMRN analysis of UKROC – 2013-2023	**Key Success** • Understand the pattern of patients and their outcome this will help us to plan the SMART goals for future patients. **Key Actions:** • No concerns identified. Further sub analysis of the data to understand the trend in each subgroup. • Ongoing collection of UK Rehabilitations Outcomes Collaborative (UKROC) data.

Neurosurgery clinical audits and service evaluations

Audit title	Actions
Cerebral Cavernomas Operative Indications	**Key Successes:** • Asymptomatic cavernomas: Out of 339 only 3 received surgical treatment, all of which were in a no-eloquent area as per guidelines. • Early resection of those presenting with seizures: 27 out of 167 cavernomas that presented with seizures were resected within 32.7 months. • Resection of brain stem cavernomas: 7 out of 96 brain stem cavernomas were resected. 3 had multiple haemorrhages and 4 had 0 to 1. **No key concerns or actions identified.**
Factors associated with morbidity and mortality following first cranioplasty	**Key Successes:** • This project identified that Porus polyethylene (acrylic) is highly protective against explantation. **No key concerns or actions identified.**
Use of venous thromboembolism (VTE) prophylaxis in elective and cranial neurosurgery	**Key Successes:** • VTE risk assessment completed on 222/223 (99.6%) of patients. • Mechanical prophylaxis given to 218/223 (97.8%) of patients. **Key Concerns:**

	• Pharmacological prophylaxis was prescribed inconsistently- 61/223 (27.3%). • One case of post-operative haematoma (patient did not receive pharmacological prophylaxis). **No actions identified at this time.**
A service evaluation to assess the need for a best supportive care clinic to follow-up High-grade glioma (Glioblastoma Multiforme) patients on best supportive care	**Key Successes:** • Patients were promptly reviewed in the multi-disciplinary team meeting (MDT) following initial referral. **Key Concerns:** • Only a third of non-treatable patients with newly diagnosed high grade primary brain tumours are being seen in clinic. • Communication between the MDT and the patient offering clinic review is poor. • Longer term survivors suggest an incorrect diagnosis who may benefit from further review. **Key Actions:** • Integrate a best supportive care clinic, led by specialist nurses, into the collaborative care pathways to enable patients from local healthcare service to receive specialized input, advice and care. This will also provide an opportunity for follow-up of patients with longer survival who may benefit from re-assessment. • Develop a local protocol that guarantees direct communication between Walton and the patient to inform them of the MDT best supportive care outcome and invites them to for clinic review. This can be achieved by including the clinic invitation to the MDT outcome letter and sending it to the patient, or by having neuro-oncology nurses make a documented phone call to the patient.
Fluid Balance	**Key Successes:** • Fluid balance charting was generally acceptable in the ward area and excellent in critical care. • Fluid balance charting was further improved when thorough ward round review took place. **Key Concerns:** • Poor fluid balance charting can be a patient safety concern when dealing with the neurosurgical patients as illness/ surgery can cause alterations and may result in unnecessary hypo and hyper perfusion of organs. Many neuro patients do not have the ability to regulate homeostasis, it is our job as clinicians to ensure this. • Subarachnoid Haemorrhage guidelines refer to maintaining euvolaemia which has been advised to improve outcomes, yet not all ward rounds review. • Despite teaching and guidelines on management of SAH, without accuracy, when there are clinical changes to the patient this vital information is not to hand and treating teams are not able to make rapid clinical recommendations/ management plans in the deteriorating patient without this assessment. This in turn may lead to unnecessary blood tests. • Fluid balance charting doesn't appear to be thoroughly embedded into the safety culture of the medical ward round and the nursing reviews as proven by the fact there was no improvement despite education and previous presentation of results at clinical audit, in the quality/accuracy of fluid balance

	charts being completed. Safety is now target driven rather than the culture meaning that to gain an improvement there is a plan for it to be added to regular audit. **Key Actions:** • Fluid balance charting now taught at preceptorship days. • Implement mandatory training online via power point presentation/Q+A. • Fluid balance charting added to the neurovascular study days to continue teaching. • Fluid balance charting compliance added to matron's spot audit. • Findings presented at Sharing and Learning.

Assessing Delayed Patient Discharge due to Delayed Completion of Discharge Letters	**Key Successes:**
	• A new system was created which involves the bed managers doing a daily round on the wards of the Walton Centre, asking the nurse in charge on each ward "who are the patient's due to be discharged tomorrow?". A list of names who are estimated to be discharged the next day is compiled and emailed to the SHO's every afternoon. Discharge letters are therefore completed and ready for the next day.
	• The audit showed that the proportion of earlier discharges increased after the new system was introduced:
	  • Discharges on the same day of the decision made by the medical team increased from 45% to 90%
	  • Discharges before 5pm increased from 50% to 65%
	• Bed managers did not find this additional role laborious, and it continues to be implemented.
	Key Concerns:
	• If the contents of the take home medications do get changed on the day of discharge (which very rarely happens) then an amendment needs to take place, and this can still delay a patient's discharge.
	No actions identified at this time.

Perioperative Modified-Release (MR) Opiates Stewardship	**Key Successes:** • All 391 spinal cases were followed up- most of this information could be collected from the medicines management system (JAC). Only 13 (14%) of patients were contacted over the phone. **Key Concerns:** • 35.5% of the patients who were sent home on MR opiates were newly started on these drugs postoperatively. • 35.5% of the patients sent home on MR opiates, got a repeat prescription by their GP. **Key Actions:** • A stop date was implemented on JAC when prescribing MR opiates post-operatively, if not intended for long-term use. • A note to GP is now completed if MR opiates are prescribed without a stop date and the patient is to be sent home on MR opiates.
Patterns of recurrence and growth following surgical resection of intracranial meningioma	**Key Successes:** • Only 5% of patients with a residual meningioma developed clinical symptoms due to regrowth of their tumour. • 50% of patients had significant growth (40%) at 5 years of follow

	up, however 84% of patients were successfully managed conservatively for this. **Key Concerns:** • Adjuvant radiotherapy being a significant predictor of progression of a residual tumour when this should reduce the incidence of progression. This is likely because adjuvant radiotherapy is administered to selected patients based on risk of tumour regrowth, rather than radiotherapy causing regrowth. **No actions identified at this time.**
Local Control of Brain Metastasis	**Key Successes:** • We are one of the largest treatment centres for brain metastases by volume in the UK with low complication rates and comparable local control rates to the international literature. • The tissue, imaging and now clinical annotation will be shared with the WRTB coordinator and provides a valuable resource for translational research projects. **Key Concerns:** • Decision making around which patients receive adjuvant therapy such as WRTB, local radiotherapy or cavity boost stereotactic brain surgery (SRS) remains tricky – would a brain metastases subsection of the MDT or a named brain metastasis clinical oncologist be helpful? Both ideas discussed at cancer services meeting. **Key Actions:** • Need for documented decision making around post-operative radiotherapy before undertaking surgery relayed at quarterly cancer services meeting.
Re-audit for consent for Posterior Lumbar Discectomy (2023)	**Key Successes:** • 71% visual loss mentioned in risks compared to 49% in first cycle of audit. • 62% major vascular injury mentioned in risks compared to 41% in the first audit cycle. **No key concerns or actions identified.**
Effectiveness of Erector Spinae Block for pain relief in Lumbar spine surgery	**Key Successes:** • There is not much data on the effectiveness of x-ray guided erector spinae block for pain relief. This audit evidenced that this is an effective method to control post op pain in patients undergoing lumbar spine surgery. **No key concerns or actions identified.**

Surgical Site Infection Audit (for Reduction of Surgical Site Infections using Novel Interventions (ROSSINI) trial workshop)	**No Key Successes Identified.**
	• Audit to support application for Reduction of Surgical Site Infections using Novel Interventions (ROSSINI-2) trial workshop.
	Key Concerns:
	• Numbers too small to discern infection risk related to:
	  • Skin closure material.
	  • Dural substitute.
	  • Tissue glue.
	• 2 of 17 oncology cases (12%) developed infection after radiotherapy.
	  • Wound drain was used in 2 cases (12%).
	  • Drains are not standard practice regionally.

	• Prophylactic antibiotics are the only standard of care in regionally. • Skin prep, drapes, drains, skin closure and dressings vary by surgeon. **No key actions identified.** Await outcome of grant application for clinical trial

Radiological outcome after single level anterior cervical discectomy and fusion (ACDF) using Titanium-C ® cage	**Key Successes:**
	At 1-year:
	• 25/41 patients (61%) demonstrated radiological evidence of fusion defined as 'complete trabecular bony bridging either posteriorly and/or anteriorly to the cage', while 16/41 patients (39%) demonstrated radiological evidence of incomplete fusion with incomplete bony bridging.
	• 20/41 patients (49%) demonstrated no evidence of cage subsidence into the superior or inferior end plates; 6/41 patients (14%) demonstrated evidence of probable/ minimal subsidence (i.e. <2mm); and 15/41 patients (37%) had evidence of clear subsidence in – the majority being into the superior endplates of the caudal vertebral bodies.
	• Median segmental Cobb angle did not change between pre-op and post-op imaging at 1-year (1-degree & 2-degrees kyphosis, respectively).
	• Pre-op and 1-year (or more) post-op Core Outcome Measures Index (COMI) data was available for 25/41 patients:
	  • Median neck pain improved from VAS 5/10 to 3/10 and arm pain improved from 7/10 to 4/10 at 1-year
	Key Concerns:
	• Implant-related complications were reported in only 3/41 patients (7%):
	  • 2 patients (5%) suffered anterior migration of the cage (20% & 25% cage anterior to disc space), which were managed conservatively:
	  • 1 patient (2%) required posterior cervical stabilisation due to cage subsidence and neck pain
	  • 2 patients (5%) required further posterior decompression due to ongoing cervical compression – unrelated to cage implant:
	  • 1 patient (2%) was required return to theatre within the year – unrelated to cage implant
	No key actions identified. Titanium-C cage model no longer stocked or in use locally.

A Specialist Pain Management Programme (PMP) for Young Adults: 10 Years On	**Key Successes:** • The implementation of a specialist PMP for young adults was well received by patients and has high efficacy. **Key Concerns:** • Staff need to review how outcome data is collected and prioritised to avoid incomplete datasets. • Online programmes are less preferable. **Key Actions:** • Liaise with assistant psychologist on rates of completion and patient reasons for not completing outcomes.
Neurodiversity in Children of Chronic Pain Patients	**Key Successes:**

	• Only 1.2% of clinic letters (n = 7) did not have the offspring's health documented – 98.8% of clinic letters documented offspring's health. • These preliminary numbers demonstrate that neurodiversity is much more prevalent if parents have specific primary chronic pain conditions (fibromyalgia and complex regional pain syndrome) compared to other chronic pain populations and the general population. **No key concerns or actions identified at this time.**
Anaesthetic Chart Documentation Audit	**Key Successes:** • Use of descriptive free text for airway management in the absence of appropriate airway grading system on our charts currently. **Key Concerns:** • Globally poor compliance with minimum documentation standards. **Key Actions:** • Inform department of poor compliance with minimum documentation standards and request better compliance. Departmental meeting 7th September. • Update airway management section to chart to be relevant to current VL use. Departmental meeting 7th September.
Tracheostomy Wound Infection in Intensive Care	**Summary of Findings:** • This demonstrates that the tracheostomy site infection rate was 20% over the 7-month period between 01.05.2022 – 30.12.2022. Of these 10 patients, 9 of them required antibiotics for the infection. • No definite cause of the increased tracheostomy site infection rate could be concluded from the data collected during this audit. • However, there were certain recommendations that were made to bring stoma care in line with best practice recommendations. This included carrying out and documenting tracheostomy stoma care twice daily whilst the patient remains on critical care. **Recommendations:** • Complete tracheostomy stoma care x2 daily whilst the patient remains on critical care and document appropriately on eP2.
Antibiotic prescribing for patients with ventilator associated pneumonia	**Key Successes:** • 100% adherence to starting antibiotics after sufficient time and reviewing them after 48-72hrs. • 93% of indications documented (n=1 for prescriptions without documented indication). • 85% of prescriptions as per formulary (prescriptions that were outside of the formulary were still deemed clinically appropriate). • 71% of prescriptions did not have a stop-date at time of prescribing, but all were stopped within 5 days. **Key Concerns:** • Clinical Pulmonary Infection Score (CPIS) not deemed useful to aid clinical diagnosis and prescriptions with CPIS <6 were still clinically indicated. • Only 14% of prescription switched from intravenous (IV) to oral/enteral administration, suggesting there is room for improvement for de-escalation of antibiotics.

	Key Actions: • Remove CPIS from antimicrobial formulary. • Circulate importance for IV to oral switch as per national guidance via Horsley bulletin.
Audit on practice of Total Intravenous Anaesthesia (TIVA) at WCFT	**Summary of Findings:** • 73 patients received TIVA during audit period at Walton centre. • Demographics: 53.4% male and 45.6% female • Used across all age groups, 55% between 51 and 70 years. • Indications for TIVA: Anaesthetists preference: 83.6%, Surgical requirement: 16.4%. • Only 41% documented TCI models. • Drugs used for TIVA included Propofol, Remifentanil, Dexmedetomidine, Ketamine and Alfentanil. Majority of anaesthetists used propofol and remifentanil. • Neuromuscular blockade used in 97.2% of cases, 70.8% only for induction. • Drug concentration was documented in 62% of anaesthetic charts. • Depth of Anaesthesia is monitoring was documented in 55% of the charts. • Processed electroencephalography (pEEG) monitoring was documented in 11% of the anaesthetic charts. • Total drug administered was documented in 10 of the anaesthetic charts. • Luer locker and anti-syphon valve use (documented): 5%. **Key Actions:** • Development of New TIVA guideline. • New TIVA checklist for trainees, to be included in trainee induction pack.
Horsley ITU compliances with guidelines for best practice for care of Naso-gastric tube (NGT) during enteral feeding and route for medication administration.	**Key Successes:** • Improvement in compliance. • NGT position at nose documented and which nostril- 100% compliance. • NGT position checked when starting feed and in same position- 100% compliance. • NGT position checked before administrating medication and in same position- 100% compliance. • NGT aspirate checked- 100% compliance. • Aspirate pH checked- 90% compliance. **No key concerns or actions identified at this time.**
How often is a high-risk paraneoplastic antineuronal antibody identified in a regional neurological centre?	**Key Successes:** • Detection rate for paraneoplastic antibodies (PNAb) in a regional neuroimmunology department has been determined, providing a crude baseline for the incidence of high risk PNAb in the Cheshire and Mersey region. • PNAb testing remains a vital investigation in neurology and also for the detection of cancer. **No key concerns or actions identified at this time.**
Evaluation of Borderline Anti-Glycolipid Results	**Key Successes:** • A high proportion of borderline anti-glycolipid results are associated with another abnormal related lab test, indicating that

	identifying the borderline results is of clinical value. Current practice of screening anti-glycolipid requests at 2 dilutions is supported by these results. **No key concerns or actions identified at this time.**
Evaluation of reflex testing for Immunoglobin M (IgM) immunofixation results 2022	**Key Successes:** • Most samples (93.3%) with new IgM paraproteins were also tested for anti-MAG (myelin-associated glycoprotein) and anti-glycolipid antibodies. • Most WCFT samples testing positive for anti-MAG were also tested for anti-glycolipid antibodies (86.6%) and serum protein electrophoresis (97.1%). • In the WCFT patient population, 48.3% of patients with an IgM paraprotein were found to have anti-MAG antibodies, which corresponds to published values of 40-50%; 20% of the remainder had anti-glycolipid antibodies, which is slightly lower than the published value of 1/3. **Key Concerns:** • Very few samples testing positive for anti-MAG or anti glycolipid antibodies had reflex tests added or recommended by the laboratory. **Key Actions:** • Disseminate findings at Neurobiochemistry Lab Meeting to remind laboratory staff to add tests/comments when reporting anti-MAG or anti-glycolipid assays.
A Clinical Evaluation of Positive Anti-N-methyl-D-aspartate receptor (NMDAR) Results	**Key Successes:** • Of the 3 patients diagnosed with anti- NMDAR, 2 were positive for anti-NMDAR. The negative patient only provided serum samples for anti-NMDAR testing, which may explain why there was no anti-NMDAR antibodies detected despite the anti-NMDAR encephalitis diagnosis. • Of the 20 patients diagnosed with other illnesses for which anti-NMDAR antibodies is not considered, 0 were positive for anti-NMDAR antibodies. **No key concerns or actions identified at this time.**

Quality of reporting muscle biopsies Audit 2022	**Key Successes:**
	• 100% compliance in recording of 86% of the data items in the muscle biopsy report as per the Royal College of Pathologists (RCPath) proforma.
	Key Concerns:
	• No major concerns identified.
	• The following observations were made:
	  • Date of biopsy data is available on the request card but not included as part of the current reporting template.
	  • Time to freezing is currently not recorded.
	  • One report with limited stain panel albeit appropriate panel did not state the reason why limited panel was performed.
	Key Actions:
	• Reporting template amended to include date of biopsy.
	• Lab staff are now recording data on the request card- SOP changed to reflect.

Neuroimmunology Vertical Audit 2023 - Autoimmune Encephalitis Panel	**Key Successes:** • 1 non-conformance was noted, indicating this is a well-functioning assay. • Request numbers appear to be rising, increasing the potential for more patients to be identified. **Key Concerns:** • Disparities were identified between the internet document and SOP for the Autoimmune Encephalitis Panel in terms of missing information: assay information requires more clarity, type and specimen could be more detailed and sample stability to inform service users. **Key Actions:** • Neuroimmunology website information to be updated.
Neuropathology Surgical Vertical Audit (2023)	**Key Successes:** • The specimen was handled in accordance with Trust and The Neuroscience Laboratory policies, procedures, and SOP's. • PDR's completed for all staff. • Records available for all reagents and all reagents acceptance tested. • Neuropathology report contained all relevant information. **Key Concerns:** • Essential information was missing from the request card. • The down flow bench was more than 3 months overdue servicing. • All equipment was more than 3 months overdue portable appliance testing (PAT) testing. • Bulk reagents (formalin, xylene and industrial denatured alcohol), although acceptance tested, are not traceable to when they are brought into use. **Key Actions:** • Annual horizontal audit to be undertaken on request card completion. Implementation of order communications. • Estates department to remove downflow bench servicing through Aintree contract and bring in house. • Estates to arrange PAT testing ahead of due date to ensure company can attend to perform before expiry date. • Implementation of a process to record the date bulk reagents are brought into use- SOP updated to reflect.
Specimen Acceptance Policy Horizontal Audit 2023	**Key Successes:** • 65/66 (98.5%) request forms and sample containers had the minimum patient information required to meet specimen acceptance criteria- equal to the previous year. • 74/95 (78%) of request forms and sample containers contained all essential information- a significant improvement on the previous year (32%). • 19% of forms had missing biohazard information- an improvement on the previous year (40%). **Key Concerns:** • 21/95 (22%) of requests forms were missing some essential information: • Potential biohazard- 19%

	• Consultant- 5% • Requestors signature- 3% **Key Actions:** • Electronic order communications requesting system to be implemented.
Research Consent forms Audit 2022	**Key Successes:** • 634/643 (98.7%) of consent forms complete and valid. **Key Concerns:** • 3/255 Liverpool Neuroscience Biobank at the Walton Centre (LNBW)- WRTB consent forms (1.1%) were not signed by the person taking consent. • 6/388 LNBW-Walton CSF Research Biobank (WRCB) consent forms (1.5%) were not signed by the person taking consent. • 5/255 LNBW-WRTB consent forms (2.0%) of the wrong colour copy received instead of the white copy (although still valid). • 13/388 LNBW-WRCB consent forms (3.3%) had been ticked instead of initiated. **Key Actions:** • Contact specialist nurses to retrospectively complete consent forms. • Contact theatre staff - disseminate reminder to submit white copy of consent form to LNBW. Blue for case notes, pink to patient.
Neurobiochemistry vertical audit 2023 – Serum protein electrophoresis	**Key Successes:** • The specimen was handled in accordance with Trust and The Neuroscience Laboratory policies, procedures, and SOP's. All documentation was in date. **No key concerns or actions identified at this time.**
Traceability Audit 2022	**Key Successes:** • 99% of cases were accounted for- an improvement on the previous audit (91%). • All post-mortem and CSF cytology cases accounted for. **Key Concerns:** • One block couldn't be located although referral information provided in a separate referral data base rather than on Laboratory Information Management System (LIMS) and a tracer on the file (Non-conformance raised). **Key Actions:** • Existing process for recording referrals reinforced at neuropathology meeting.
Research Consent forms Audit 2021	**Key Successes:** • 366/367 (99%) consent forms were complete and valid**.** **Key Concerns:** • 9/273 LNBW-WRTB consent forms (3.2%) were not signed by the person taking consent (Non-conformance raised). • 14/273 (5.0%) LNBW-WRTB consent forms of the wrong colour copy were received instead of the white copy (consent forms still valid). • 16/94 (16.9%) LNBW-WCRB consent forms had been ticked instead of initiated (consent forms still valid). **Key Actions:**

	• Specialist nurses contacted to retrospectively complete the consent forms. • Consent forms now checked upon arrival and weekly- issues to be addressed immediately. • Theatre staff contacted and reminded to submit white copy of consent form to LNBW, blue for patient notes and pink for patient as per protocol.
Anti-glycolipid Antibodies Clinical Audit 2022	**Key Successes:** • Concordance for the assay is 71%, indicating the assay is fit for purpose. **No key concerns or actions identified at this time.**
Cytology Vertical Audit 2023	**Key Successes:** • The specimen was handled in accordance with Trust and the Neuroscience Laboratory policies procedures and SOP's. All documentation was in date. • The request card was completed correctly by both clinical staff and laboratory staff. • All information for service users was up to date and readily available on the trust intranet. **No key concerns or actions identified at this time.**
Intraoperative Diagnosis versus Final Diagnosis 2022	**Key Successes:** • Diagnostic accuracy for intraoperative specimens reported in 2022 was 98.3% against a target of 93.6%. **No key concerns or actions identified at this time.**
Research Request Forms R2 & R3 Horizontal Audit 2022	**Key Successes:** • All samples were released with the correct respective forms and signed by either the designated individual or the person designated. **No key concerns or actions identified at this time.**
Research Ethics Committee (REC) & Regional Governance Committee (RGC) Approvals Audit 2022	**Key Successes:** • 28/28 (100%) had either had an REC or an RGC number present (or both) which could be found on the documentation/file in the Neuroscience Laboratories. **No key concerns or actions identified at this time.**
Coroner's and Hospital Post Mortems Horizontal Audit 2022	**Key Successes:** • Post-mortem tissue (wet tissue, blocks and slides) received in the Neuroscience Laboratories has been handled as per the Human Tissue Authority (HTA) standards and guidance. • All 16 cases had signed next of kin statement, and the final instructions were followed correctly and completed in a timely manner. • The post-mortem retention database is now in use and has been completed with all current tissue retained on site. This is updated each time a post-mortem case is retained in the department. **No key concerns or actions identified at this time.**
CSF cell count comparison audit 2021	**Key Successes:** • In 84% of cases, the CSF cell count results were consistent with each other and the clinical picture, independent of the site on which the sample was analysed. **Key Concerns:**

	• In 4 cases, a cell count result was out of consensus with other samples from the same patient. In 3 of these cases, the discrepancies could be explained by other factors. In the fourth there was insufficient data to determine whether the result was discrepant or part of an emerging trend. • In 17/68 (25%) of samples the results from Liverpool Clinical Laboratories (LCL) Microbiology appeared on TD-Web clinical reporting system as an "interim report", containing the cell count result but no culture results. **Key Actions:** • LCL IT department contacted to investigate the absence of culture results.
Quality of reporting muscle biopsies Audit 2023	**Key Successes:** • 100% compliance in reporting of 11/14 data set items. • Time to freeze (introduced following previous audit) reported in all but 1 case. **Key Concerns:** • Site of biopsy missing in 1/8 cases, date of biopsy missing in 2/8 cases. Request cards for muscle biopsies are completed by the neurology team and biopsies are performed at a later date, which may be why some cards had missing information. • Time to freeze was not recorded in 1 case at the time of freezing the muscle, the reason for not recording this information is not clear (non-conformance raised). **Key Actions:** • Disseminate findings at the Neuroscience Labs Audit Meeting and the Neuropathology Lab Meeting. • Discuss findings at the Neuromuscular Pathology MDT.
Audit of the accuracy of neuropathology reports 2022	**Key Successes:** • No major errors were detected. • None of the errors identified had an impact on the final diagnosis. **Key Concerns:** • An overall error rate of 9% was identified- the standard to be achieved is <5%, with no major errors where the report is unintelligible. **Key Actions:** • Consultants advised to carefully review reports prior to authorisation and use report templates where possible.

Trustwide clinical audits and service evaluations

Audit title	Actions
Consent to treatment audit 2021-22	**Key Successes:** • Correct consent form used and present in the patient note for 125 (100%) cases. • Consent form signed by patient/relative in 100% of cases. **Key Concerns:** • Where consent was signed by the patient/relative in advance, confirmation of consent was not signed on the day of the procedure in 27% of cases (19/70).

	• There was no evidence of the consent form copy being given to the patient/relative in 52/125 (41.6%) cases. • In 4 (3.2%) cases, the health professional taking consent did not sign the form. • In 1 case (0.8%), the intended risks/benefits of the procedure were not documented on the consent form. • In 108 (86.4%) cases the patient was not documented as having received an information leaflet about their procedure. • 21 (16.8%) cases did not evidence consent for the use of anaesthesia. **No key actions identified at this time.** Electronic Consent platform being rolled out to standardise consent process for all neurosurgical procedures.
7-Day Service	**Key Successes:** • 86/136 (63%) patients were seen by a consultant within 24 hours of admission. **Key Concerns:** • 84/136 (62%) of patients were not seen by a consultant within 14 hours of admission. • 18/136 (13%) of patients were not documented as having seen a consultant at any point during the admission. • 8/15 (53%) of patients were not documented as having twice daily review by a consultant while in critical care. **No key actions identified at this time.**

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

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

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

2.3.6 Participation in clinical research and development

There are currently 85 clinical studies open to recruitment at The Walton Centre, with a research pipeline of 18 new studies in the feasibility and/or set-up phase.

Overall, 1222 patients receiving relevant health services provided or sub-contracted by The Walton Centre in 2023/24 were recruited during that period to participate in research approved by a research ethics committee and Health Research Authority. Although no yearly recruitment target was set for this financial year, this is a 16% increase from the number of patients recruited in the previous financial year.

Encouraging a research-positive culture among all staff is essential for diversifying the research portfolio and ensuring that research is meaningfully embedded in the experience of patients and service users.

We will continue to review and enhance research quality systems while working towards external accreditation for our quality management system so that we can continue to provide assurances to stakeholders on the quality of research being delivered.

During 2023/24 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 - Joint Research Office
- Innovation Agency, the North West Coast's Academic Health Science Network
- North West Coast Collaboration for Leadership in Applied Health Research and Care (NWC CLAHRC) now the ARC (Applied Research Collaboration)
- Local Higher Education Institutions
- Spinal Network
- Stroke Network
- Other NHS organisations
- Pharmaceutical companies (industry)

2.3.7 CQUIN framework and performance

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2023/24 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.

The CQUINs we focused on throughout the reporting period were:

- Flu vaccinations
- Supporting patients to drink, eat and mobilise (DrEaMing) after surgery
- Prompt switching of intravenous to oral antibiotic
- Recording of National Early Warning Score 2 (NEWS2) for unplanned critical care admissions
- Achieving high quality shared decision making (SDM)
- Assessment and documentation of pressure ulcer risk assessments

A proportion of the Trust's income in 2023/24 was conditional upon achieving quality improvement and innovation goals. The total payment received against the CQUINs in 2023/24 was £1,467,873.

2.3.8 Care Quality Commission (CQC) registration

The Trust is required to register with the Care Quality Commission. Its current registration status is registered without conditions for the Health and Social Care Act 2008. The trust is fully compliant with the registration requirements of the CQC. The CQC has not taken any enforcement action against The Walton Centre during 2023/24.

In February 2024, the CQC announced a new approach to the assessment . The new framework retains the 5 key questions and the 4 point ratings scale. They will assess services against quality statements replacing our key lines of enquiry (KLOEs), prompts and ratings characteristics. The trust is registered for the new online assessment process.

At the last CQC inspection of the trust in 2019, we were rated as 'outstanding' overall and achieved 'good' in the well led domain. The actions arising from this have formed the basis of an improvement plan agreed by the board which was monitored by the Quality Committee until actions were complete or had become part of business as usual and was then closed off during 2022/2023. The full report is available on the CQC website https://www.cqc.org.uk/provider/RET.

The Trust continues to ensure that the requirements set out within the Health and Social Care Act (Regulated Activities) Regulations 2015 are being met and annual assurance that the trust is fully compliant is provided to the Audit Committee. The Trust is fully compliant with the registration requirements of the CQC.

The Trust meets regularly with the CQC to discuss its performance, quality of care and patient experience.

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 2023/24 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:

- 99.8% for admitted patient care
- 99.9% for outpatient care

The percentage of records in the published data which included the patient's valid Registered GP Practice was:

- 100% for outpatient care
- 99.9% for admitted patient care

This year is the seventh year of the new Data Security and Protection Toolkit. The toolkit is an online tool that enables organisations to measure their performance against data security and information governance requirements which reflect legal rules and Department of Health policy. Within the toolkit there are 34 assertions and 108 mandatory evidence items.

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

The Trust is on target to meet all assertions and mandatory evidence items for the Data Security and Protection Toolkit, which is due to be submitted to NHS Digital on 30 June 2024. This deadline was extended in line with Covid-19 and will now remain as the new submission date for future years.

The Trust has implemented action plans to aim to achieve another high score on the new Data Security and Protection Toolkit and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessments undertaken as part of the mandated 2023/24 Data Security and Protection audit requirements is currently ongoing throughout February and April 2024 and the Trust will then receive the outcome of this review in May 2024.

The Walton Centre was not subject to the Payment by Results clinical coding audit during 2023/24 by the Audit Commission.

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

The Walton Centre Internal Clinical Coding Audit 2023/24

Coding Field	2020/21	2021/22	2022/23	2023/24	Difference 22/23 - 23/24	Mandatory	Advisory
Primary diagnosis	91.00%	96.70%	97%	95%	-2%	90%	95%
Secondary diagnosis	86.00%	94.14%	95%	91%	-4%	80%	90%
Primary procedure	97.00%	99.40%	98.5%	99%	+0.5%	90%	95%
Secondary procedure	98.00%	93.87%	96%	93%	+3%	80%	90%

The Walton Centre maintained the Advisory level for the DPSP Audit.

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 2023/24, 116 of The Walton Centre's patients died. This can be broken down by the following number of deaths which occurred in each quarter of that reporting period:

- 20 in the first quarter
- 34 the second quarter
- 30 the third quarter
- 32 the fourth quarter

By 31 March 2024, 99 case record reviews had been carried out in relation to 116 of the deaths included in item 2.3.10.1. Seventeen case records are awaiting review.

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

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

Note: During the first quarter 4 deaths were investigated jointly with referring hospitals and were unavoidable deaths. In the second and fourth quarters we are awaiting the outcome of two coroners inquests.

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

In relation to each quarter, this consisted of:

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

Note: The figures above may change once we receive the outcomes of the coroners inquests.

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

0 case record reviews and zero investigations completed after 31 March 2023 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.

Following a recent coroners report 1 patients death was reported to have been due to post-operative complications. This patients admission was in 2022, however the report was received in January 2024.

2.3.11 Progress in implementing clinical standards for seven day hospital services

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

Prior to Covid the Trust made steady progress with CS2. In the seven-day service audits from 2016-2019 the overall rate of compliance improved from 50% to 79%. The compliance rate at the weekends in the audits have consistently been high, demonstrating a consultant presence for review throughout seven days. As a specialist Trust there has been discussion with the seven-day services team regarding difficulties that arise for us with this standard. Post-covid there have not been formal audits, but the practice remains in place and will be audited during 2024.

All patients who are transferred to The Walton Centre will have been seen and assessed in their local hospital, will usually have had investigations such as scans, and in neurosurgery admissions (which are the vast majority) the diagnosis will usually be clear.

All admissions are discussed with a consultant prior to transfer and a management plan is formulated. There is a two-tier middle grade on-call system in neurosurgery so there is always a senior trainee on-call. In some cases, there is a clear plan for the patient on arrival and assessment by a senior trainee is considered clinically appropriate. Also, all patients admitted as an emergency will be initially assessed by a member of our MDT SMART (Surgical and Medical Acute Response Team) team, which consists of medical staff and outreach /critical care trained nursing staff.

Therefore, the differences in the service will reflect some difficulty with compliance with this standard in all patients, but there remains the aim to reach the target of 90%.

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

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

There is an MDT ward round for all neurosurgery and critical care patients. This comprises medical, nursing, Advanced Practitioners (AP) and pharmacy staff. The SMART team join the ward round at weekends.

In neurology there is a weekday daily board round involving medical, nursing, pharmacy and therapy staff.

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

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

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

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

Quality improvement: The Trust mortality report is reviewed as per the cycle of business by Quality Committee and reported to Trust Board. The Trust Board receives a quarterly report from the Guardian of safe working hours on junior doctor working hours.

2.3.12 Speaking Up

We have established a robust framework for promoting a culture of openness and transparency through its Freedom to Speak Up process.

Information on the key roles and structures within the FTSU framework is below:

- **Executive Lead for FTSU**: The Chief Nurse serves as the Executive Lead for FTSU, demonstrating the Trust's commitment to fostering an environment where staff feel empowered to raise concerns without fear of reprisal. As a senior leader, the Chief Nurse plays a pivotal role in championing the FTSU agenda and driving organisational change to support a culture of speaking up.
- **Non-Executive Director Speak Up Champion**: Having a Non-Executive Director dedicated to serving as a Speak Up Champion underscores the importance of FTSU at the governance level. This individual provides oversight and strategic direction for FTSU initiatives, ensuring that the board remains informed and engaged in promoting a culture of openness and accountability.
- **Freedom to Speak Up Guardian**: Our FTSU Guardian plays a vital role in ensuring the safety and well-being of staff within the Trust. By completing the National Guardians Office training and participating in networking meetings and conferences, she stays informed about best practices and developments in the field. As a Quality Manager within the senior nursing team, she has a comprehensive understanding of healthcare standards and regulations, allowing her to effectively address any issues related to staff welfare and patient care quality. This dual role demonstrates her commitment to promoting a culture of openness, safety, and accountability within the Trust. The FTSU Guardian serves as an independent and confidential resource for staff to raise concerns or seek advice about FTSU matters. This role provides assurance to staff that their concerns will be listened to and addressed appropriately, further fostering trust in the FTSU process.
  The FTSU Guardian is actively involved in promoting a culture of speaking up and addressing concerns. She presents to both clinical and non-clinical staff during their induction and ensures colleagues are aware of the role and how to contact her if needed. Attending the junior doctors forum with the Guardian for Safe Working confirms how she supports all colleagues, regardless of their level or experience.

  Providing colleagues with business cards containing contact details for raising concerns and offering the flexibility of arranging meetings on or off-site offers accessibility and confidentiality, which are crucial aspects of fostering trust in the reporting process.

  Presenting Speak Up reports to the Trust Board at least three times a year, along with an Annual Report, underscores the accountability and transparency of the Trust in addressing staff concerns. This regular reporting ensures that concerns are being reported to the highest levels within the Trust which promotes a culture of continuous improvement and safety.

- **Speak Up Champions**: The network of twenty Speak Up Champions plays a crucial role in promoting and supporting the FTSU process at the grassroots level. The diverse team of individuals serve as advocates for speaking up, providing guidance and signposting to policies, teams, departments, and support services available to staff. Their presence helps to normalise speaking up and encourages staff to raise concerns in a timely and constructive manner.

Providing multiple channels for staff to speak up demonstrates a commitment to accessibility and confidentiality, which are essential for fostering an open and safe work environment. A confidential email address allows employees to raise concerns discreetly, while a dedicated section on the Trust intranet site provides comprehensive information on speaking up, including guidance on how to do so, who to contact, and what to expect after speaking up. This section of the intranet also includes information about the FTSU Guardian and Champions, their pledges, and contact details where colleagues can easily identify who they can turn to for support and guidance in addressing their concerns.

Offering various avenues for communication and support, we encourage colleagues to speak up without fear of detriment and facilitate the prompt resolution of issues. Offering support services outside of the usual team or line management routes, such as the FTSU service, staff members have additional resources to turn to for assistance and guidance within the Trust such as Equality, Diversity and Inclusion Team, Unions, HR, Occupational Health, and Anti-Fraud Specialists, demonstrates a holistic approach to supporting staff members with diverse needs and concerns. This approach ensures that employees have access to the appropriate support channels tailored to their specific situation, whether it involves issues related to workplace culture, health and well-being, employment rights, or ethical conduct.

Additionally, empowering staff to raise concerns externally if they feel it necessary further reinforces the Trusts commitment to accountability and transparency. This demonstrates a willingness to address issues even if they extend beyond the confines of the Trust, ultimately contributing to a culture of trust and integrity.

Scheduling drop-in sessions throughout the year across different areas within the Trust provides opportunities for staff to engage with the FTSU Guardian and Champions and seek support or guidance in a convenient and accessible manner. Holding sessions within the Health & Wellbeing Hub twice per month for varying durations and times of day further enhances accessibility, accommodating colleagues' schedules and needs of staff members.

Regular contact from the FTSUG following a colleagues decision to speak up is crucial for several reasons. First and foremost, it demonstrates our commitment to addressing concerns and ensuring that progress is being made towards resolution. This ongoing communication helps to keep the individual or team informed about the status of their concern and provides reassurance that it is being taken seriously.

Regular check-ins serve as a safeguard against any potential detriment that the person or team who raised the concern may face. By maintaining open lines of communication, the FTSUG can promptly address any issues or obstacles that arise during the resolution process, thereby mitigating the risk of retaliation or negative consequences for the individual or team involved.

Establishing the above roles and structures within the FTSU framework, we demonstrate our commitment to creating a culture where staff feel empowered to raise concerns and contribute to continuous improvement in patient care and organisational practices. It also ensures that support mechanisms are readily accessible to staff at all levels, promoting psychological safety and enhancing overall staff well-being.

2.3.13 NHS Doctors in Training

The Trust typically has around 52 Health Education England (HEE) trainees on rotation, adhering to the Terms and Conditions for NHS Doctors and Dentists in Training (England) 2016. Some trainees may not participate in out-of-hours duties and are considered supernumerary for training purposes.

If we have a gap for daytime duties only it will not have a detrimental effect on patient care as they are supernumerary to the workforce and primarily focused on training.

When a trainee is essential for out-of-hours rotas and there's a gap in daytime duties, the Trust will arrange for Locally Employed doctors, agency locums, or internal locum cover until a replacement can be recruited through NHS Jobs.

The Trust employs Clinical Fellows to bolster the trainee workforce and support both elective and emergency work. Rotation periods are monitored by the Medical HR Manager and Clinical and Divisional Managers, who take action to recruit additional doctors if needed.

There have not been any exception reports regarding recruitment gaps. The Guardian of Safe Working reports directly to the Trust Board as per the cycle of business. Any exception reports usually involve breaches in minimum rest requirements, which are addressed through time off in lieu and payment.

This framework ensures that staffing levels are maintained to uphold patient care standards while also providing adequate training opportunities for medical professionals.

Part 3 Trust overview of quality 2023/24

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2023/24.

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 Trust.

Patient Safety Indicators						
Trust acquired	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**	**National trajectory**
C Difficile	5	3	8	7	11	6
MRSA Bacteraemia	0	0	0	0	0	0
E. coli	13	7	11	12	10	10
MSSA	5	13	10	11	8	10
Klebsiella	3	6	5	5	4	3
Pseudomonas	1	3	2	2	3	1
Minor and moderate falls	37	19	30	31	27	n/a
Never Events	1	0	2	0	1	n/a
Data Source: Infection Prevention and Control NHSE Set following review of previous years' performance using NHSE national calculation						

Clinical Effectiveness Indicators					
Mortality	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Neoplasms	13	7	8	15	12
Diseases of circulatory system	36	52	23	43	46
Injury, poisoning and certain other consequences of external causes	29	27	24	37	41
Diseases of the nervous system	9	15	7	13	14
Other	6	10	2	4	3
Total	93	111	64	112	116
Data Source: Patient Administration System					

Patient Experience Indicators					
Patient experience questions	**2019/20**	**2020/21**	**2021/22**	**2022/23**	**2023/24**
Were you involved as much as you wanted to be in decisions about your care and treatment?	95%	89%	89%	Much Better (8.1)	Available Sept 2024
Overall, did you feel you were treated with respect and dignity while you were in the hospital?	99%	99%	93%	Better (9.5)	Available Sept 2024
Were you given enough privacy when discussing your condition or treatment?	94%	84%	99%	About the same (9.6)	Available Sept 2024
Did you find someone (hospital staff) to talk to about your worries & fears?	82%	93%	93%	Better (8.4)	Available Sept 2024
Data Source: CQC Adult Inpatient Survey					

The overall experience scored Much Better at 8.9%

3.1 Complaints

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

The Walton Centre's Patient and Family Experience Team (PFET) is dedicated to ensuring that patients and their families receive support and assistance throughout their healthcare journey. Offering a confidential support and advice service can greatly alleviate the stress and anxiety that often accompanies hospital visits. Providing multiple channels of communication, such as telephone, email, and in-person appointments, shows a commitment to accessibility and patient centred care.

This proactive approach to addressing enquiries, concerns, and complaints demonstrates a commitment to improving the overall patient experience and ensuring that patients feel supported and heard throughout their interactions with the Trust.

The Walton Centre's Patient and Family Experience Team takes concerns seriously and strives to address them promptly and effectively. By providing support in managing and resolving complaints via the formal procedure, the team ensures that even more serious or sensitive issues are handled with care and attention.

A total of 119 new complaints were received in 2023/24, along with 9 re-opened complaints, representing a decrease compared to the previous year where 138 complaints were received.

The Divisional split for complaints was Corporate (4), Neurology (76) including cross-divisional *complaints with neurosurgery and/or corporate divisions, and Neurosurgery (56).

Complaint Outcomes for Closed Complaints:

- 17 complaints were upheld requiring action/learning.
- 14 partially upheld, some aspect of the complaint was upheld.
- 59 not upheld, no action or learning was required.
- The remainder of complaints are under investigation.

Acknowledging and incorporating feedback and learning from complaints is crucial for continuous improvement in service delivery. Clearly explaining the actions taken and how they will lead to improvements demonstrates accountability and transparency, which are essential for maintaining trust with patients and their families.

Respecting the diversity of families and acknowledging that a family member isn't always a blood relative reflects a commitment to inclusivity and sensitivity to individual circumstances. Seeking consent from the patient before investigating concerns or complaints shows respect for their autonomy and ensures that their wishes are prioritised throughout the process. This approach fosters a culture of collaboration and partnership between patients, their families, and the healthcare providers, ultimately contributing to a more patient centred care environment.

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

- PET continue to listen to feedback, act and support patients thereby effectively resolving enquiries and concerns before they escalate to formal complaints.
- Participated in staff de-briefing sessions facilitated by Cheshire & Mersey Rehabilitation Network following the management of challenging relatives to listen to staff feedback and provide input on the improvements required on managing future complex cases including early intervention from Patient Experience Team.
- Provide bi-monthly detailed assurance to Trust Board by presenting complaints data/trends and analysis, divisional controls and mitigations and updates on patient experience activity to the Executive Team.
- Our home from home relatives' accommodation is for family members who need urgent accommodation following an admission for urgent care or treatment and in the last year support has been provided to >250 families during their most difficult times.
- The volunteering team continues to develop by recruiting new volunteers and introducing new roles, these include Mobile Trolley service, expansion of current sweets n treats trolley to include Sid Watkins, Volunteer Trained to deliver Reader Group Sessions to commence in June 2024 to deliver a reading group to patients in our rehabilitation ward. In addition, two volunteers involved in supporting the Exercise in the Community Project and are acting as a patient's voice to support our mental health services by providing feedback and liaising with our Mental Health Clinical Nurse Specialist .
- As part of the Trust's NHS 75th Birthday celebrations and two volunteers were interviewed on BBC Radio Merseyside to share their experience of volunteering at The Walton Centre.

- In October 2023, the Trust recruited three Patient Safety Partners (PSPs) in line with the implementation of the Patient Safety Incident Response Framework (PSIRF) to involve lay people to influence and improve governance and leadership of safety within NHS organisations. Each Trust is required to have at least two representatives to sit on relevant governance committees to support compliance monitoring and how safety issues should be addressed. We recruited three volunteer PSPs who have diverse experience of being ex-NHS staff members, volunteers and patients were recruited in October 2023 and as volunteers the relationship is based on a mutually agreed expectation of the role. All have now been assigned to appropriate groups including Quality & Patient Safety Group, Patient Experience Group, Falls Steering Group, Patient Information Group and Lived Experience Group Panel. This will provide the PSPs with a variety of engagement and involvement in line with their interests and the Trust with assurance of involvement in patient safety projects. Following networking with local Trusts, next steps include expanding the roles to include the feasibility of involvement in clinical audit and other platforms including Learning & Sharing and Infection Prevention Committee.
- Facilitated internal annual engagement listening events in partnership with Healthwatch to gain and act on feedback provided from patients and groups who represented them, and feedback presented via the Patient Experience Group in May 2024.
- Continue to work in partnership with the Communications and Marketing Team to arrange a patient story for the monthly Trust Board meeting either in person or via MS Teams from each of the different service lines. For completeness, following a board story from a relative of a patient with learning disabilities, they were invited and participated on the interview panel for the new learning disability nurse.
- Acted upon feedback from CQC National Inpatient Survey the launch of the Shh Campaign – Sleep helps healing launched to reduce noise at night , and all wards were provided with sleep packs including eye mask, ear plugs, leaflet, and sole use earphones for TVs.
- Mock Inquest held with >50 attendees to support clinicians in what to expect should they be required to attend an inquest.
- Engagement and attendance at off-site patient support groups including MND and Parkinson's disease to seek feedback and share with Clinical Director with the aim of improving the care and services provided to patients and their families.
- Re-launched the Patient and Family Centred Care steering group in partnership with the Quality Service Improvement Team to ensure the 6 steps to PFCC framework are integrated into the 6i's of improvement as the Trust strives to work towards a culture of quality improvement. As part of our overall improvement plan across our ward areas family rooms are being refurbished to enhance the environment and facilities available to patients and visitors. A project is near completion to introduce a low sensory room on Chavasse Ward to help minimise sensory stimulation and promote calmness and relaxation for patients with hyper-sensory needs. The room will use neutral and non-contrasting colours and soft furnishings including a beanbag for relaxation, there are plans to expand this onto Jefferson ward for patients with additional needs including those with learning disabilities.

- Plans are underway to implement a patient diary for patients during their recovery from a subarachnoid haemorrhage. This is to support patients make sense of their inpatient time as this can often be a long and frustrating progress. The diary will help fill in the gaps in memory enabling them to chart progress in their recovery to reflect on the achievements they have made and set goals and structure to support self-help for recovery. It is aimed to have a diary prototype by end of May 24 and following implementation the plan is to survey patients after 6 months to monitor the impact of the project.
- To improve Friends and Family Feedback, the methodology for capturing feedback is in the development stage to progress to SMS messaging and voice messaging for those who do not have a mobile phone number on record. This will include all discharges to provide real time feedback and all outpatients including those who attend satellite clinics hosted by The Walton Centre which are not currently captured. This is planned to be rolled out by the end of May 2024.
- Text message appointment reminders for both new and follow up appointments was launched to provide patients with timely reminders of their upcoming appointments with the aim of improving communication pathways and reduce missed appointments.
- Patient representatives with long-term conditions including Parkinson's Disease, Motor Neurone Disease and Muscular Sclerosis were include in the Neuroscience Programme Board to provide feedback on services and future plans.
- After two days of assessments in August 2023, the Trust achieved its Navajo Merseyside & Cheshire LGBTQIA+ Charter Mark reaccreditation for a further two years. The mark reflects our commitment to equality, diversity and inclusion for our patients and staff.
- A new Transgender Patient Policy was developed with input from Genderspace UK for patients, families, and staff. input from to ensure appropriateness and respecting lived experience, to provide guidance for staff and support patients and their families as well as staff. Following further discussions with our LGBTQIA+ Staff Network and staff across the Trust, the policy is now being revised to include further definition and inclusive language. In addition to this, information, and resources in relation to trans inclusion, including specific guidance relating to healthcare settings has been shared with all Trust staff.

3.1.2 Complaints management and lessons learnt

Collaborating with Neurosurgical, Neurology Divisions, and Corporate teams to investigate and manage complaints demonstrates a holistic approach to addressing patient concerns. By working together, the Patient and Family Experience Team can leverage expertise from various departments to thoroughly investigate complaints and develop tailored solutions that meet the needs of each individual patient or family member.

Undertaking local resolution meetings in patients' or family members' preferred places, including their homes, shows a commitment to accessibility and personalised care. This approach acknowledges that each patient's situation is unique and may require different considerations for resolution.

Meeting patients and families in familiar environments, the team can create a more comfortable and supportive atmosphere for discussions, which may lead to more effective problem-solving and a higher likelihood of reaching mutually satisfactory outcomes.

Overall, this collaborative and personalised approach reflects a commitment to patient and family centred care and demonstrates the team's dedication to addressing complaints in a thorough, empathetic, and effective manner.

Every enquiry, informal concern and formal complaint is given careful triage and consideration in line with the best process to reach a resolution for patients and families.

We have a thorough process in place for addressing concerns and complaints from patients and their families. Offering multiple channels for communication and providing options for response formats, such as telephone calls, emails, or letters, the Trust is prioritising accessibility and flexibility for those reaching out with concerns. Additionally, the involvement of the Patient and Family Experience Team (PET) shows our commitment to ensuring that patient perspectives are heard and addressed effectively.

The inclusion of formal complaint responses from the Chief Executive demonstrates a top-down commitment to accountability and transparency. Offering meetings with senior clinical and operations teams further emphasises the seriousness with which we take feedback and its dedication to resolving issues at all levels.

The regular joint divisional meetings involving the Patient and Family Experience Team and Divisional Management Teams demonstrate a proactive approach to problem solving and accountability. The use of a Live Complaints Tracker ensures that complaints are actively monitored, and that progress is documented transparently. The emphasis on documenting progress and ensuring that outstanding actions are followed up on until closure shows our continuous improvement. Discussing outstanding actions at relevant divisional governance meetings, the Trust ensures that accountability is maintained at all levels of management.

The involvement of the Chief Nurse and/or Medical Director in quality reviewing draft responses before they are reviewed by the Chief Executive highlights the importance placed on ensuring that responses are comprehensive and reflect of our commitment to addressing concerns effectively.

We are committed to not only addressing individual complaints but also to analysing trends, themes, and lessons learned from these experiences. Reporting outcomes from complaints monthly to Divisional and Ward Managers, as well as Risk and Governance committees, the Trust ensures that there is awareness and accountability at various levels of management.

Documenting trends, themes, and lessons learned within executive reports and patient experience reports on a regular basis provides valuable insights for ongoing improvement efforts. Presenting these reports to the Quality Committee and externally at Specialist Commissioners meetings demonstrates transparency and a willingness to share learnings with stakeholders both within and outside the Trust.

The real time escalation of any identified trends in subject, operator, or area of concern to the Executive Team offers a proactive risk management approach which enables continuous improvement.

Reporting and discussing complaints with the Executive Team as part of the bi-monthly Patient Experience Update Report is a crucial step in ensuring transparency and accountability at senior level. These reports ensure the Executive Team can stay informed about the management process and gain assurance that actions are being addressed in a timely and effective manner. This process also allows colleagues to stay informed about any emerging concerns or escalations that may require their attention. This approach helps ensure that complaints are not viewed in isolation but are instead integrated into the Trusts broader efforts to enhance patient satisfaction and outcomes. Complainants are kept informed and updated throughout the process by regular contact from the team which ensures that complainants are aware of the progress being made and feel supported throughout the resolution process.

Utilising the feedback from those who have used the complaints process to improve and shape the services provided is a proactive approach to quality improvement. Listening to the experiences and suggestions of complainants, the Trust can identify areas for enhancement and make meaningful changes to better meet patient needs and expectations.

Recording compliments received on Datix and sharing positive patient feedback at the daily Safety Huddle not only recognises the efforts of the team but also reinforces a culture of appreciation and continuous improvement. It highlights the importance of providing excellent support to complainants and acknowledges the impact of their feedback on shaping our services.

The examples below highlight our proactive approach to addressing concerns raised through complaints and implementing meaningful improvements to enhance patient care and safety:

Management of Patients with Midlines:

- Reviewing the process for managing patients with midlines following discharge demonstrates a commitment to improving continuity of care.
- Enhancements to communication and advice provided to patients post-discharge can help prevent misunderstandings and promote better outcomes.
- Amending practices to ensure appropriate length insertion of midlines reflects a focus on patient safety and reducing potential complications.

Escalation Process for Deteriorating Patients:

- Implementing a "Call for Concern" process for relatives to contact SMART directly in cases of deteriorating patients indicates a proactive approach to addressing urgent concerns.
- This escalation process can lead to faster intervention and potentially prevent adverse outcomes for patients.

New Bite Block Standard Operating Procedure (SOP):

- Implementing a new SOP for bite blocks demonstrates a commitment to standardising procedures to enhance patient safety during certain medical interventions.
- These standardised procedures can help reduce the risk of errors and improve overall quality of care.

Improvements in Communication with Families:

- Enhancing communication with families of inpatients ensures that important discussions are clear, accurate, and sensitive to their needs.
- Clear communication can alleviate anxiety and improve trust between healthcare providers and families, contributing to a more positive patient experience.

Bowel Monitoring Documentation:

- Frequent auditing of bowel monitoring documentation reflects a commitment to maintaining comprehensive records for effective patient care.
- Accurate documentation is essential for tracking patient progress and identifying any potential issues or trends.

Nurse Training for Intermittent Self-Catheterisation:

- Reviewing nurse training for intermittent self-catheterization and improving training materials and education indicates a commitment to ensuring that staff have the necessary skills and knowledge to provide safe and effective care.
- Enhanced training can lead to better patient outcomes and reduce the risk of complications associated with this procedure.

These examples demonstrate a culture of learning and continuous improvement within the Trust, where feedback from complaints is used as an opportunity to identify areas for enhancement and implement meaningful changes to improve patient care and safety.

3.1.3 Complaints activity

We use feedback from patients, families, and carers who have used the complaints process. This patient and family centred approach not only demonstrates a commitment to transparency and accountability but also emphasises the importance of involving patients and their loved ones in improving the care and services provided.

Keeping complainants informed during the investigation process with regular contact from members of the Patient and Family Experience Team is a crucial aspect of maintaining trust and ensuring that complainants feel heard and supported throughout the resolution process. This proactive communication helps to manage expectations, provide updates on progress, and address any concerns or questions that may arise along the way.

The Local Authority Social Services and NHS Complaints (England) Regulations 2009 outline a two-stage complaint process involving local resolution by NHS bodies and referral to the Parliamentary Health Service Ombudsman (PHSO) if the complainant remains dissatisfied. The Trust's complaints policy prioritizes local resolution to prevent concerns from escalating unnecessarily. Since 2009, national timescales for complaint responses have been replaced with NHS providers agreeing on response timeframes. At the Walton Centre, complaints are graded upon receipt as Level 1 (respond within 25 working days), Level 2 (within 45 working days), and Level 3 (within 60 working days) in accordance with the policy guidelines. The annual report details the numbers of complaints and concerns, the response timeframes, and outcomes in line with Trust KPIs. Highlighting key themes and trends with actions identified to address.

A total of 119 formal complaints were received in 2023/24, which represents a decrease compared to the previous year's total of 138 in 2022/23. In addition, 949 concerns were received which is an increase from the previous year's total of 831 in 2022/23.

Furthermore, in addition to concerns 492 contacts requesting advice or support or general hospital inquiries from The Patient Experience Team (PET) were received and responded to.

Complaints received 1 April 2023 – 31 March 2024

	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Number of new complaints received	19	27	34	39

The top four areas of complaints which were trends for 2023/24:

- Diagnosis/Treatment
- Values and behaviours
- Communication
- Appointments

Focusing on individual outcomes that patients and families seek when raising concerns is a fundamental aspect of person and family centred care. It shows a commitment to understanding and addressing the specific needs and expectations of each individual, rather than applying a one-size-fits-all approach to complaint resolution.

Acknowledging all complaints and agreeing on the best way to address concerns with patients and families demonstrates respect for their perspectives and input. Managing expectations is also crucial in ensuring that patients and families understand the process and potential outcomes of their complaints, which can help alleviate anxiety and foster trust in our commitment to addressing their concerns.

Collaborating with other NHS trusts to investigate joint complaints further underscores a commitment to partnership working and a holistic approach to patient care. Highlighting concerns related to care received within The Walton Centre as part of joint complaints, we recognise the importance of a coordinated approach and the importance of addressing issues that may impact patient outcomes across different settings.

3.1.4 Duty of candour

The Trust fully acknowledges its duty of candour which supports one of its core values of openness. Incidents which fall under the requirements of the regulation are identified through the weekly scrutiny of the Datix Risk Management system and discussed at the weekly safety meeting and biweekly Patient Safety Incident Review Group (PSIRG). We have fulfilled the duty of candour and achieved 100% compliance via an audit.

To fulfil the duty of candour, you must apologise for the harm caused, regardless of fault, as well as being open and transparent about what has happened. NHS Resolution is the organisation that manages clinical negligence claims against the NHS.

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

3.2 Local engagement – Quality Account

The Walton Centre has made significant strides in ensuring that its Quality Account is robust and reflective of various perspectives. By actively engaging with stakeholders, including staff, local health economy representatives, Healthwatch organisations, and charities such as The Brain Charity, the Neuro Therapy Centre, and Headway, the hospital is fostering a culture of collaboration and inclusivity. This approach not only enhances transparency but also helps in identifying areas for improvement and ensuring that the services provided meet the needs of patients and the community. Building strong relationships with stakeholders is crucial for maintaining trust and continuously evolving to meet the ever changing healthcare landscape.

Engaging with Governors in a forward planning event is a proactive approach to ensure alignment and collaboration on quality initiatives within the Trust. Involving Governors in discussions about quality indicators for the upcoming year, the Trust can benefit from their diverse perspectives and insights. This not only fosters transparency and accountability but also ensures that the chosen indicators reflect the priorities and values of the Trust as a whole.

3.3 Quality Governance

Implementing a Quality Governance framework was a crucial step in ensuring that we uphold high standards of quality and governance. By designing such a framework, The Trust is demonstrating its commitment to promoting and supporting good practice in quality governance within its operations.

The strategy which we introduced covering the years 2022 to 2025 reflects the dynamic nature of the healthcare landscape, particularly with the challenges posed by the COVID-19 pandemic and the changes brought about by the Health and Social Care Bill 2021. This forward-looking strategy acknowledges the need for adaptation and innovation to meet evolving demands and seize opportunities for improvement.

Outlined within this strategy are plans to expand services, innovate, conduct research, and develop further. These initiatives underscore the Trust's dedication to enhancing patient care, advancing clinical knowledge, and contributing to the broader healthcare ecosystem. Additionally, the focus on developing services across regions and expanding national neuroscience services highlights a commitment to both local communities and broader national healthcare priorities.

Setting out key initiatives and priorities for the next three years, the Trust provides clarity and direction for its stakeholders, ensuring alignment and focus on common goals. This strategic approach not only fosters organisational growth but also strengthens the Trust's ability to deliver high-quality, patient and family centred.

Our strategy aligns with national, regional and local system plans, including acute and primary care services, along with the voluntary and third sector, linking in with the Cheshire and Merseyside ICS place-based plans and those of One Liverpool, North Wales, and across Merseyside.
Involving a diverse range of stakeholders in the development of the strategy shows our approach that fosters ownership, inclusivity, and alignment with the needs and priorities of the broader community. Engaging staff from across the Trust, patients, carers, voluntary sector organisations, support groups, Governors and members, representatives from partner trusts, primary care, and the Integrated Care System (ICS), ensures that the strategy reflects a comprehensive understanding of the perspectives and interests of various stakeholders.

The positive engagement from staff and stakeholders reflects a shared commitment and passion for the mission and vision of The Walton Centre. This collective dedication not only strengthens organisational culture but also enhances trust and collaboration among stakeholders.

Continuing to listen and engage with stakeholders even after the strategy's development demonstrates a commitment to ongoing improvement and responsiveness to evolving needs and circumstances.

Overall, this collaborative and inclusive approach to strategy development and implementation reinforces The Walton Centre's commitment to patient and family centred care, continuous improvement, and partnership working within the broader healthcare ecosystem.

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

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

Underpinning these ambitions are seven enabling strategies:

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

3.4 Key Achievements

- **Doctor become Professor of Pain Medicine at the Institute of Life Course and Medical Sciences**

Professor Andreas Goebel, Consultant in Pain Medicine at The Walton Centre, attained a professorship at the University of Liverpool, after demonstrating substantial progress in research into causes and new treatments for chronic primary pain.

- **The opening of a new Staff Wellbeing Hub to support staff within the Trust**

A new Staff Wellbeing Hub was opened at The Walton Centre which provides a dedicated space where staff can retreat from their work environment, access resources, and take time for themselves which is invaluable in promoting mental and emotional well-being.

Offering a comfortable and relaxing environment acknowledges the importance of creating a positive workplace culture that prioritises the needs of staff members. Providing access to resources, such as mental health support services or wellness programs, the hub can serve as an area for self-care and professional development.

- **Consultant Neurologist Professor elected into Academy of Medical Sciences Fellowship**

Professor Tony Marson became a fellow of the Academy of Medical Sciences. This is a significant recognition of his outstanding contributions to biomedical and health research, as well as his dedication to advancing the field of neurology.

As a Consultant Neurologist and Professor of Neurology at the University of Liverpool, Professor Marson has undoubtedly made substantial contributions to both clinical practice and academic research. His expertise and leadership in the field of neurology have undoubtedly had a positive impact on patient care and the broader medical community.

- **Liverpool Philharmonic announces partnership with The Walton Centre**

The partnership between Liverpool Philharmonic and The Walton Centre NHS Foundation Trust, supported by The Walton Centre Charity and the Foyle Foundation, is a fantastic collaboration aimed at enhancing the health and well-being of patients, families, carers, and staff at The Walton Centre.

Using music as a therapeutic tool to improve the lives of individuals with neurological and neurosurgical conditions demonstrates an innovative and holistic approach to healthcare.

- **Brain tumour patients benefit from improved NHS collaborations**

NHS Trusts across the North West have worked together to improve the process for people diagnosed and treated for a brain tumour following a visit to A&E. More and more partners are onboarding with a view to improving the patient pathway and reducing pressures on A&E in exceptionally challenging times.

- **Innovative video system ensures vulnerable patients receive outstanding care**

The implementation of an innovative camera system on Lipton Ward, the hyper-acute rehabilitation unit, is a noteworthy development that underscores a commitment to providing outstanding care to vulnerable patients.

This camera system offers several benefits, such as enhanced monitoring capabilities, improved safety measures, and increased efficiency in patient care. By utilising advanced technology, healthcare professionals can closely monitor patients' conditions, promptly identify any changes or concerns, and intervene as necessary.

- **UK first for charitably funded rehab table at The Walton Centre**

We were the first NHS Trust in the UK to utilise an innovative 'tilt table' for patients in need of immediate rehabilitation, made possible through the support of The Walton Centre Charity's incredible fundraising campaign.

- **Spinal implants arrive at The Walton Centre net zero in a bid to improve sustainability**

Staff from The Walton Centre, alongside implant manufacturers Abbott UK, cycled nearly 120 miles to deliver medical implants carbon neutrally. Starting in Solihull, the team transferred the spinal cord stimulators to The Walton Centre for use in future procedures.

- **Cutting-edge neurosurgery revealed in extraordinary national documentary series**

The Walton Centre featured in a fascinating national documentary series about neurosurgery and trauma. In 'Trauma Room One' viewers saw patient stories from cutting-edge robotic spinal surgery to urgent stroke interventions, all led by leading staff at the specialist hospital.

- **UK’s biggest pain management service celebrates 40 years of supporting people with chronic pain**

The Walton Centre NHS Foundation Trust’s Pain Management Programme (PMP) has reached the incredible milestone of 40 years of service delivery.

- **The Cheshire and Merseyside Rehabilitation Network celebrates ten-year anniversary**

Professionals from a number of different backgrounds gathered at The Walton Centre in November to celebrate ten years of the Cheshire and Merseyside Rehabilitation Network (CMRN).

- **Neurosurgical team hits 100 case milestone in robotic spinal surgery**

Achieving the milestone of 100 complex spinal operations using innovative robotic surgery is a remarkable feat for the top neurosurgeons at The Walton Centre. This achievement highlights their expertise, dedication to patient care, and commitment to leveraging cutting-edge technology to improve surgical outcomes.

❖ **Awarded the Laser Interstitial Thermal Therapy for Epilepsy (LITT)**

The Trust was one of only two centres in the country to be awarded the Laser Interstitial Thermal Therapy for Epilepsy (LITT) service for adults and the only centre in the north of England. LITT is a minimally invasive treatment which the Trust will establish in 2024/25 for patients with focal refractory epilepsy, where open surgery is not appropriate.

❖ **Spinal service re-accredited as Centre of Excellence**

The spinal service at The Walton Centre was re-accredited this year as a Surgical Spine Centre of Excellence (SSCoE) from EUROSPINE following an in-depth review process. The Trust was initially awarded this accreditation in 2019.

❖ **Achieved Silver under the Ministry of Defence Employer Recognition Scheme**

The Trust has achieved Silver under the Ministry of Defence Employer Recognition Scheme for our commitment and support to Defence and the wider Armed Forces community. The Employer Recognition Scheme was launched to recognise employers who support Defence People objectives and encourage others to do the same. This includes employing serving and former members of the Armed Forces community and demonstrating flexibility towards training and mobilisation commitments for Reservists and Cadet Force Adult Volunteers.

❖ **Investors in People (IIP) Gold Status**

Following our reaccreditation assessment for our Investors in People standards (Investors in People and Investors in Wellbeing), we retained Gold. By meeting these standards, we have shown that our staff have created a great culture at The Walton Centre, that enables people to achieve their best, and facilitates outstanding patient care.

❖ **National Preceptorship for Nursing Quality Mark**

Following an intense application for the National Preceptorship Quality Mark we were successful and have been awarded the Quality Mark.

3.5 Overview of performance in 2023/24 against national priorities from the Department of Health's Operating Framework

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

Performance indicator	2021/22 performance	2022/23 performance	2023/24 performance	2023/24 Target
Incidence of MRSA	0	0	0	0
Screening all inpatients for MRSA	97.94%	97.38%	No longer collected	95%
Incidence of Clostridium difficile	8	7	11	11

All cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery	100%	94%	100%	100%
All cancers: 62 days wait for first treatment from urgent GP referral to treatment	100%	N/A	100%	85%
All cancers: Max waiting time of 31 days from diagnosis to first treatment	100%	100%	100%	96%
All cancers: Two week wait from referral date to date first seen	100%	99.5%	100%	93%
All cancers: 28 Day faster diagnosis	98.75%	98.97%	100%	70%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	N/A	N/A	NA	N/A
Maximum six week wait for diagnostic procedures	0.30%	0.37%	0.54%	1%
Certification against compliance with requirements regarding access to health care for people with a learning disability	Compliant			

3.6 Overview of performance in 2023/24 against NHS Outcomes Framework

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

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

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

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

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

During 2023/24 The Walton Centre provided and/or sub-contracted six relevant health services. These were neurology, neurosurgery, pain management, rehabilitation, spinal surgery and clinical neurophysiology.

3.7 Indicators

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

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

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

2. **Percentage of patients on care programme approach:** NOT APPLICABLE

Rationale: The Trust does not provide mental health services

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

Rationale: The Trust is not an ambulance trust

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

Rationale: The Trust is not an ambulance trust

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

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

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

Rationale: The Trust does not perform these procedures

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

Response:

Year	No. of readmissions	% of inpatient discharges readmitted
2020/21	139	4.25%
2021/22	201	4.56%
2022/23	210	4.40%
2023/24	213	4.54%
Change 2022/23 - 2023/24	+3	0.14%

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 will largely be 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:

- Readmission rates and causes monitored quarterly to identify themes.
- 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:

Our patients who were inpatients in November 2022 were surveyed in February 2023 and results published by the CQC in October 2023. Below are some of the highlights of the report:

- The CQC rated the Walton Centre as Better than Expected for 2022 Inpatient Survey.
- The Trust scored fell in the Top 5 trusts in the Region for all 11 areas of the survey and was scored Better than expected in 10 out of the 11 areas.
- The Trust's highest score was for 'Respect & Dignity' at 9.5/10.
- The Trust remained the same for 18 questions compared to last year and did not score any worse for any of the questions which is an improvement from 2021.
- The Trust scored 8.9/10 for overall patient experience, with the national score being 9.2.

The questions had slightly changed for the 2021 survey and the CQC benchmark methodology to provide Trusts with more detailed results and the scores were categorised as:

- Much better
- Better
- Somewhat better
- Same
- Much worse
- Somewhat worse

National Inpatient Survey question	2019 Result	2020 Result	2021 Result	2022 Result	2022 National Comparison	2023 Result
1. Were you involved as much as you wanted to be in decisions about your care?	About the same	89% Better	Better	Much Better (8.1)	7.8	Results available Sept 2024
2. Did you find a member of hospital staff to talk to about your worries or fears?	About the same	93% Better	Somewhat Better	Better (9.5)	7.5	Results available Sept 2024

National Inpatient Survey question	2019 Result	2020 Result	2021 Result	2022 Result	2022 National Comparison	2023 Result
3. Were you given enough privacy when discussing your condition or treatment?	Slightly worse	84% Better	Somewhat Better	About the same (9.6)	9.5	Results available Sept 2024
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	Better	92% Much Better	Better	This question was not asked in the 2022 survey, therefore, is not comparable		
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	Better	91% Much Better	About the same	Better (8.8)	7.5	Results available Sept 2024

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

Friends & Family Test (FFT)

The annual average response rate for inpatients was 53.24% with a recommendation rate of 98.35%, while for outpatients had a response rate of 6.5% with a recommended 98.35%.

In an aim to increase both response and recommendation rates together with capturing real time feedback, the Trust are currently undertaking a project with their current provider to initiate SMS feedback and voice message feedback for those who do not have a mobile phone number. This will provide real time feedback for key people to monitor response/recommendation rates in their area and directly receive both negative and positive feedback. It is planned for this to go-live by the end of May 2024.

Patient and family experience initiatives

The practice of presenting patient, family, and staff stories to the Trust Board and other committees is incredibly valuable for fostering empathy, understanding, and continuous improvement within the Trust. Sharing lived experiences in various formats, such as verbal readings, live video links, or recorded videos, we ensure that the voices of those directly impacted by healthcare services are heard and respected.

These stories offer a firsthand perspective on the successes, challenges, and areas for improvement within different service lines, allowing decision makers to gain insights into the real life experiences of patients, families and staff. Whether the content is positive, negative, or indifferent, each story provides valuable feedback that can inform quality improvement efforts and shape strategic decisions.

Presenting stories in their own words allows for the authentic expression of emotions, concerns, and perspectives, which can have a powerful impact on those listening.

Noise at Night Campaign:

- Successful launch of the Noise at Night campaign, providing sleep packs to all wards with essential items like eye masks, earplugs, and sole-use earphones for TVs to promote restful sleep and patient comfort.
- Noise ears implemented in all areas following successful charitable funds bid.

Continuous Feedback Collection:

- Commitment to continuously collate feedback from patients, families, and carers to understand their needs and priorities, aligning with CQC guidance on focusing on what matters most to people.
- Implementation of patient and family shadowing with students.

Ward Enhancements and Refurbishments:

- Refurbishment of family rooms across ward areas to enhance the healing environment and facilities for patients and visitors.
- Introduction of a low sensory room on Chavasse Ward and plans to expand to Jefferson Ward to support patients with hyper-sensory needs and learning disabilities.

Specialised Support Rooms:

- Refurbishment of a side room on Cairns Ward to specifically support young adults with cancer diagnoses and photophobia symptoms, creating a more inviting and less clinical environment.

Patient Diaries for Recovery Support:

- Implementation of patient diaries for patients recovering from subarachnoid haemorrhage to aid in memory retention, track progress, reflect on achievements, and set recovery goals.
- Redesigned patient diaries for ITU patients to include unit information, equipment details, and diagrams to serve as a reflective tool post-discharge.

Text Message Reminders for Appointments:

- Launch of text message reminders for both new and follow-up appointments to improve communication pathways and reduce missed appointments.

Feedback Mechanisms:

- Initiating a project to introduce SMS and voice message feedback for Friends and Family Tests demonstrates a commitment to gathering feedback in accessible ways and using it to improve the patient experience.

Engagement with External Stakeholders:

- Participation in events with organisations like Healthwatch Sefton and attendance at support groups like MND Liverpool and Parkinson's Support Group demonstrate a commitment to listening to the community and understanding their needs.

Training Development:

- The development of bi-annual training for the Cheshire and Merseyside Rehabilitation Network indicates a dedication to enhancing the skills and knowledge of healthcare professionals to provide better care.

Policy Development:

- Collaborating with Genderspace UK to develop a policy for transgender, non-binary, and gender-fluid patients shows inclusivity and responsiveness to the diverse needs of the patient population.

Representation and Support:

- Representation of Patient and Family Experience staff on various Trust staff network groups, such as LGBTQ+ and Disability Group, ensures that diverse perspectives are considered in decision-making processes.

Patient Safety Partners:

- Recruiting Patient Safety Partners and supporting their involvement in committees and groups reflects a commitment to patient safety and involving patients and families in quality improvement efforts.

Improving Family Experience:

- Updating the Home from Home Welcome Pack and introducing new feedback mechanisms through QR codes and welcome letters demonstrate a focus on enhancing the experience for families of patients.

Volunteer Recruitment and Engagement:

- Recruiting Trust volunteers for community exercise and wellbeing initiatives and involving family representatives in committees like the End of Life Committee underscores a commitment to involving the community in various aspects of care delivery.

Inclusive Recruitment Practices:

- Involving family members in the recruitment process for specific roles, such as recruiting a family member of a patient with learning disabilities for the LD nurse position, promotes inclusivity and ensures that the perspectives of those directly affected are considered.

Establishment of Steering Group:

- The formation of a new Patient and Family Centred Care Steering Group highlights a structured approach to prioritizing patient and family centred care initiatives and driving organisational change.

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

Response:

The Trust had a response rate of 38.3% (581 staff) for the 2023 national staff survey. The national average for acute specialist trusts in England for 2023 was 54%.

It's encouraging to see improvements in the percentage of staff who would recommend the Trust as both a place to work and a place to receive treatment. These increases reflect positively on the organisation and suggest that efforts to enhance the staff experience and quality of care are being recognized and appreciated by employees.

Recommendation as a Place to Work:

- With a recommendation rate of 72.31% for the reporting period which is an increase from the previous year which stood at 70.18% demonstrates our commitment to providing a positive work environment for staff. The national average for 2023/24 was 71.12%.
- A higher recommendation rate indicates that employees are satisfied with their workplace culture, colleagues, leadership, and overall experience, which can contribute to staff retention, morale, and engagement.

Recommendation as a Place to Receive Treatment:

- Achieving a recommendation rate of 89.9% for patients is also commendable, reflecting positively on the quality of care and services provided by the Trust.
- The increase from the previous year's score in 2022/23 of 86.5% surpasses the national average of 87.82% indicates that patients are satisfied with the care they receive and would confidently recommend the Trust to others seeking treatment.

These results not only highlight the Trust's dedication to providing high-quality care and a supportive work environment but also underscore the importance of staff satisfaction and patient experience in delivering excellent healthcare services.

The findings for 2023 are arranged in the form of People Promises. There are seven people promises, plus two themes:

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

The Trust scored higher than average or average in all elements of the NHS People Promise with the exception of “we’re always learning” which scored average but was an improvement on last year’s score and has improved consistently since 2021.

Staff engagement

Staff engagement is measured across three sub scores:

- Motivation
- Involvement
- Advocacy

The Trusts overall score for staff engagement is similar to last year's score at 7.3 (7.4 in 2022) and is the same as the average score.

Morale

Morale is measured across three sub-scores:

- Thinking about leaving
- Work pressure
- Stressors

The Trusts overall score for morale improved from last year's score of 6.2 to 6.3 and is above the average of 6.2.

Implementing quarterly People Pulse surveys alongside the annual staff survey demonstrates a proactive approach to monitoring staff sentiments and wellbeing throughout the year. These surveys provide a more frequent and regular opportunity to assess staff perceptions and satisfaction levels, allowing us to identify trends, address emerging issues, and make timely improvements.

The focus on assessing staff likelihood to recommend The Walton Centre as both a place to work and a place to receive treatment aligns with the Trusts commitment to promoting a positive workplace culture and delivering high-quality patient care. By measuring staff willingness to recommend the Trust, the surveys capture important indicators of staff engagement, satisfaction, and trust in The Walton Centre.

The use of these surveys as a "temperature check" helps gauge the overall health of the Trust and can inform targeted interventions or initiatives to address specific areas of concern or improvement. Regular feedback allows for prompt adjustments to strategies, policies, or practices, ensuring that we remain responsive to the evolving needs and expectations of its workforce.

The April 2023 People Pulse survey results indicate that a significant majority of staff who completed the survey would recommend The Walton Centre to friends and family if they needed care or treatment, with 84.6% expressing a positive likelihood to recommend. This suggests a strong level of confidence and satisfaction among staff regarding the quality of care and treatment provided by the Trust. Results for staff recommending The Walton Centre as a place to work to friends and family was 57.5%.

The July 2023 People Pulse survey results continue to indicate a strong likelihood among staff to recommend The Walton Centre to friends and family if they needed care or treatment, with 75.6% expressing a positive recommendation. While this score is slightly lower than the April 2023 results, it still reflects a significant majority of staff who are confident in the quality of care and treatment provided by the Trust. Similarly, the results show that 57.8% of staff who completed the survey would recommend The Walton Centre as a place to work to friends and family which remains relatively consistent with the April 2023 results.

The January 2024 People Pulse survey results indicate a continued strong likelihood among staff to recommend The Walton Centre to friends and family if they needed care or treatment, with 83.7% expressing a positive recommendation. This percentage reflects a high level of confidence and satisfaction among staff regarding the quality of care and treatment provided by the Trust, which is consistent with previous survey results.

Additionally, the results show an improvement in the percentage of staff who would recommend The Walton Centre as a place to work to friends and family, with 67.3% expressing a positive recommendation. This increase from the previous survey indicates progress in enhancing the workplace experience and improving staff satisfaction and engagement.

Workforce Race Equality Standard (WRES)

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

- Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months. This score has decreased from 2022 for both white staff and all other ethnic groups.
- Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months. This score has decreased from 2022 for both white staff and all other ethnic groups.
- Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. This score has decreased by over 8% for white staff and increased by 11% for all other ethnic groups.
- Percentage of staff experiencing discrimination at work from manger/team leader or other colleagues in the last 12 months. This score has decreased from 2022 for both white staff and all other ethnic groups.
- 554 white staff responded to the survey and 37 staff from other ethnic groups.

Workforce Disability Equality Standard (WDES)

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

- Percentage of staff experiencing harassment, bullying or abuse from patients/service users, relatives or the public in the last 12 months. This score has decreased for staff with or without a long-term illness (LTC).
- Percentage of staff experiencing harassment, bullying or abuse from managers in the last 12 months. This score has decreased by 7% for staff with a LTC and has increased for staff without an LTC.

- Percentage of staff experiencing harassment, bullying or abuse from colleagues in the last 12 months. This score has decreased by 4% for staff with a LTC and has increased slightly for staff without an LTC.
- Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it. This score has decreased for both groups of staff.
- Percentage of staff who believe that their organisation provides equal opportunities for career progression or promotion. This score has decreased for both groups of staff.
- Percentage of staff who have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties. This score has decreased by 7.6% for staff with an LTC and decreased by 3,21%for staff without an LTC.
- Percentage of staff satisfied with the extent to which their organisation values their work. This score has decreased for both groups of staff.

479 staff without an LTC responded to the survey and 120 staff responded with an LTC.

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

- Collaborating with Staff side and staff through various engagement sessions demonstrates a commitment to involving employees in the improvement process and ensuring their voices are heard. This collaboration is intended to increase survey participation and scores for the 2024 survey.

Formulating a Trust action plan and Divisional action plans, to be approved by the People Group, underscores a structured approach to addressing the identified challenges and implementing targeted initiatives for improvement.

10. Patient experience of community mental health services: NOT APPLICABLE

Rationale: The Trust does not provide community mental health services

11. Percentage of admitted patients risk-assessed for venous thromboembolism: APPLICABLE

Response:

YEAR		Q1	Q2	Q3	Q4
2019/20	The Walton Centre	98.79%	98.97%	98.85%	98.58%
	National Average	95.63%	95.47%	95.33%	Suspended
2020/21	The Walton Centre	95.35%	98.17%	98.08%	97.94%
	National Average	Suspended	Suspended	Suspended	Suspended
2021/22	The Walton Centre	99.03%	98.7%	98.44%	98.6%
	National Average	Suspended	Suspended	Suspended	Suspended
2022/23	The Walton Centre	98.44%	98.43%	98.69%	98.88%
	National Average	Suspended	Suspended	Suspended	Suspended
2023/24	The Walton Centre	95.96%	96.77%	97.59%	95.28%
	National Average	Suspended	Suspended	Suspended	Suspended
Note: National average figures were suspended due to COVID 19					

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

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

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

- For any VTEs that do occur for inpatients at The Walton Centre a rapid review is triggered to be undertaken. These reviews are conducted by the medical team which allow for a comprehensive assessment of patient care, treatment, and interventions applied. Identifying any lapses in care or delivery issues is crucial for continuous improvement. Actions are taken promptly to address any practice issues that may arise. Additionally, informing patients fully about any harm that has occurred aligns with the duty of candour process, fostering transparency and trust between healthcare providers and patients.
- A working group will be established to comprehensively review the VTE prevention process at the Trust. This group will review the VTE policy to ensure it aligns with the latest evidence and best practices. A revision of the risk assessment will also be undertaken to ensure we accurately identify patients at risk of VTE and implement appropriate preventive measures.

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

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

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

	2018/19	2019/20	2020/21	2021/22	2022/23	2023/24
The Walton Centre	13.7	9.5	7.81	17.48	13.43	23.85

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

- In 2023/24 The Walton Centre had a total of 11 C. difficile infections against the trajectory set by NHSE/I of six. Although this is disappointing this is in line with both the regional and national picture.

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

- Implementation of a single “proactive action plan” to deliver year two of the Infection Prevention and Control (IPC) Framework.
- We successfully achieved level three Global Antimicrobial Stewardship Accreditation Scheme (GAMSAS) to demonstrate we have strong antimicrobial stewardship.
- Use of technology e.g. Hydrogen Peroxide Vapour (HPV) and UV machine to support environmental cleanliness.
- We will continue work on the digital HCAI surveillance programme.

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

Mersey Internal Audit Agency (MIAA) undertook an audit of the Infection Prevention and Control Board Assurance Framework. The overall objective of the audit was to provide assurance that systems and processes are in place to accurately report performance against the Trusts key performance indicators.

It was noted that an updated IPC board assurance framework (BAF) was expected and the Trust were given limited assurance with the following recommendations:

- The Trust needs to formally define the committee management and oversight of the IPC BAF with appropriate reporting lines to the Trust Board either in corporate policy/procedures or through terms of reference and standing agenda items. The assigned committee should ensure that the IPC BAF is reviewed formally in line with a schedule and is updated to reflect ongoing assurance reports the committee receive.
- The Trust need to ensure that there is a robust action planning process linked to the IPC BAF. Action owners and timescales need to be identified where gaps in assurance are documented. Where gaps in compliance have been identified from IPC audits linked to the IPC BAF, a clear and robust action planning process needs to be embedded at an operational/divisional level. These gaps/actions need to be reported to the appropriate committee where oversight of the IPC BAF is maintained. Evidence to demonstrate implementation of actions should be provided to the committee with day-to-day oversight [of the IPC BAF] to ensure the IPC BAF assurance.

All recommendations were implemented and evidence provided to MIAA

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

Response:

In 2023/24 1194 incidents occurred against 50,564 bed days this equals 23.61 incidents per 1000 bed days.

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

- Implementation of the new national Patient Safety Incident Response Framework in September 2023 has resulted in a raised awareness with regards to patient safety incidents. Level 1 patient safety training (Trust wide), Level 2 patient safety training (Health Care professionals' band 6 and above) and Levels 3-5 patient safety training (Senior Health Care professionals) has contributed to the raised awareness.
- Compliance with the new Learn from Patient Safety Events (LFPSE) system
- Improved incident reporting across the Trust because of raised awareness through ongoing monthly incident training, Governance newsletters, Patient Safety newsletters and Patient Safety alerts.
- Improved timeliness of incident investigation

- Introduction of the new investigation tools including the patient safety incident decision tools, swarm huddles, patient safety incident investigation and after-action reviews.
- Improved timeliness of implementation of actions identified following investigation.

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

- Continuing to investigate incidents utilising the Patient Safety Incident Response Framework.
- Continue with Datix incident reporting training across the Trust.
- Conduct a review of Risk Management systems available, to explore available alternatives or upgrades to improve the mechanisms for reporting of incidents and reporting of themes and trends.

The Trust will continue to:

- Discuss all investigations at the relevant meetings to ensure the sharing of learning Trust wide.
- Conduct investigations where required.
- Continue to share the Governance newsletters, Patient safety newsletters and Patient safety alerts.
- Improve the reporting of incidents through discussions at the Trust safety huddle and Trust wide incident training sessions.
- Improve the reporting of incidents and investigation utilising the Patient Safety training levels 1-5.

14. Serious Incidents and Never Events

During 2023/24 there were a total of 4 serious incidents compared with 6 in 2022/23.

There was 1 never event reported during 2023/24 and zero during the previous reporting period.

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

The Trusts Commissioners are liaised with frequently during investigations, with all of the 4 incidents reported during 2023/24 investigated within the appropriate timescales set out within our Incident Reporting Policy.

All 4 incidents reported during 2023/24 complied with the requirements of Duty of Candour

To note as of 1st September 2023, the Serious incident framework was replaced by the Patient Safety Incident Response Framework. Dual reporting to LFPSE and StEIS was in place up until the end of April 2024. StEIS will cease to exist from May 2024.

Annex 1

healthwatch Liverpool

The Walton Centre Foundation Trust 2023-24 Quality Account commentary

Healthwatch Liverpool welcomes the opportunity to comment on the 2023-24 Quality Account for the Walton Centre. We base our commentary on this report, and relevant feedback and enquiries that we receive throughout the year.

In January 2024 we carried out an in-person listening event at the Trust, speaking with inpatients and their visitors on various wards. The feedback we received was very positive, especially about the staff and the treatment received. People we spoke to awarded the Trust a high average 'star rating' of 4.8 out of 5, with 5 being the highest possible.

Over the years the Trust has consistently had better than average feedback from the CQC (Care Quality Commission) national annual inpatient survey, and we look forward to seeing the results from the 2023-24 survey which will be published in September 2024.

It was pleasing to note the Trust has learned from patient feedback in the survey and has taken steps to help patients get a better night sleep by implementing the 'shh' campaign.

Many of the quality priorities that the Trust had set itself for 2022-23 were achieved including the patient experience outcomes, although none of the patient safety priorities. We note that despite the ongoing work to combat this, the number of hospital acquired pressure ulcers was very slightly up compared to the previous year but welcome the reduction in CAUTI infections, although it was below the target the Trust had set itself. It is unfortunate that only limited progress was made on the low stimulation room due to building work, but we look forward to hearing of it being fully used in the year ahead, and whether it can lead to a reduction of incidents on the ward.

The priorities for 2024-25 include reducing 'Did Not Attend' appointments (DNAs). Sending patients text reminders about upcoming appointments is a common-sense approach and is likely to reduce the number that are missed.

We also welcome the establishment of a Lived Experience Panel. We were pleased to learn that the Trust has been engaging with patient organisations such as the Motor Neurone Disease Association, as patients and relatives are the experts in deciding what is important to them, and it can lead to improved patient care. Having patient representatives with various long-term conditions included on the Neuroscience Programme Board is another positive step.

The report contains comprehensive information about the audits that the Trust has taken part in, including some of the discussions taking place, lessons learnt and actions taken. The audit information provided is often highly clinical and not always comprehensible to lay readers, but the overview appears to show that there is a lot of valuable work which can assure and improve patient safety and care. Positive outcomes included an increase in timely discharges for patients.

However, the audit information also shows that some patient care issues, e.g. what happens after patient falls and handing out time-specific medication are areas that have needed more attention.

Although most safety metrics remained stable or showed a slight decrease, we noted there was an increase in C-difficile infections. The report explains the actions the Trust aims to take to improve on this.

Providing 7-day consultant cover appears to need more work, although the report states that there are no trends showing worse patient outcomes linked to this. We understand that providing 7-day cover may be more difficult to fulfil for a smaller trust compared to larger, non-tertiary trusts.

There have been pressures across the system for cancer referral and treatment times, so we were particularly pleased that the Trust had a 100% rate against these indicators.

As the Trust covers a wide geographical area the ‘Home from home’ accommodation that is available to some families is a thoughtful, welcome and obviously well-used initiative.
We also feel that implementing a patient diary for patients who are recovering from a subarachnoid haemorrhage is a positive initiative. If the review shows that this has had a good impact on patient experience we would welcome the roll-out of this to other patients with relevant conditions.

The previous year’s report mentioned the Trust was to provide staff training to support patients who have difficulties communicating. We would have welcomed some feedback about how many staff received this training and whether it has led to better patient experience and outcomes.

In terms of working towards the equity of services, we were pleased that the trust had its Navajo kitemark renewed, and that it collaborated with relevant organisations and staff to develop a policy for transgender, non-binary and gender-fluid patients.

The report provides several clear examples of where complaints have led to improvements, which should encourage patients and relatives to make complaints where they feel a change is necessary.

There are lots of positive achievements from the past year mentioned in the report, and we are confident that The Walton Centre will continue to achieve many positive milestones. We look forward to our continuing engagement with the Trust in the year ahead.

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05 June 2024

SENT VIA EMAIL

To: Ms Nicola Martin - Chief Nurse. The Walton Centre NHS Foundation Trust and Charity, Liverpool.

Re: Quality Accounts 2023 - 2024.

Dear Ms Martin,

I am writing on behalf of NHS Cheshire and Merseyside, who, along with NHSE/I Specialist Commissioning had the opportunity to jointly comment on the Walton Centre Foundation Trust Quality Account for 2023-24. Partners express their thanks for the Quality account presentation that was delivered to Cheshire and Merseyside commissioners for 2023–2024 on Friday 17th May 2024.

NHS Cheshire and Merseyside recognise the pressures and challenges for the organisation and the local health economy in the last year. The Trust affirmed the continuing outstanding CQC rating.

We note the priorities, key achievements and progress made in 2023–2024:

1. The improvement in the organisation of staff agreeing The Walton Centre is the place to work.
2. The Walton Centre continues to be a Centre of excellence.
3. All CQUINS were achieved apart from Staff influenza – this was seen across Cheshire and Merseyside providers.
4. The acknowledgement of a 16% increase in clinical research.
5. Silver MOD awareness has been achieved by the Trust, as well as Spinal service accreditation as centre of excellence awarded.
6. The Trust had identified 10 priorities – achieved 5, 4 had not, 1 currently awaiting the outcome. One of the not achieved was Urinary Tract Infection which did see UTI reduction but not reached the target. Pressure Ulcer target was not achieved but it was acknowledged staff absence was a contributary factor.
7. The Management plan is now embedded to review priorities.
8. The Sepsis pathway has been achieved– 90% and above.
9. Blood pathway – collaboration with other departments – one stop shop.

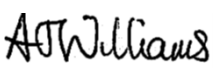
10. The Lived experience panel is being established with patient representation to ensure partnership working.

NHS Cheshire and Merseyside have noted and accepted the Trust's ambition and intention to work in relation to maintaining focus upon 2024/ 2025 priorities – Did Not Attend/ Was not Brought reduction by 20%.

NHS Cheshire and Merseyside recognises the challenges for providers in the coming year. We look forward to continuing working with The Walton Centre Foundation Trust during 2024–2025 as you continue to deliver improvement in service quality, safety, and patient experience, as well as continuing to strengthen integrated partnership working to deliver the greatest and fastest possible improvement in people's health and wellbeing within a strong, safe, and sustainable health and care system.

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

Yours sincerely,



Associate Director of Quality & Safety Improvement, NHS Cheshire and Merseyside (Liverpool Place).

QUALITY ACCOUNT 2023-24

GOVERNORS SUMMARY

Following feedback on last years quality account from the governors, in which it was noted to be hard to understand and did not have an introduction, we have prepared and written the 2023/24 quality account with this in mind.

Some of the comments from the Governors include:

- “I’m impressed by the number of audits staff have participated in, but it does seem from some of the actions, that there is still a lot of education of staff, and changing of templates/forms to be done in order to improve outcomes”

- “Inclusion in audits has got to be a strength of the Trust as it shows a desire for continuous improvement, and recognises that there are areas for learning, and improving patient safety”

Governors commented that Jan Ross’ CEO honest opening comments, and an easy-to-read and logical text throughout, makes a much better and accessible account of the work and impact of the Centre and is a document that ought to be made wider use of.

The Governors welcomed the openness and honesty about targets not achieved, about difficulties being faced, and about a willingness to keep pressing for improvements where needed.

The Governors also recognised that the QA are not just ‘dry’ statistical accounts but give an insight into the results of so much hard work and dedication, and above all, into the outcomes and experiences of our patients and their families.

Governors past on their thanks for the report and the many staff who contributed to the many successes, innovations and improvements mentioned in it.

Annex 2 Statement of Directors' responsibilities for the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2021/22
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2023 to June 2024
  - Papers relating to quality reported to the Board over the period April 2023 to June 2024
  - Feedback from Cheshire and Merseyside ICB including NHSE/I Specialist Commissioning 5th June 2024.
  - Feedback from Governors dated 24th May 2024
  - Feedback from local Healthwatch Liverpool dated 6th June 2024
  - The Trust's Complaints Report published under Regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated June 2024
  - The National Patient Survey dated October 2023
  - The National Staff Survey for 2022 presented to Trust Board in April 2024
  - The Head of Internal Audit's annual opinion of the Trust's control environment dated May 2024
  - The Care Quality Commission's inspection report dated 19th August 2019
- the Quality Report presents a balanced picture of the NHS Foundation Trusts performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

By order of the Board

Signature of Chair

Max Steinberg CBE

Date 24 June 2024

Signature of Chief Executive

Jan Ross

Date 24 June 2024

Glossary of terms

ANTT	Aseptic Non-Touch Technique
ARC	Applied Research Collaboration
BMUS	British Medical Ultrasound Society
BSCN	British Society of Clinical Neurophysiology
CAUTI	Catheter Acquired Urinary Tract Infection
CPEO	Chronic Progressive External Ophthalmoplegia
CMP	Case Mix Programme
CPIS	Clinical Pulmonary Infection Score
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CRN	Clinical Research Network
CS	Clinical Standards
CSF	Cerebrospinal Fluid
CTS	Carpal Tunnel Syndrome
CVST	Central Venous Sinus Thrombosis
DNA	Did Not Attend
EEG	Electroencephalogram
EMG	Electromygraphy
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FTSUG	Freedom to Speak Up Guardian
GPICS	Guidelines for the Provision of Intensive Care Services
HAPU	Hospital Acquired Pressure Ulcers
HCA	Health Care Assistants
HES	Hospital Episode Statistics
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit and Research Centre
ICU	Intensive Care Unit
IPC	Infection Prevention and Control
IR(ME)R	Ionising Radiation (medical exposure) Regulations
KPI	Key Performance Indicator
LCL	Liverpool Clinical Laboratories
LIMS	Laboratory Information Management Systems
LITT	Laser Interstitial Thermal Therapy
LNBW	Liverpool Neuroscience Biobank at The Walton Centre
LTC	Long Term Condition
MDT	Multidisciplinary Team
MIAA	Mersey Internal Audit Agency
MND	Motor Neurone Disease
MR	Magnetic Resonance
MRSA	Methicillin-Resistant Staphylococcus Aureus Bacteraemia
MUST	Malnutrition Universal Screening Tool

NACEL	National Audit of Care at the End of Life
NELA	National Emergency Laparotomy Audit
NG	Nasogastric
NICE	National Institute for Clinical Excellence
NIHR	National Institute of Health Research
NNAP	National Neurosurgery Audit Programme
ONS	Oral Nutritional Supplement
OPD	Outpatient Department
PAT	Portable Appliance Testing
PD	Parkinsons Disease
PDR	Personal Development Review
PFET	Patient and Family Experience Team
PPMS	Primary Progressive Multiple Sclerosis
PSIRF	Patient Safety Incident Response Framework
PVA	Polyvinyl Alcohol
QI	Quality Improvement
RANA	Rapid Access to Neurology Assessment
RCR	Royal College of Radiologists
REC	Research Ethic Committee
REM	Rapid Eye Movement
RGC	Regional Governance Committee
SAH	Subarachnoid Haemorrhage
SHO	Senior House Officer
SMART	Surgical and Medical Acute Response Team
SOP	Standard Operating Procedure
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TARN	Trauma Audit and Research Network
TDC	Time Density Curves
TIVA	Total Intravenous Anaesthesia
TTO	To Take Out
TVN	Tissue Viability Nurse
UKROC	UK Rehabilitations Outcomes Collaborative
VFSS	Video-Fluoroscopy Swallow Study
VTE	Venous Thromboembolism
VZV	Varicella Zoster Virus
WCFT	The Walton Centre NHS Foundation Trust
WDES	Workforce Disability Equality Standard
WLI	Waiting List Initiative
WRES	Workforce Race Equality Standard
WRTB	Walton Centre Research Tissue Bank