The Walton Centre
NHS Foundation Trust

Quality Account

2019 – 2020

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Part 1 Statement on Quality from the Chief Executive

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

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

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

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

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

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

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

In addition, this year we have achieved:

- Top Industry Award
- International Engage Award (ShinyMind App)
- International Engage Lifetime Contribution Award
- BBC Two Hospital Episode
- Director of Clinical Academic Development – October 2019 (University of Liverpool)
- Applied Research Collaboration North West (ARC NW)
- CQC Inspection
- Launch of Childrens Book
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Quality initiatives are discussed and debated through various Committees which include the Audit Committee, Quality Committee and Business & Performance Committee in order to ensure that quality assurance is achieved. These Committees report to Trust Board to ensure that patient safety is a priority and is progressed.

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

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

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

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

Hayley Citrine, Chief Executive

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

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

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

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

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

2.1 Update for Improvement Priorities for 2019–2020

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

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

2.1.1 Patient Safety

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

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

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

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

Priority 2: Implement Aseptic Non Touch Technique

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

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

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

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

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

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

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

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

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

2.2.2 Clinical Effectiveness

Priority 1: Introduce In-house Masters Neurosciences Training Module

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

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

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

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

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

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

Priority 3: Introduce the A3 methodology for Quality Improvement

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

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

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

2.2.3 Patient Experience

Priority 1: Introduce Patient and Family Centred Champions

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

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

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

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

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

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

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

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

Outcome: Achieved

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

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

Reason for Prioritising:

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

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

Outcome: Achieved

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

2.2 What are our priorities for 2020 – 2021?

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

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

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

How progress to achieve these priorities will be reported:

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

2.2.1 Patient Safety

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

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

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

Priority: FOCUS – Free of Criticism for Universal Safety

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

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

Priority: Introduction of MITEL System

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

Outcome Required:

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

2.2.2 Clinical Effectiveness

Priority: Introduce Multitom Rax 3D Imaging

Reason for Prioritising:

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

Outcome Required:

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

Priority: HCA Apprenticeship Training

Reason for Prioritising:

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

Outcome Required:

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

Priority: Bespoke Spinal Module

Reason for Prioritising:

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

Outcome Required:

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

2.2.3 Patient Experience

Priority: Introduce the Road to Recovery

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

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

Priority: LASTLAP – Looking After Staff That Look After People

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

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

Priority: Outsourcing Mail

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

Outcome Required:

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

2.3 Statements of Assurance from the Board

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

- Neurology
- Neurosurgery
- Pain Management
- Rehabilitation

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

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

2.3.1 Data Quality

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

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

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

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

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

2.3.2 Participation in Clinical Audit and National Confidential Enquiries

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

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

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

2.3.3 National Audits

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

2.3.4 National Confidential Enquiries

- Dysphagia in Parkinson's Disease

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

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

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

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

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

2.3.5 Participation in Local Clinical Audits

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

Neurology Clinical Audits & Service Evaluations

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

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

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

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

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

Neurosurgery Clinical Audits & Service Evaluations

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

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

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

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

Trust wide Clinical Audits & Service Evaluations

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

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

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

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

2.3.6 Participation in Clinical Research and Development

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

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

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

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

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

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

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

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

2.3.7 CQUIN Framework & Performance

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

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

The CQUINS agreed for 2020/21 are the following:

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

2.3.8 Care Quality Commission (CQC) Registration

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

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

Ratings for The Walton Centre

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

2.3.9 Trust Data Quality

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Walton Centre Internal Clinical Coding Audit 2019/20

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

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

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

2.3.10 Learning from Deaths

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

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

17 in the first quarter

13 in the second quarter

37 in the third quarter

25 in the fourth quarter

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

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

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

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

In relation to each quarter, this consisted of:

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

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

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

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

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

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

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

2.3.11 Progress in Implementing Clinical Standards for Seven Day Hospital Services

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

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

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

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

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

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

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

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

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

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

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

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

2.3.12 Speaking Up

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

Part 3 Trust Overview of Quality 2019/20

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

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

Patient Safety Indicators

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

Clinical Effectiveness Indicators

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

Patient Experience Indicators

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

3.1 Complaints

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

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

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

3.1.2 Complaints Management and Lessons Learnt

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

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

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

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

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

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

3.1.3 Complaints Activity

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

Complaints received 01 April 2019 – 31 March 2020

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

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

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

3.1.4 Duty of Candour

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

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

3.2 Local Engagement – Quality Account

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

3.3 Quality Governance

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

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

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

- Deliver
- Invest
- Adopt
- Provide

- Lead
- Recognise

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

3.4 Top Industry Award – Nov 2019

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

3.5 International Engage Award (ShinyMind App)

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

3.6 International Engage Lifetime Contribution Award

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

3.7 BBC Two Hospital Episode

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

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

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

3.9 Applied Research Collaboration North West (ARC NW)

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

3.10 CQC Inspection

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

3.11 Launch of children's book

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

3.12 Official opening of the garden room

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

3.13 Surgical Spine Centre of Excellence (SSCoE)

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

3.14 Roy Ferguson Award

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

3.15 Centre of Clinical Excellence Award

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

3.16 Joined Rainbow Badge Initiative (ED&I)

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

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

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

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

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

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

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

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

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

- Our performance against these indicators
- The national average

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

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

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

3.19 Indicators

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

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

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

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

Rationale: The Trust does not provide mental health services

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

Rationale: The Trust is not an ambulance trust

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

Rationale: The Trust is not an ambulance trust

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

Rationale: The Trust does not provide mental health services

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

Rationale: The Trust does not perform these procedures

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

Response:

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

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

Actions to be taken

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

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

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

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

Response:

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

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

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

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

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

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

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

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

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

Response:

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

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

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

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

Some Key Highlights are as follows:

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

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

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

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

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

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

Key staff survey questions:

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

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

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

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

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

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

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

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

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

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

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

Rationale: The Trust does not provide mental health services

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

Response: * To be updated once National data published

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

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

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

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

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

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

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

Response:

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

WCFT Clostridium difficile infections per 100,000 bed days:

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

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

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

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

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

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

13. Rate of patient safety incidents per 100 admissions

Response:

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

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

- Increased patient acuity
- Increase in capacity and activity

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

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

The Trust will continue to:

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

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

Annex 1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Walton Centre NHS Foundation Trust

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

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

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

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

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

An impressive account of clinical effectiveness and safety.

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

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

Quality Account Statement – The Walton Centre NHS Foundation Trust.

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

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

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

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

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

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

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

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

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

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

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

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

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

South Sefton and Southport & Formby CCGs
Signed

Fiona Taylor, Chief Officer Date: 20 November 2020

Liverpool CCG

Signed Date: 24 November 2020

Chief Officer

Knowsley CCG

Chief Executive Date: 24 November 2020

Specialised Commissioning (North West)

Signed  Date: 20 November 2020

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

Glossary of Terms

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