The Walton Centre
NHS Foundation Trust

The Walton Centre NHS Foundation Trust

Annual Report and Accounts 2017/18

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Presented to Parliament pursuant to
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the National Health Service Act 2006

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Welcome to our annual report and accounts for 2017/18.

Our vision is: Excellence in Neuroscience.

About this annual report

Foreword from the Chair and Chief Executive

Welcome to The Walton Centre NHS Foundation Trust's Annual Report for the period 1st April 2017 to 31st March 2018.

About The Walton Centre

The Walton Centre was established in 1992 and attained Foundation Trust status on 1st August 2009. It is the only standalone neurosciences Trust in the UK and serves a patient population of circa 3.5 million from Merseyside, Cheshire, Lancashire, Greater Manchester, the Isle of Man and North Wales.

The Walton Centre was inspected by the Care Quality Commission (CQC) in April 2016. The Trust was given an Outstanding rating in October 2016, making it the first specialist NHS trust in the country to be given the rating without having any areas deemed as 'needing improvement'. The report highlighted many examples where staff had 'gone the extra mile' to support patients' individual needs, that there was a positive culture throughout the Trust, and that staff were highly-skilled and committed.

Recognising that the NHS is facing a period of profound change, The Walton Centre's strategy continues to put patients at the heart of delivering care and focuses on six key areas:

- sustaining and developing our services;
- developing our hospital;
- improving quality;
- research and innovation for patient care;
- our workforce; and
- our financial health.

New Chair Janet Rosser

In April 2017 Janet Rosser took up the position as the Trust's new Chair following the departure of Ken Hoskisson MBE.

Janet has been a member of the Trust's Board for a number of years, and brings a deep understanding of the Trust and the local health economy to the role.

New Chief Executive Hayley Citrine

In December 2017 the Trust appointed Director of Nursing and Operations Hayley Citrine as the new Chief Executive following the departure of former Chief Executive Chris Harrop and a rigorous recruitment process. Hayley took up the position in February 2018.

The Chief Executive has been working alongside staff from across the hospital to refresh and refocus the overall vision and strategy for the Trust during 2018, and to enhance links with other organisations in the local and national health and social care economy.

Intraoperative Magnetic Resonance Imaging (iMRI)

The Trust has now completed a £8.1m project to create two new theatres and an intra-operative Magnetic Resonance Imaging scanner to benefit patients and give the organisation more capacity to meet growing demand. The iMRI scanner was provided via a £2m donation by the Marina Dalglish Appeal. The new facilities were first used in April 2017 and they were officially opened by the Marina Dalglish Appeal in November 2017.

Investors in People Gold Standard

The Trust was reaccredited with the Investors in People Gold Standard in June 2017, a reflection of the open and supportive culture that staff have built together. Investors in People is the international standard for people management, testing organisations against a rigorous framework for best practice in the workplace.

The Walton Centre Charity

During the year, the Charity continued to go from strength to strength. Community support grew steadily and in addition to raising awareness, the Charity also raised funds for specific purposes such as the Home from Home Fund to support the annual costs of the relatives' accommodation; and the Sid Watkins Innovation Fund which enabled the Trust to purchase a Robotic Arm – a state-of-the-art piece of equipment to support a number of neurosurgical procedures.

Vanguard Programme

The Walton Centre was chosen to lead an Acute Care Collaborative Vanguard in 2015 – The Neuro Network - under NHS England's New Care Models of Care Programme. Vanguards have been finding new ways of working that can close the widening gaps in the health of the population, improve the quality of care, and improve the funding of services. This is part of the vision of The NHS Five Year Forward View to create a sustainable NHS.

Over the last three years the Trust has worked closely with other key partner organisations within Cheshire & Merseyside to improve care for patients with back pain as well as those with neurological conditions, including specifically:

- Achieve a clinically and financially sustainable integrated neurology service by enhancing the community support, clinical pathways and advice and support for primary and secondary care;

- To support a whole system spinal services network, embedding the National Back Pain Pathway – new evidence based guidance for back pain treatment and referral.

The work of The Neuro Network has already led to significant improvements in patient care. The Integrated Neurology Nurse Specialists for example have seen more than 1,500 patients with neurological conditions at home or in a community setting, and the Nurse Advice Line has provided advice and guidance to over 3,000 patients since expanding its service.

PLACE Report

The Walton Centre excelled again in the national Patient-led Assessment of Care Environment (PLACE) inspection. The Trust's average across all seven areas of the assessment including cleanliness, disability access, and food was 99.9%; which was the second highest scoring in the region.

Improving Quality

Significant work has been undertaken to improve the quality of care to both patients and their families. In line with the Trust's strategy, we have continued to engage with staff, patients and families through varied opportunities including Berwick Sessions, Schwartz Rounds, Staff Listening Events and patient and family engagement. The Trust has continued to reduce hospital acquired pressure ulcers and hospital acquired infections. This year the Trust was presented with positive feedback from NHS Improvement as an organisation that had reduced e-coli infections by 17.6%, over and above the 10% reduction trajectory.

- Catheter Associated Urinary Tract Infections (CAUTI):

  The Trust has made substantial progress in reducing CAUTIs. During 2017-2018 there were 23 patients with CAUTIs against an internal reduction target of 31 and we aim to reduce cases further during 2018-2019 with our comprehensive education programme.

- Methicillin-resistant Staphylococcus Aureus (MRSA)
  There is zero tolerance at both national level and internally within the Trust. Therefore, it was disappointing to have a patient who developed an MRSA bloodstream infection. A comprehensive investigation was undertaken and an action plan implemented. Our aim is to embed learning across the Trust to improve patient safety and we will continue this work throughout 2018-2019.

- Methicillin-sensitive Staphylococcus Aureus (MSSA)
  There were 11 patients with MSSA against an internal target of 9. All cases were investigated and learning opportunities shared across the Trust. We aim to reduce MSSA during 2018-2019 and have set an internal target of no more than 9 cases.

The Trust achieved all Quality Account priorities, which highlighted the continued motivation and enthusiasm of staff to achieve a reduction in harm thus enabling enhanced patient safety.

Health and Wellbeing

As a Health and Wellbeing exemplar trust, The Walton Centre has continued to offer a range of benefits and support to staff to promote physical and mental wellbeing, and was awarded the Health@Work Workplace Wellbeing Charter following an independent assessment. Director of Workforce Mike Gibney and Jane Mullin, Deputy Director of HR, have spoken at national conferences and events to share insights and advice about Health and Wellbeing provision with other NHS trusts and organisations.

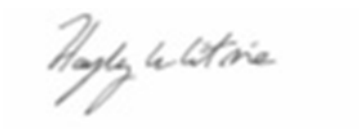
The Trust was also reaccredited with the Investors In People Gold Standard, reflecting the strong supportive culture staff have created.

This year staff have had the opportunity to take part in Schwartz Rounds, discussion forums for staff to share experiences and reflections of working in a healthcare setting; Berwick Sessions, engagement events for all staff groups built around a new theme each time; a range of exercise classes and health and wellbeing events; and had the opportunity to download a free app with daily healthy living tips.

Acknowledgements

The Trust Board would like to pay tribute to the hard work and dedication of staff and the invaluable assistance provided by many supporters, including volunteers, support groups, charitable groups, fundraisers, members, governors, current and previous patients. Special thanks also go to Chris Harrop, the Trust's former Chief Executive who stepped down at the end of January 2018, for his many years of service to the organisation during a period of great change and success. The Board of Directors would also like to thank all those who have raised funds and donated money to The Walton Centre Charity and the Home from Home Appeal. The Trust is very grateful for the continued support and hard work.

The Board of Directors is responsible for ensuring the production of the Trust's annual report and accounts and considers this document, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess The Walton Centre's performance, business model and strategy.



Hayley Citrine, Chief Executive

25 May 2018

Janet Rosser, Chair

25 May 2018

This report was approved and adopted by the Board of Directors on 25 May 2018. The Trust's 2017/18 accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

2i. Performance Report – overview of performance

Principal Purpose

The principal purpose of the Trust is the provision of goods and services for the health service in England.

The Walton Way

Guiding the work of the Trust are the Walton Way values and behaviours, developed with staff, which have become well embedded over recent years – caring, pride, openness, dignity and respect.

Strategic Objectives

The Trust had six overarching strategic aims to support the delivery of its five year strategic plan 2014-19:

1. Improving quality by focusing on patient safety, patient experience and clinical effectiveness
2. Sustaining and developing our services
3. Research and innovation for patient care
4. Developing our hospital
5. Recruiting, retaining and developing our workforce
6. Maintaining our financial health.

The Trust's strategy for the next five years is currently under development. The development of services and the hospital to ensure the growing number of patients requiring specialist neuroscience services get the care they need, when and where they need it remains fundamental to the Trust.

Increasingly, we are working as the hub for a network of services provided in hospitals and community locations across Merseyside, Cheshire, North Wales and the wider North West – the Cheshire and Merseyside Major Trauma Centre Collaborative, Cheshire and Merseyside Rehabilitation Network, our

neurology services provided in 34 locations, and the developing spinal surgery network. This also includes supporting GPs and hospitals to manage patients with neurological conditions better locally, without referring to the specialist centre. Our work in leading whole system services in neurology and spinal services was recognised and supported through NHS England's Acute Care Collaborative Vanguard programme for the two years to March 2018. This is continuing, and we are also supporting others to replicate our models elsewhere across the country.

As the hub, the Trust needs to ensure it remains at the leading edge of neuroscience care. Support for research is therefore essential for underpinning high quality care into the future. The Trust had invested for the future by creating the first adult intraoperative MRI scanner suite in the North, to improve outcomes for patients with brain tumours and enable the introduction of innovative treatments. This was part of an £8.1m capital investment to develop two additional operating theatres to treat the growing number of patients. The theatres/IMRI development came into operational use in April 2017 and the numbers of patients benefiting from the new technology has been built up through the last year. We are now turning our minds to planning our next major innovative investment to improve patient care.

Hand-in-hand with this investment is a focus on working smarter – streamlining patient pathways and processes to improve safety, enhance patients' experience of care and enable the Trust to see more patients in line with its growing demand. This includes enhancing the opportunities of information management and technology, including progressing towards a full electronic patient record.
Running throughout is the commitment to improving the quality of the care provided by the Trust, wherever this is.

Business, Activity and Performance

Throughout 2017/18, the Trust has remained in a strong position on quality and performance. Through the Trust's two divisions - Neurosurgery and Neurology, it continues to deliver excellent care to patients.

The Division of Neurosurgery is responsible for:

- Neurosurgery
- Anaesthetics
- Theatres
- Surgical wards
- Critical Care
- Pain Medicine
- Pain Management Programme
- Neuroscience Laboratories
- Day Case Unit
- Advanced Neurosurgery Nurses

- Advanced Pain Medicine Nurses
- Cancer Services
- Major Trauma Service
- Clinical Audit and Outcomes
- Teaching and Training across the specialities within the division

The Division of Neurology is responsible for:

- Neurology; hub and spoke outpatient service, day cases and inpatient ward
- Therapies
- Integrated Neurology Nurses
- Disease specific Specialist Nurses
- Neurophysiology
- Neuropsychiatry
- Neuropsychology
- Pharmacy Service Level Agreement
- Patient Access Centre
- Medical Secretariat
- Complex rehabilitation
- Neuroradiology
- Clinical Audit

Division of Neurosurgery

Over the last year there has been significant development in the infrastructure, resource and innovation portfolio of the Division. The iMRI, O-ARM and Robotic Arm have been operationalised in year placing us at the forefront of operative capability in the UK, enhancing our Oncological, Spinal and Functional Service provision. Further expansion of our theatre complex and bed base has also provided the physical capacity to meet current demand and provides the ability to increase our workload in the future to meet projected future demand.

The division also continues to expand our multi-professional specialist team. Within the Neurosurgery Service there are 20 Consultant Neurosurgeons, 2 Consultant Orthopaedic surgeons and 25 Specialist Nurses working alongside Allied Health Professionals (AHPs) to deliver specialist services at the centre and at eight satellites sites at partner Trusts across Cheshire and Merseyside, Isle of Man and Wales.

Within the Pain Medicine Service there are 7 Consultants in Pain Medicine and 4 Specialist Nurses again supported by AHP's to deliver a highly specialised pain service on site enhanced by joint specialist clinics working with Liverpool Womens and Alder Hey.

Neurosurgery

The department continues to be one of the busiest neurosurgical units in the country, seeing 10,000 new patients, 4,000 elective, and 1,800 emergency inpatients during 2017/18.

Achievement of the Referral to Treat (RTT) target has been successfully maintained across all specialities in year however this remains one of the biggest challenges faced by the division which has become more challenging due to the increased patient activity seen whilst supporting a local hospital who have temporarily suspended their spinal service. To date, just over 1,200 of these patients have transferred to our service and have been assessed, treated or discharged. We continue to receive patients for follow up on a monthly basis from the provider. While RTT was met inclusive of the transferred patients, the Trust reported 7 patients who exceeded the 52 week maximum wait as a result of the transfer. These patients had been waiting over 10 months at their previous Trust when The Walton Centre received the referral. While we endeavoured to see all patients as timely as possible, due to the wait at the previous Trust, patient choice and the requirement for further investigations, the 52 week threshold was exceeded in this small number of patients.

The number of emergency referrals also continues to increase year on year. In 2017/18 almost 9,000 referrals were received by the on-call team compared to 7,720 in 2016/17. The addition of two emergency admission co-ordinators in year has provided the clinical teams with valuable support and also improved the speed at which calls are dealt with and response times to referring clinicians.

Since September 2017, we have been running a Complex Spinal on-call rota alongside our Neurosurgical on-call rota. Complex spinal expertise has always been accessible out of hours however this development is the formalisation of this access and reflects the increasing volume and complexity of emergency patient referrals as well as being a recommendation suggested by the national GIRFT team during their visit to review our Spinal service in summer 2017.

The Neurosurgical Division maintains a high presence at the Society of British Neurological Surgeons (SBNS) and hosted the Society meeting in Liverpool in 2017, jointly with the African Neurosurgical Societies in September 2017. Mr May, Consultant Neurosurgeon remains President of the SBNS until September and Miss Gilkes, Consultant Neurosurgeon has been appointed Meetings Secretary and sits on the Executive Council of the SBNS.

Other designations held nationally and internally include Mr Pigott as President Elect of Eurospine and Professor Eldridge is the Northern Representative on the Neuroscience Clinical Reference Group for Neurosurgery.

Internally, Mr Wilby was appointed as the Trust Clinical Research Director.

The demand for our deformity service continues and we were delighted to expand our Orthopaedic workforce with the recruitment of a further Consultant Orthopaedic surgeon in March 2018.

At the beginning of the year our new theatre suite and £2m Intra operative (iMRI) scanner, funded by the Marina Dalglish Appeal, was used to treat patients with brain tumours and other complex conditions for the first time. The development was an extension to the existing Theatre complex allowing business to continue as usual with no disruption to admissions, surgery or clinics.

Since then the iMRI scanner has been used regularly to scan patients during surgery, enabling our surgeons to be as thorough as possible when removing tumours. Having the state-of-the-art scanner in the theatres department reduces the chances of patients needing more surgery in the future. There are now six neurosurgeons using the iMRI as part of their standard operative practice. This new theatres configuration with iMRI is the first of its kind for adults in the North of England.

As part of this development, two new theatres were built around the iMRI scanner, thus increasing the existing number of theatres from six to eight. This increased capacity has enabled the Trust to treat more patients. While the demand on services currently only requires the commissioning of one of the new theatres, we were able to support a neighbouring Trust for a period while their theatre complex was undergoing refurbishment by allowing them to use our unused theatre thus enabling continuity of service provision for the local population.

Further technological advances were also introduced to support surgical procedures including:

- A new robotic arm for use particularly in the field of Epilepsy. Comparable to a “GPS” for the brain, the robot can be used for any type of cranial procedure which requires surgical planning with pre-operative data, patient registration and precise positioning and handling of instruments. The Robotic Arm became operational in March 2018
- The O-ARM intraoperative spinal navigation system used for spinal fixation cases increasing the safety of complicated surgery. The technology improves accuracy of instrumentation placement, exposes patients to less radiation than other techniques and allows for immediate revision of instrumentation avoiding repeat revision surgeries. The O-ARM has been in use since May 2017.

Same Day Admission (SDA) for all eligible elective patients was launched in May 2017. The project saw an increase of our patients with admission on the day of surgery rate from 7% to a rate of 60%. Several key improvements were made to our processes and systems involved in preparing patients for admission including revised patient information, anaesthetic and consent protocols, increased pre-operative assessment capacity, and creation of a Surgical Admissions Lounge. This was alongside the project led by our IT department to digitalise patient records (ep2) which supports Same Day Admission by highlighting patients’ pre-operative status and requirements for admission.

A further Same Day Admission roll out is planned for interventional radiology patients who were not included in the first phase which will increase the rate of SDA further.

The regional major trauma service was further enhanced with the opening of a new £1m helicopter landing pad in July 2017 on the Aintree University Hospital (AUH) site. The regional trauma centre receives patients from across Cheshire and Merseyside who need urgent specialist care which isn't necessarily available in their local hospital. This addition will save vital minutes when transferring trauma and other time critical patients to The Walton Centre which ultimately improves chances of survival and reduces the risk of long-term injury.

The division have been focused on strengthening the major incident plans over the past year and have participated in a number of test exercises. The first was held in October 2017; Exercise Brave Defender, which involved all tiers of management on-call, Executive Directors, Clinical Directors, Medical staff, Theatres, Bed Management, Matrons, Critical Care and representatives from AUH. This exercise was designed to test the effectiveness of all departmental major incident action cards and the escalation process. The exercise was held across multiple rooms in the Sid Watkins Building, utilising telephones and radios to simulate the separation of departments including AUH A&E. All staff were briefed only moments before declaration of a major incident, which effectively tested the action cards. The exercise was a huge success, with only minor alterations to the action cards necessary. AUH teams commented on how well the exercise was facilitated and will be using elements when planning their own exercise.

In February 2018, the division undertook a mass casualty simulated exercise. This was specifically designed to test the response and capacity of our Theatre department and Critical Care Unit. Staff were only informed moments before the simulated major incident was declared and the bed state on the day was used for the exercise. The exercise was received extremely positively and lots of feedback was collated during the hot debrief. A small working group continues to work through this feedback to improve our mass casualty plan.

In March 2018 Aintree University Hospital undertook their first Mass Casualty exercise: Follow the File. This was a huge success and showcased the fantastic collaborative working between both Trusts. Internally, Consultant Neurosurgeons and Anaesthetists participated, along with representatives from Theatres, Critical Care and both Tactical and Strategic command. Again, lots of feedback was provided during the hot debrief and as a collaborative Major Trauma Centre we continue to work through to ensure our plans are robust.

A joint simulation exercise for ourselves and Aintree University Hospitals is planned for 2018, involving North West Ambulance Service (NWAS) to further strengthen our Major Trauma Centre Collaborative Major Incident Plan.

NHS England's Quality Surveillance Team undertook the first Peer Review of our Skull Base service, which is provided jointly with ENT specialists from Aintree University Hospital. The formal report is due in Spring

2018 however feedback from the reviewers on the day was overwhelmingly positive and no immediate or major concerns having been highlighted in respect of this service. The reviewers commented on the excellent quality of our documentation and the supporting evidence, as well as the patient centred approach that we have adopted.

The NERVES trial looking at nerve root block treatment versus surgery for sciatica is a NIHR funded multi-centre trial led by Consultant Neurosurgeon and the Trust's Clinical Research Director, Mr Martin Wilby, in collaboration with Liverpool University. Recruitment finished in December 2017 with over 160 patients recruited. Follow up of patients is on-going and will continue until December 2018 at which point analysis of results will begin, with publication of results due in 2019. The trial will assess efficacy of nerve root block injections for sciatica secondary to a prolapsed lumbar disc and hopefully guide a national treatment paradigm for this common and disabling condition.

Three brain cancer patients benefited from a cutting-edge treatment which creates electrical fields that interfere with cancer cell division. The treatment, called Optune, involves wearing electrodes which disrupt cancer cell division, limiting the size of tumours. Patients with Glioblastoma (GBM), a very aggressive form of brain tumour, have to wear a device for at least 18 hours a day to get the best response from the treatment. Based on the results of a large clinical trial, this treatment, alongside chemotherapy, could extend the lifespan of patients with GBM. The aim is to establish if the treatment is acceptable to UK patients, allow clinical colleagues to gain some practical experience with the equipment, to see if it works with difficult to treat brain cancer and to see if there are ways to make it more affordable for the UK in the future.

Anaesthesia and Critical Care

The anaesthetic department received the Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists (RCoA) at a ceremony held in February 2018. ACSA is the RCoA's peer-reviewed scheme which promotes quality improvement and the highest standards of patient experience, patient safety and clinical leadership within the anaesthetic service. Our anaesthetic department is the eighth in the North of England and the seventeenth in the UK to receive the prestigious accreditation.

The department continues to proactively seek solutions to the national shortage of medical staffing across all specialties. The successful introduction of Advanced Critical Care Nurse Practitioners (ACCPs) to complement the existing roles and ensure that safe care for patients is maintained, has been expanded in year bringing the total number of ACCPs to 4.50 WTE. Further expansion is planned in the future. The department was granted permission by the Royal College of Anaesthetists to recruit Anaesthetic Trainees from developing countries. The Medical Training Initiative programme has enabled increased stabilisation

of the department's medical staffing position with the recruitment of 3 additional junior doctors via this programme.

As part of the continuing delirium prevention initiative on the Critical Care Unit, cutting-edge technology was installed allowing patients to visualise the sky to help minimise delirium. The innovative 'Sky View Ceiling System' streams high quality footage of the day and night's sky to help improve patient sleep patterns and thereby reducing the incidence of delirium, a phenomenon of which intensive care patients are at a higher risk and a complication which hampers rehabilitation.

The annual Critical Care peer review visit took place in March 2018. The formal report is expected later in the year however no immediate concerns were identified and the review team commended the department's preparation for the visit and were extremely impressed with the SMART team and the service they deliver to our patients.

The Trust has met the ITU Delayed Discharge 2nd year CQUIN. The stretch target has seen performance increase from only 41% of discharged from ITU within 4 hours to over 60% by the end of March 2018. It has been extremely challenging given the support given to neighbouring DGH's as part of our Winter Plan. This support was well received by trusts.

Pain Medicine

Activity growth continues within the service seeing over 5,000 new patients in 2017/18 and 2,000 elective inpatient admissions, compared to 1,900 in 2016/17.

We have strengthened the patient outcome collection for the service, especially within the Spinal Cord Stimulation service. We continue to work on other areas of outcome collection to expand and consolidate processes for collection and integrate digital solutions to reduce the reliance on clinical staff time.

In September 2017, the clinical leadership of the Pain Service transferred from Dr Manohar Sharma to Dr John Wiles. During his time as Clinical Director for the Pain Service Dr Sharma introduced significant changes to clinical practice including development of the Spinal Cord Stimulator pathway in Pain, expansion of the cordotomy provision at the Trust along with significant research collaborating with neuroradiology and neurology.

Following the departure of one of our Pain Medicine consultants in 2016 and an unsuccessful recruitment process in 2017, the department have looked at alternative ways to manage the demand, which has been significant over the past 3 years. The team has expanded by two further specialist pain physiotherapists and a further Pain Clinical Fellow, supported via industry.

In an age of over prescription of opioids it has become necessary to expand the inpatient detoxification service. We now see approximately 25 patients per annum who required inpatient detoxification.

Our regional Complex Regional Pain Syndrome (CRPS) service works collaboratively with pain physiotherapists and pain consultants throughout the region who refer patients with complicated CRPS to us. In March a meeting was held and hosted by Dr Goebel, for regional pain health care professionals who work alongside us to network and share updates.

A bespoke e-referral system for the Pain Service was successfully launched in May 2017. Pain service colleagues worked with the Trust IT department to design the system which provides a robust audit trail, reduces the risk of referral loss and the time taken to action referrals.

The 33rd Liverpool Annual Pain course on the Management of Chronic Pain was held in July 2017, supported by The Pain Relief Foundation. The practical and interactive course was attended by a range of disciplines including Consultants, GP's, Anaesthetists, Nurses and Physiotherapists (from the UK and internationally) and offered the opportunity for attendees to develop their skills of assessing and treating complex chronic pain patients. This continues to receive excellent feedback from delegates.

The department participated in a research project aimed at patients with severe and disabling lower back pain which is beginning to look optimistic. An implantable device is used for 30 minutes twice a day to reactivate the muscles in the lower back aiming to relieve back pain, caused by inactivity of the multifidus muscle, potentially avoiding the need for surgery. There are 11 patients enrolled on the study at The Walton Centre.

Pain Management Programme (PMP)

Referrals into the programme have seen a 6.5% increase and the number of medical conversion clinics are due to expand in early 2018/19 to ensure we can assess patients as timely as possible. The year has been a challenging one in terms of RTT achievement within the sub-speciality and it may be that the MDT assessment clinic capacity also needs to be expanded if referrals continue to increase.

We offer the following range of PMPs for people experiencing chronic pain:

- Intensive 16 day Pain Management Programme with outpatient and residential options
- 5 day Pain Management Programme
- Chronic Pelvic Pain Management Programme
- Young Adult Pain Management Programme (approx. 18-25 years)
- Facial Pain Management Programme
- Individualised Pain Management Programme for more complex needs that cannot be met in a group based PMP setting

In addition, as one of the selected 'Vanguards' for the New Care Models Programme which is playing a key part in the delivery of the Five Year Forward View, The Neuro Network have worked with the Pain Management Team within the Trust over the past year to develop a Community Pain Management Programme (CPMP). The programme forms part of a wider package of care in line with NHS England's National Back and Radicular Pain Pathway, designed to ensure patients get faster access to the treatment they need. Phase one of the roll out is located in Warrington for Warrington CCG patients and began accepting referrals in February 2018, with the first Programme due to run in April 2018. Patients with chronic pain can currently be referred to the programme via the newly established Treat and Triage service in Warrington, which commenced in September 2017 as part of the Vanguard programme.

The PMP was awarded the top prize at the annual Grünenthal Pain Awards, winning £10,000 for the second time. The seventh annual Grünenthal Pain Awards aimed to recognise excellence in the field of innovative pain management. The department have used the funding to produce a booklet aimed at helping children and relatives of people with chronic pain understand their condition better, as well as projects related to the use of technology in pain management rehabilitation.

Selina Johnson, a Pain and Neuromodulation Specialist Physiotherapist at the Trust, was awarded 'Clinical Research Rising Star of the Year' at The North West Coast Research and Innovation Awards 2018. This category recognised the work of an individual new to research who had achieved a significant amount in a short space of time.

The Neuroscience Laboratories

Following the departure of both Consultant Neuropathologists during 2016/17 due to retirement and relocation, the department have faced significant challenges but manged to maintain all clinical services during the recruitment process for Consultant replacements with robust Service Level Agreements (SLA's) in place with other providers. The Trust has successfully recruited to both posts, welcoming one consultant neuropathologist in May 2017, with the second due to start in July 2018. The consultants are supported by a full time Consultant Clinical Scientist and Laboratory Director.

Following United Kingdom Accreditation Service (UKAS) accreditation in 2015; The Neuroscience Laboratories had their second annual surveillance visit by UKAS in November 2017 and successfully maintained accreditation. During this process, further specialist neuro diagnostic work was added to the accreditation scope of the services provided, evidence submitted and assessed, which resulted in full accreditation across the new scope.

The cerebrospinal fluid (CSF) BioBank repository was launched in 2017 with the purpose of collecting and storing samples and relevant clinical information for use in current and future neurological research projects. It allows our clinicians active in research, and also other researchers nationally and internationally, increased access to samples when conducting important research into neurological diseases, including

Dementia and Parkinson's, and the treatments of those diseases. Patients undergoing routine tests are asked to donate CSF and blood to be included in the Biobank with samples taken at the same time as their test, making the donation quick and easy for consenting patients.

The department are currently implementing the National Pathology Exchange (NPEx) software, which provides digital integration of UK laboratories enabling pathology test requests and results to be sent from any lab to any lab in a matter of seconds. Prior to this technology, our method of receiving referred work and outsourcing was dependent on a paper based system. This development will result in reduced turnaround times, reduced risk of transcription errors, income generation potential and added visibility of tests by Provider showing price and performance data enabling informed decision making in order to get the best quality and most efficient service for patients.

Division of Neurology

The Neurology Division continues to deliver a responsive specialist service to patients both in the centre and at partner Trusts and community settings via an outreach service. This model of care was chosen as a NHS acute care collaboration Vanguard site, allowing its further development to improve the level of neurology services provided to patients closer to their homes.

The Neurology Service provides a responsive specialist service to patients across Cheshire, Merseyside, North Wales and Isle of Man, from both The Walton Centre and at partner Trusts and community settings via an outreach service. The network of satellite clinics operates from 15 acute hospitals, providing both an outpatient service and support to inpatients. It is a large and busy neurology service seeing 30,383 new patients in 2017/18 and treating 4,932 inpatients, in either The Walton Centre's day case unit or on its inpatient ward.

The neurology service is delivered by a multi-skilled professional team. There are 41 Consultants, 25 specialist nurses, who work alongside an experienced therapy team to provide the holistic and multidisciplinary care required for our patients. Sub-speciality clinics are provided in epilepsy, movement disorders, headache, neuromuscular, multiple sclerosis, vascular and neuromyelitis optica.

The service expanded its geographical footprint in 2017/18, entering into a sub-contract with Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust to support their adult neurology service. The Walton Centre now supports fortnightly clinics from this hospital.

As with most other clinical specialities, neurology continues to see a year-on-year increase in demand for services. Having a robust workforce plan to ensure the successful recruitment of new colleagues to the service is critical to meet the ever growing demand. The service successfully recruited and welcomed a further two consultant neurologists during 2017/18; one in the area of headache and one in epilepsy. Epilepsy is one of the larger areas of growth due to the success of embedding the post seizure pathway into A&E departments and ensuring that patients who need to be under specialist care after experiencing a

seizure are. In addition, the service introduced a new Clinical Fellow post within movement disorders. This post allows the Trust to support individuals to develop their sub-specialty interest and ensure the development of Consultants in this area for the future.

The Cochrane Epilepsy Group continues to be based in Liverpool. There remains a high national and international profile with awards of NIHR grants and close collaboration with the European Brain Council. There continues to be major interest in the service delivery of epilepsy, the genetics of epilepsy, MRI scanning and the drug treatment of epilepsy including issues associated with prescribing valproate in pregnancy.

As previously outlined, The Walton Centre was chosen to lead an Acute Care Collaborative Vanguard – The Neuro Network under NHS England's New Care Models of Care Programme. This opportunity is facilitating and seeing a number of developments within the neurology service to enhance its current satellite model with community support, rollout of clinical pathways and increasing the advice and support available for primary and secondary care. 2017/18 is the final year of central funding for this programme and therefore many projects have matured and become embedded to continue as 'business as usual' into 2018/19. A summary of the projects are as follows: rollout and embedment of a post seizure and headache pathway; nurse advice line; integrated neurology nurse specialists; functional neurological disorder clinics; tele-neurology and Education to both primary care and secondary care colleagues.

Many of the projects are interrelated, designed to improve access to neurology services / expertise, reduce avoidable admissions and shorten length of stay and support earlier diagnosis and treatment for patients.

One of the most significant developments within neurology during the year, has been the services leadership of expanding the mechanical thrombectomy service for stroke patients across Cheshire and Merseyside. Mechanical thrombectomy is a momentous development in the treatment of stroke demonstrating significantly improved outcomes; for every four to six patients who undergo a thrombectomy following stroke, one more will be able to function independently at 90 days compared to those that receive intravenous (IV) thrombolysis ('clot busting' drugs) alone.

It is a relatively new procedure and with its strong evidence-base, NHS England are looking to commissioning the service routinely and see this treatment available 24/7 over the next five to ten years. As one of the 24 neuroscience centres within England and already providing a weekday thrombectomy service, The Walton Centre has started work to expand this service, both outside of standard working hours during the week and plans for introducing during the weekend.

Therapy Services

The newly extended Neuromuscular Disease therapy outpatient service was successfully evaluated after a nine month pilot period and has now introduced a number of new multidisciplinary / therapy clinics and patient groups for education in condition management, occupational performance, exercise and

employment. The service going forward will also be extended to patients with Parkinson's Disease and Motor Neurone Disease (MND).

As reflected in the development above, the therapies outpatient service reflects the emerging national strategy of improving multi-disciplinary team access for people living with long term neurological conditions. Aligned to this and as part of the Vanguard Programme, the service has also contributed to developing a project aimed at improving access to exercise and activity for people with neurological disorders. Engagement events have been held between community teams, service users, providers and the public to make health and leisure facilities accessible and the service has been part of a successful bid for funding from Sport England to develop neurology based training for leisure centre staff.

The department has continued to be actively involved in research and development with several therapy based projects underway. Several members of the therapy team are currently undertaking post-graduate research degrees including Masters in Research and PhDs. The Therapy Service has just been shortlisted for a 'Culture of Innovation' Award hosted by the North West Coasts Research and Innovation Collaboration and one of our Occupational Therapy staff has been shortlisted in the 'Research Student of the Year' category.

During 2017/18, the Therapies service has extended a project started by our 'Ideas Forums,' which involves hosting and delivering in-house courses for external health care professionals. These courses increase the profile of the service, improve collaborative links with other professionals and organisations and allow wider dissemination of expert knowledge. Following the success of the 'Physiotherapy Respiratory' Training Course hosted in March 2017, the therapy service as a whole delivered a 'Specialist Therapy Study' day in March 2018.

Complex Rehabilitation

The Walton Centre is both the host and hub of the Cheshire and Merseyside Rehabilitation Network formed in January 2013 to integrate complex rehabilitation services from hyper acute to community in the region. The Rehabilitation Network is a unique collaboration of seven partner organisations; The Walton Centre has two rehabilitation units, hyper acute (level 1a) and level 1b and there are four spoke units across the region at The Walton Centre, St. Helens Hospital, Broadgreen Hospital and Clatterbridge Hospital, who all provide inpatient beds for level 2 rehabilitation. There is one unit, Oak Vale Gardens, for level 3 rehabilitation with continuing rehabilitation provided by the specialist rehabilitation community services.

The aim of the Network is to work in partnership across seven providers to deliver a high quality, fully co-ordinated and seamless pathway of care, of supported, active and extended rehabilitation with a multidisciplinary team of medical, therapy and nursing staff. The team is supported by other specialists in key areas such as rehabilitation co-ordination, clinical and neuropsychology, neuropsychiatry, vocational rehabilitation therapy, social support and clerical / administrative / managerial staff. Patients accessing the Network do so based on need not diagnosis following traumatic injury or illness.

The annual Cheshire and Merseyside Rehabilitation Network (CMRN) Values for staff award ceremony was held in April 2017 to recognise staff.

During 2017/18 there was an emphasis on patient flow and the Network developed regular groups to identify delays and put in place strategies that aimed to reduce delays where possible. Moving forward into 2018/19 the Network will continue to work with the NHS England case manager to further reduce external delays.

Managers and Clinical Leads continue to attend workshops and conferences nationally to showcase the work of the Network and this included a presentation given to the Welsh Neurosciences Board in September 2017. During the year visitors from Leeds and Manchester came to the Hub to review and discuss the model and benchmark their services against the Network model.

1st November 2017 saw the transfer of the Clinical Psychology Network team from Merseycare NHS Foundation Trust to The Walton Centre NHS Foundation Trust. This will provide a more integrated service for the patents across the Network.

A process mapping exercise took place in January 2018 with the Acquired Brain Injury service delivered by Merseycare NHS Foundation Trust. This workshop identified the gaps and the differences in the pathways and work will continue with the commissioners to look at how these gaps can be addressed.

The Education Group completed its development of a Masters level Complex Rehabilitation Module which was accredited for three years by Liverpool John Moores University. The first cohort of this module ran from September to December 2017 with very positive feedback. The Network has been approached by Betsi Cadwaladr University Health Board to deliver the module to a cohort of their staff and this was planned to start in March 2018.

After an independent review in 2015 commissioned by the six Merseyside Clinical Commissioning Groups, work has been ongoing to review both the provider and commissioner model. A workshop was held in February 2018 with all stakeholders from providers, CCG's and NHS England attending to further explore the agreed Strategic Priority set in January 2017 to develop and embed a single provider and commissioner model.

CMRN held its inaugural Quality Partnership Event in March 2018. There were six verbal presentations and 21 poster presentations that showcased the projects, audit and best practice from across the Network.

Neuropsychology

During 2017/18, the department continued to see patients benefit from the new assessment and treatment service for people diagnosed with a functional neurological disorder. The service is currently being evaluated as part of the Vanguard Programme and hopefully the early success of this service will in the longer-term result in an expanded service to accommodate more complex patients who require longer treatment lengths than the current model allows. A recent and exciting development for this service is a

new assessment pathway that leads to focused inpatient treatment for those patients with functional weakness that require physiotherapy as well as psychotherapy. A Consultant in Rehabilitation Medicine now regularly attends the monthly Functional MDT to facilitate this patient pathway.

The Neuropsychology team continue to support other services and staff groups. A training workshop was developed for the Patient Experience Team on dealing with difficult telephone calls (e.g. when the patient expresses suicidal thoughts or intent) on both a practical (what to say/do) and personal level (how to manage the emotional consequences of talking with a person threatening suicide and building personal resilience). This workshop was a joint collaboration developed and provided by Neuropsychology and Neuropsychiatry. The workshop was very well received. In addition, the department continues to support the "Road to Recovery" event for patients who have had subarachnoid haemorrhage.

The Neuropsychology team are committed to supporting training for Psychology and Neuropsychology within the region and beyond. The team has strong links with Liverpool, Manchester, Lancashire and Bristol Universities and provides both placements for trainees and also specialist lectures on their courses.

The department continues to maintain a high level of research activity. Two multicentre randomised controlled trials (RCT) delivering neuropsychological interventions were successfully completed in the past year. The department has begun a new multicentre RCT in herpes simplex encephalitis. In the past year we have conducted collaborative research with several major research partners including Liverpool, Manchester and Nottingham Universities and Salford Royal Foundation Trust and continue a range of projects including epilepsy, neuro-oncology and NMO research studies. We continue to develop high quality research programmes that have included leading and participating in Cochrane systematic reviews as well as contributing to grant applications for new programmes.

Neuroradiology

A new intraoperative MRI scanner was opened during 2017/18, with several intraoperative surgical cases performed successfully during the year. The cases performed include brain tumours and pituitary adenomas, with initial positive feedback and improved outcomes for patients. The opening of the new iMRI has also allowed additional scanning capacity for inpatients when the scanner isn't in use for intra-operative cases.

2017/18 also saw the procurement of a mobile O arm for use in theatre. Along with the theatre navigation system this has allowed 3D imaging in the theatre environment to support complex spinal procedures and again improve the outcomes for patients.

The Department successfully recruited and welcomed a 10th Consultant Neuroradiologist into the workforce towards the end of year, and continue to develop an Advanced Practitioner Radiographer role in Fluoroscopy.

Neuroradiology is a member of the Cheshire and Merseyside Five Year Forward View Programme, and was successful in its application to NHS Improvement to be selected as an Early Adopter site for the Stroke Pathway.

Neurophysiology

Demand for all Neurophysiology investigations in 2017/18 remained high. Historically there have been long waiting times for long-term Electroencephalography (EEG) monitoring (ambulatory monitoring and video telemetry) and work has taken place during the year to improve this situation. The service have reviewed the referral criteria for these investigations and, in addition, introduced specific EEG clinics for patients referred with non-epileptic attack disorders (NEAD). This has led to a recent reduction in waiting times for long-term EEG monitoring.

Demand for electromyography (EMG) also continues to be significant. Despite an international shortage of Consultant Neurophysiologists, the service successfully recruited two Consultants on zero hour contracts to assist in managing EMG waiting times during the year.

Neurophysiology continued to work towards a nationally recognised accreditation standard called Improving Quality in Physiological Services (IQIPS) managed by United Kingdom Accreditation System (UKAS). Achieving the standard will recognise and provide assurance of excellent quality and care. The work undertaken to date, for the self- assessment, has provided opportunities to evidence areas of good practice already embedded in service delivery.

Pharmacy

Pharmacy services are provided via a service level agreement with Aintree University Hospital NHS Foundation Trust, and the service continues to develop year on year. The pharmacist prescribing service, which started in 2016/17, has been extended during 2017/18, with pharmacists playing a key role in the same day admission process for elective surgical patients, which started in May 2017. Two pharmacists are now on duty early each morning Monday to Friday to review all patients admitted that morning for surgery and prescribe their usual medicines, ensuring any necessary changes peri-operatively are actioned. This service has been well received but has impacted on the availability of pharmacist prescribers for surgical ward rounds and prescribing for existing inpatients. The ITU pharmacist has also qualified as a prescriber which has enhanced the service to ITU patients, and added some resilience to the same day admissions service.

Audit and review of the pharmacist prescribing service is currently underway to evaluate its success, impact and potential for further development, and a full report will be presented in quarter one 2018/19.

Pharmacy have refined last year's work on the management of medicines which are dispensed and delivered to patients via external homecare companies, in keeping with national standards. Further improvements to systems have been implemented this year to improve patient safety and clinical/financial

governance, and Pharmacy also check Blueteq approval is in place for specified high cost medicines for multiple sclerosis as per NHS England requirements.

The wider role of pharmacists within The Walton Centre has expanded this year, with senior pharmacist representation newly requested at various Trust groups, committees and initiatives. In addition, the contribution of individual clinical pharmacists and technicians to patient safety was recognised with two 'good catch' awards to pharmacy staff this year.

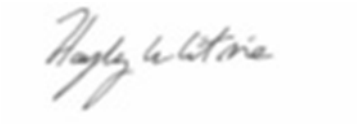
Estates and Facilities

The Trust brought the £8.1m Theatres/iMRI development fully into use in April 2017. This has created two additional operating theatres, one of which has a direct access into an addition MRI scanner to enable scans to take place during a procedure.

The Trust, again, rated highly in the annual Patient Led Assessments out of 279 NHS providers.

Going concern disclosure

Following extensive enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. They have identified no material uncertainties that cast doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.



Hayley Citrine, Chief Executive

25 May 2018

2ii Performance Report – performance analysis

The purpose of the performance report is to highlight the most important performance measures for the trust. The most significant performance areas are: quality and patient safety, finance and activity including referral to treatment targets. These are considered in detail below.

Financial Summary for the Year Ended 31 March 2018

The Trust delivered a £6,122k surplus for the financial year ending 31 March 2018. This position includes non-recurrent Sustainability and Transformation funding of £3,322k, which consists of £1,609k funding for meeting agreed financial and non-financial targets during the year and £1,713k 'bonus and incentive' funding for achievement and over performance of the planned year-end position. The position also includes a charitable donation in relation to a new robotic arm of £164k, as well as a reversal of prior year impairments of £650k (as a result of a full revaluation of the Trust Estate). 2017/18 has continued to be a challenging year for the Trust and is reflective of the difficult circumstances facing the NHS and the wider health economy. The Trust has faced significant challenges with regard to patient acuity which has required one to one therapeutic specialing care (one nurse or one healthcare assistant to one patient and sometimes two to one in some instances). Investment in a dedicated, substantive healthcare assistant nursing 'pool' for specialing in 2016/17 led to a planned reduction on the nurse agency expenditure during 2017/18 resulting in agency expenditure being below the NHSI cap, although pressure on this area of spend continues. The Trust has also faced activity and performance challenges as a result of delayed transfers of patients to general hospitals as a result of pressures across the local health economy, as well as delayed discharges due to the complexity of patients. The identification and delivery of recurrent efficiency savings has also proved a challenge for the organisation during 2017/18.

Table 1 sets out the reconciliation of the annual accounts to the Trust's Normalised Trading Surplus for the year ended 31 March 2018.

Table 1

	£'000
Surplus for the year per statement of comprehensive income	**6,122**
Normalisation adjustment:	
Capital donation from the Charitable Fund	(164)
Reversal of impairment on Sid Watkins Building	(650)
Normalised Trading Surplus (including STF)	**5,308**

Normalisation

The NHS Improvement Compliance Framework measures Trusts' performance on the underlying or normalised trading position of the Trust after allowing for the adjustment of exceptional items that are one off in nature and not related to the core routine business of the Trust.

Revaluation of Trust Property

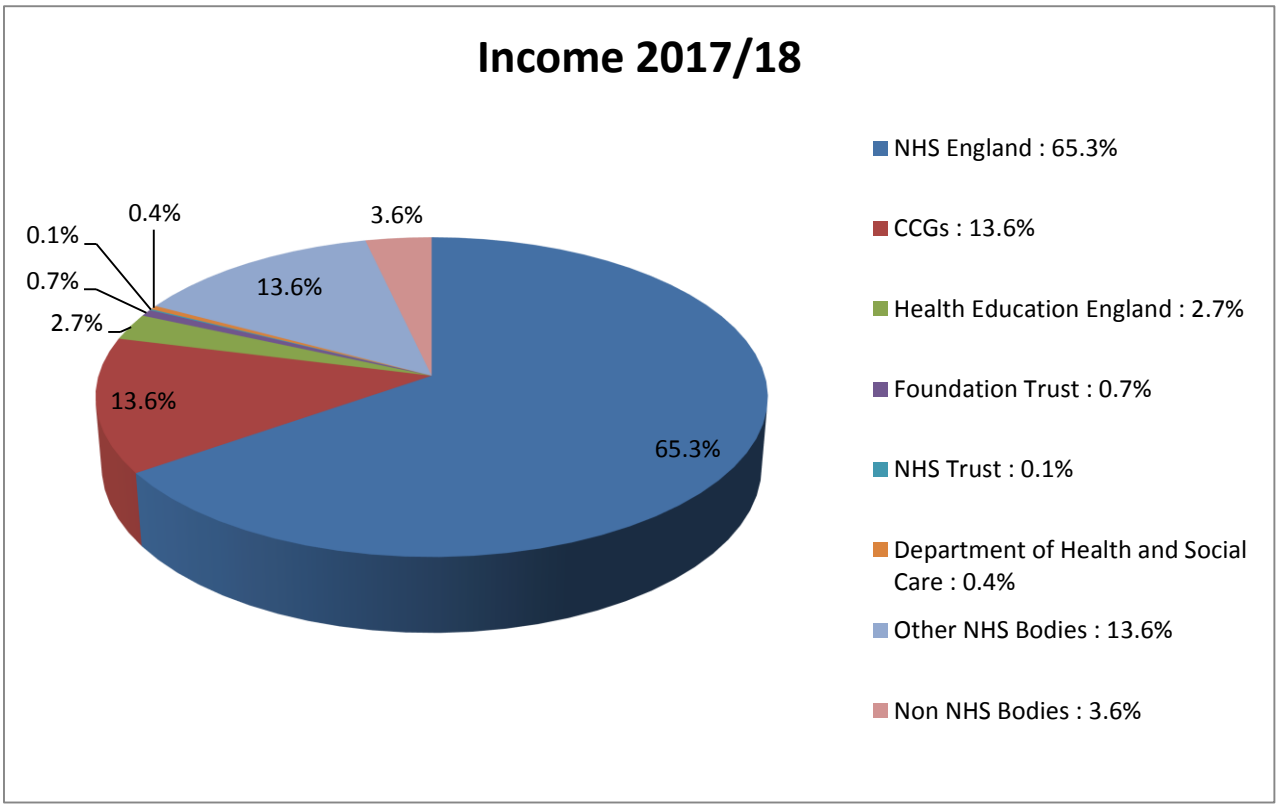
During 2017/18 a full revaluation of the Trust's land and buildings was undertaken by an independent external valuer, in which the value of Trust land and properties increased resulting in a £650k prior year net impairment being reversed in full as well as an increase in the revaluation reserve by £3,561k. The revaluation is a technical accounting adjustment which has no impact on the Trust's cash position (as it is a non-cash item) or its overall reported performance to NHS Improvement (as the adjustment is normalised) in the financial statements (see above).

Income

The Trust has seen income (turnover) growth of £8.6 million from the previous year (year ending 31 March 2018) which represents a 7.2% increase. Of this growth, £2.5m is non-recurrent. The Trust receives the largest element of its income from NHS England for the provision of Specialised Prescribed Services, the scope and coverage of which can be found in section 8 of this report. The Trust received £95.0 million from NHS England/ CCGs in the year ending 31 March 2018, an increase of £7.2 million (8.2%) on the previous financial year. This reflects a change to national specialised tariffs, increased acuity of patients treated by the organisation as well as additional agreed contract activity undertaken by the Trust on behalf of NHS England/ CCGs.

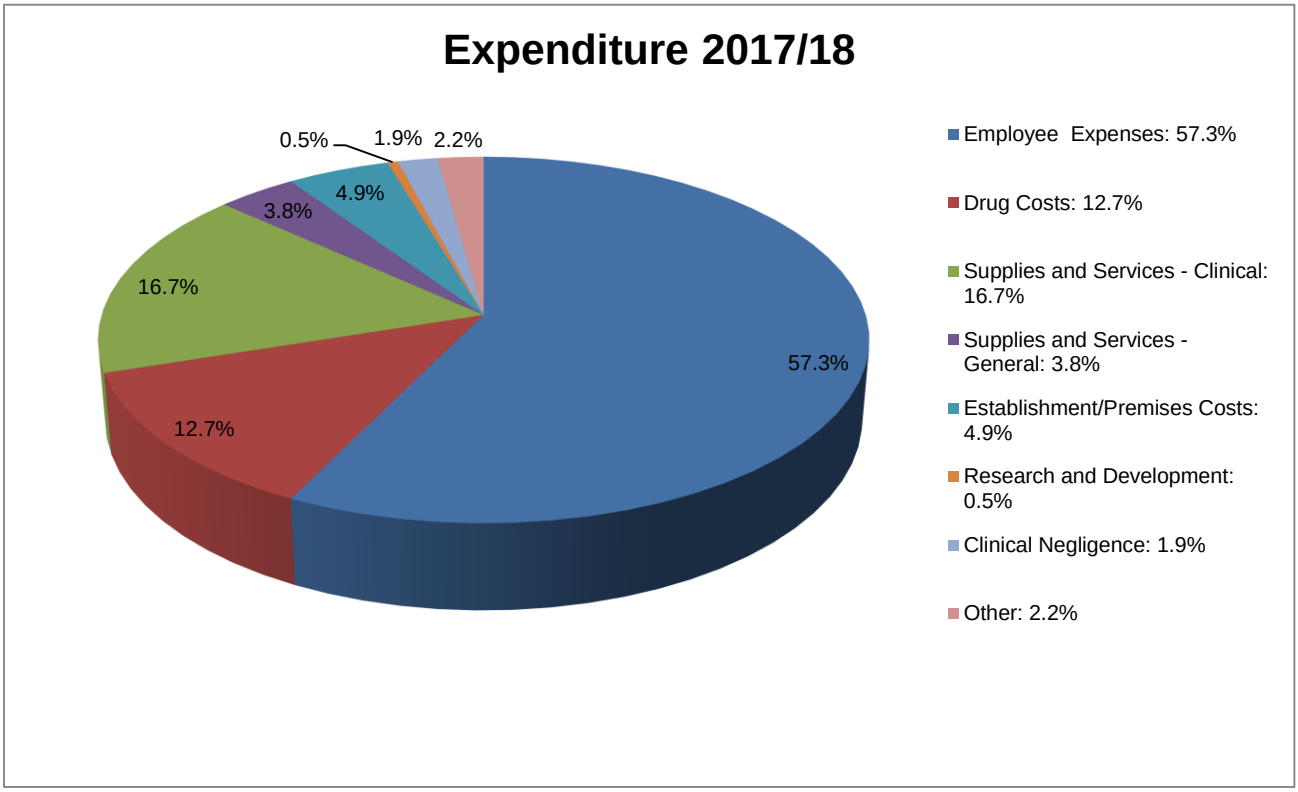
In addition, the Trust receives £17.1 million of income from Welsh Health Specialised Services Committee (WHSSC) for provision of services to the population of (mainly) North Wales, both through outreach clinics held within hospitals within Wales and for Welsh patients attending The Walton Centre, either as an out-patient or in-patient. This reflects a 14% increase from the previous year, which is in the main due to the new HRG4+ tariff as well as patient complexity and acuity.

The Trust also receives other amounts of income from different sources and these are set out in the following pie chart:



Expenditure

In line with the growth in income (turnover), the Trust has seen an increase in Operating Expenses of £6.9 million (6.1%) compared to the previous year. The following pie chart sets out the main components of expenditure incurred by the Trust in 2017/18.



The biggest single item of expenditure incurred by the Trust relates to employment of staff to deliver the range of services provided by the Trust. The Trust spent £66.4 million on staffing during 2017/18 which was an increase of £3.1 million (4.9%) on the previous year. This was due to planned investments in staffing in relation to the new theatres and intraoperative MRI machine that have been built and to ensure compliance with medical rotas (to maintain safe services) as well as the transfer of rehabilitation staff into the organisation. However, as noted above, some of this also related to patient acuity and the necessity of delivering more one to one therapeutic specialing. The average number of whole time equivalent (WTE) staff has increased by 17 from the previous year. The majority of the increase in whole time equivalent numbers is due to the TUPE transfer of rehabilitation staff into the organisation and planned investments in staffing following the full operationalisation of the intraoperative MRI scanner.

Tables 2 and 3 show staff costs and average number of employees for 2016/17 and 2017/18.

Table 2

Staff costs

	Group			Foundation Trust Only		
	Total	**Permanent**	**Other**	**Total**	**Permanent**	**Other**
2017/18	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	**54,547**	52,722	1,825	**54,547**	52,722	1,825
Social security costs	**4,889**	4,889	0	**4,889**	4,889	0
Apprenticeship levy	**244**	244	0	**244**	244	0
Pension cost - employer contributions to NHS pension scheme	**5,856**	5,856	0	**5,856**	5,856	0
Termination benefits	**54**	54	0	**54**	54	0
Temporary staff - external bank	**363**	0	363	**363**	0	363
Temporary staff - agency/contract staff	**1,714**	0	1,714	**1,714**	0	1,714
NHS charitable funds staff	**147**	147	0	**0**	0	0
Total gross staff costs	**67,814**	**63,912**	**3,902**	**67,667**	**63,765**	**3,902**
Recoveries in respect of seconded staff	**(711)**	(711)	0	**(711)**	(711)	0
Costs capitalised as part of assets	**(552)**	(552)	0	**(552)**	(552)	0
Total staff costs	**66,551**	**62,649**	**3,902**	**66,404**	**62,502**	**3,902**
2016/17	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Salaries and wages	**51,222**	49,933	1,289	**51,222**	49,933	1,289
Social security costs	**4,728**	4,728	0	**4,728**	4,728	0
Pension cost - employer contributions to NHS pension scheme	**5,571**	5,571	0	**5,571**	5,571	0
Termination benefits	**288**	288	0	**288**	288	0
Temporary staff - external bank	**466**	0	466	**466**	0	466
Temporary staff - agency/contract staff	**2,156**	0	2,156	**2,156**	0	2,156
NHS charitable funds staff	**137**	137	0	**0**	0	0
Total gross staff costs	**64,568**	**60,657**	**3,911**	**64,431**	**60,520**	**3,911**
Recoveries in respect of seconded staff	**(740)**	**(740)**	0	**(740)**	**(740)**	0
Costs capitalised as part of assets	**(364)**	**(364)**	0	**(364)**	**(364)**	0
Total staff costs	**63,464**	**59,553**	**3,911**	**63,327**	**59,416**	**3,911**

Table 3

Average number of employees (WTE basis)

	Group			Foundation Trust Only		
	Total	**Permanent**	**Other**	**Total**	**Permanent**	**Other**
2017/18	**Number**	**Number**	**Number**	**Number**	**Number**	**Number**
Medical and dental	**168**	166	2	**168**	166	2
Administration and estates	**349**	344	5	**349**	344	5
Healthcare assistants and other support staff	**248**	225	23	**248**	225	23
Nursing, midwifery and health visiting staff	**411**	403	8	**411**	403	8
Scientific, therapeutic and technical staff	**217**	217	0	**217**	217	0
Other (Charity)	**3**	3	0	**0**	0	0
Total average numbers	**1,396**	**1,358**	**38**	**1,393**	**1,355**	**38**
Of which:						
Number of employees (WTE) engaged on capital projects	**14**	14	0	**14**	14	0
2016/17	**Number**	**Number**	**Number**	**Number**	**Number**	**Number**
Medical and dental	**164**	161	3	**164**	161	3
Administration and estates	**356**	346	10	**356**	346	10
Healthcare assistants and other support staff	**210**	210	0	**210**	210	0
Nursing, midwifery and health visiting staff	**422**	399	23	**422**	399	23
Nursing, midwifery and health visiting learners	**23**	0	23	**23**	0	23
Scientific, therapeutic and technical staff	**201**	201	0	**201**	201	0
Other (Charity)	**3**	3	0	**0**	0	0
Total average numbers	**1,379**	**1,320**	**59**	**1,376**	**1,317**	**59**
Of which:						
Number of employees (WTE) engaged on capital projects	**9**	9	0	**9**	9	0

In order to respond to the well-publicised reductions in NHS allocations and at the same time maintain our ability to provide high quality, safe patient care and experience, the Trust has implemented service improvements and efficiencies across the organisation in 2017/18. To assist in facilitating the necessary changes and efficiencies, and due to a number of staff requesting such a scheme, a time limited Mutually Agreed Resignation Scheme (MARS) was introduced during 2017/18. The scheme was approved by NHS Improvement and adhered to national Agenda for Change terms and conditions of service. Tables 4, 5 and 6 show the number and value of exit packages for 2017/18 and 2016/17.

Table 4

Reporting of compensation schemes - exit packages 2017/18

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	0	3	**3**
£10,001 - £25,000	0	0	**0**
£25,001 - £50,000	0	1	**1**
£50,001 - £100,000	0	0	**0**
£100,001 - £150,000	0	0	**0**
£150,001 - £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**0**	**4**	**4**
Total resource cost (£)	£0	£54,000	**£54,000**

Table 5

Reporting of compensation schemes - exit packages 2016/17

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	0	1	**1**
£10,001 - £25,000	0	1	**1**
£25,001 - £50,000	0	2	**2**
£50,001 - £100,000	0	1	**1**
£100,001 - £150,000	0	1	**1**
£150,001 - £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**0**	**6**	**6**
Total resource cost (£)	£0	£288,000	**£288,000**

Table 6

Exit packages: other (non-compulsory) departure payments

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£'000	Number	£'000
Mutually agreed resignations (MARS) contractual costs	4	54	6	288
Total	**4**	**54**	**6**	**288**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

Delivery of Efficiency (Cost Improvement Programme)

The Trust, in line with all Trusts, is required to deliver recurrent efficiency savings on an annual basis as part of the delivery of the Trust's financial plan for the year. Within the financial plan set at the start of the financial year was the requirement to deliver £3.9 million of efficiency savings to ensure the overall delivery of the control total (financial 'target' set by NHS Improvement, delivery of which secures access to Sustainability and Transformation funding). As at 31 March 2018 the Trust had achieved £2.8m of recurrent savings, which represents 72% of the planned level. This represents 2.3% of the Trusts operating expenses. £1.1m of recurrent savings were not delivered during 2017/18 but additional savings were found through a number of non-recurrent measures. All identified savings schemes are subject to Quality Impact Assessments (QIA) and approved by the Medical Director and Director of Nursing to ensure that there is no adverse impact on patient safety, quality and patient experience.

Investments in Trust Infrastructure and Equipment

The Trust spent £3.3m of capital expenditure in 2017/18. Expenditure during the year included an equipment replacement programme and the progression of the Trust's Digital Strategy. The capital programme is guided by principles of patient safety, business continuity/ service delivery and clinical developments in line with the Trust's strategy.

Table 7 sets out the major components of the Trust's capital investment expenditure programme for the year ended 31st March 2018.

Table 7

Capital - 2017/18	
Division	**£'000**
Service Developments	(62)
Estates	446
IM&T	913
Neurology	190
Neurosurgery	1,701
Corporate	76
Total Capital	**3,264**

Going Concern

Following extensive enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have identified no material uncertainties that cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The main factors in reaching this conclusion are:

- The Trust's latest financial plan forecasts a surplus position across the coming financial year;
- Projected cash balances are sufficient to sustain the capital investment programme and meet short term operating costs. The Trust has sufficient cash headroom to support its plans;
- There is no expectation for short term loans or overdraft facilities;
- Auditors' opinions have provided assurance as to the accuracy and reliability of the Trust's financial systems and the robustness of the internal controls.

Forward Look

The financial year 2018/19 will be another challenging year for the NHS as a whole. Plans are in place to ensure that the Trust will continue to deliver against its terms of licence as a Foundation Trust by delivering excellent, safe, high quality patient care. The control total proposed by NHS Improvement is a £3.0m surplus and the Trust has set plans to achieve this. This predicted performance is driven by the continued increase in historic referral trends but delivered in an efficient and effective manner. The plan includes a cost improvement programme of £3.2 million, with year-end cash balances projected to be c.£21.7 million.

The Trust had been the lead as an acute care Vanguard site in 2016/17 and 2017/18, however central funding for this project ended on 31st March 2018. The Trust will receive no further funding in 2018/19 from NHS England although large elements of the project have been adopted by the Trust and the wider health economy (£1.75 million was received in 2017/18).

Risks and Uncertainties

There continues to be a good deal of uncertainty within the NHS and the Trust is managing a number of risks and issues. These can be broadly categorised into the following 4 main headings:

- **Productivity**: ensuring the performance levels necessary to meet patient demand and continue to deliver access targets and financial plans;
- **Workforce**: recruitment, retention and succession planning of the right workforce at the right time to deliver the increase in activity;
- **Healthcare acquired infections**: continued control of infections and management of newly emerging infections;
- **Commissioner decisions**: the funding available to commissioners and how/where commissioning decisions are taken:
    - In 2017/18 a block contract has been agreed with North Mersey CCG's as part of an 'Acting as one' arrangement across the North Merseyside region, for a period of 2 years. This means that non-specialist activity levels are fixed to 2017/18 block plus 1% (with 2017/18 block being based on 2016/17 outturn plus 1%). Any performance above this level will not be funded and as such creates some risk if referrals exceed agreed growth levels;
    - Changes to the tariff were introduced in 2017/18 which recognised the increased cost of providing specialist services. Debate continues with Welsh Commissioners regarding the increased charges relating to HRG4+. There is a continued risk on this element of income although NHS Improvement/ NHS England are aware of this and are in regular dialogue with Welsh Commissioners to come to a satisfactory conclusion with regard to funding this activity.

Principal Risks

The principal risks facing the Trust are:

- Failure to achieve CIP financial plans in accordance with the strategic plan;
- Failure to deliver financial stability in the medium term due to changes in the NHS economic environment e.g. tariff changes;
- Failure of Welsh Health Specialised Services Committee to pay tariffs at HRG4+ levels;
- Failure to meet neurosurgery and pain RTT targets required by NHS Improvement and NHS England;
- Shortfall in clinical capacity to meet anticipated demand with reliance on short term, premium rate methods to deliver key performance targets.

The above risks have been assessed and have been rated between 9 and 16. Risks rated below 16 are reported in the annual governance statement. All these risks are recorded on the Board Assurance Framework.

During 2017/18 the Trust experienced a significant reduction in violent and aggressive incidents from patients against staff. These incidents were dealt with on an individual basis with staff and patient safety being considered a priority. Staff were supported throughout all the events. In order to maintain this reduction, the Trust has invested in, and successfully appointed, an internal violence and aggression trainer, who commenced in post 1st April 2018. This will ensure that staff have all the relevant competencies in dealing with challenging patients in real-time. Also, this will provide a support mechanism to staff and ensure that all actions, including the use of sanctions, are used when required.

2017/18: Activity

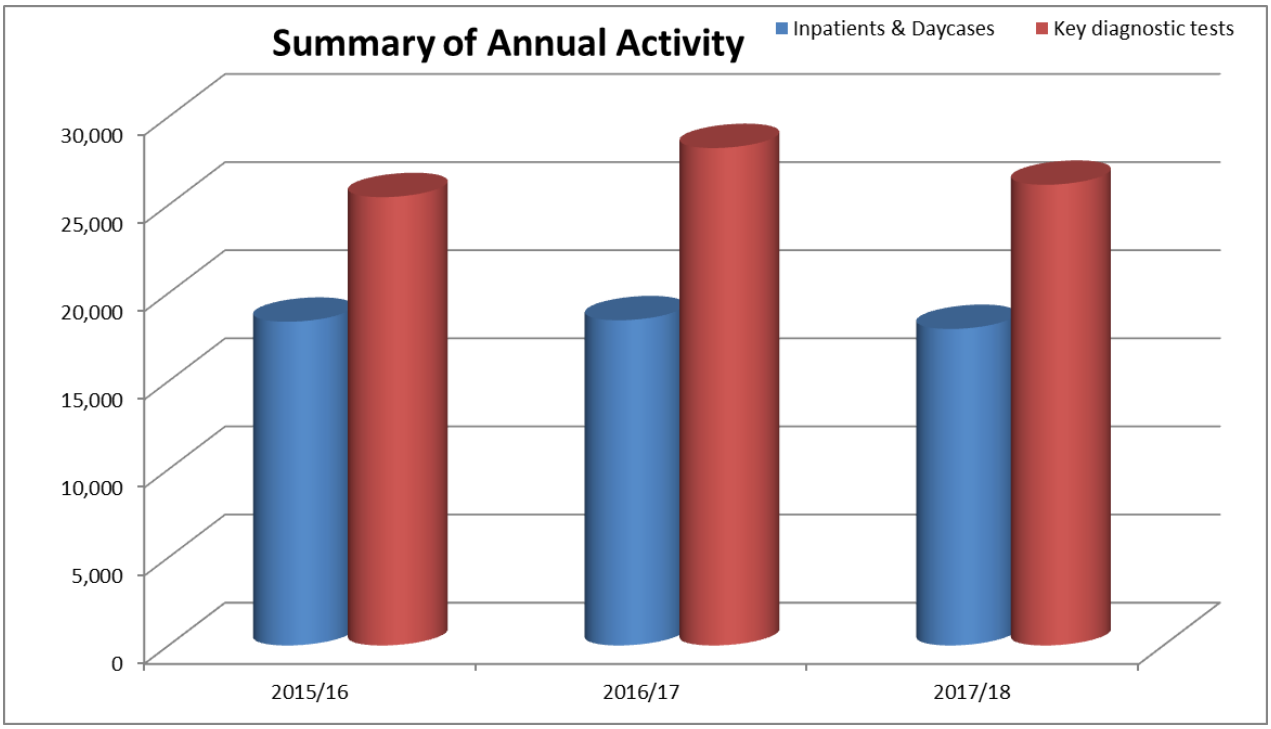
During 2017/18, the Trust's activity has decreased by 3.51% in comparison to 2016/17. There has been a decrease in elective activity of 3.39% and a decrease of 3.21% in day cases, but an increase in non-elective activity of 1.99% when compared to 2016/17.

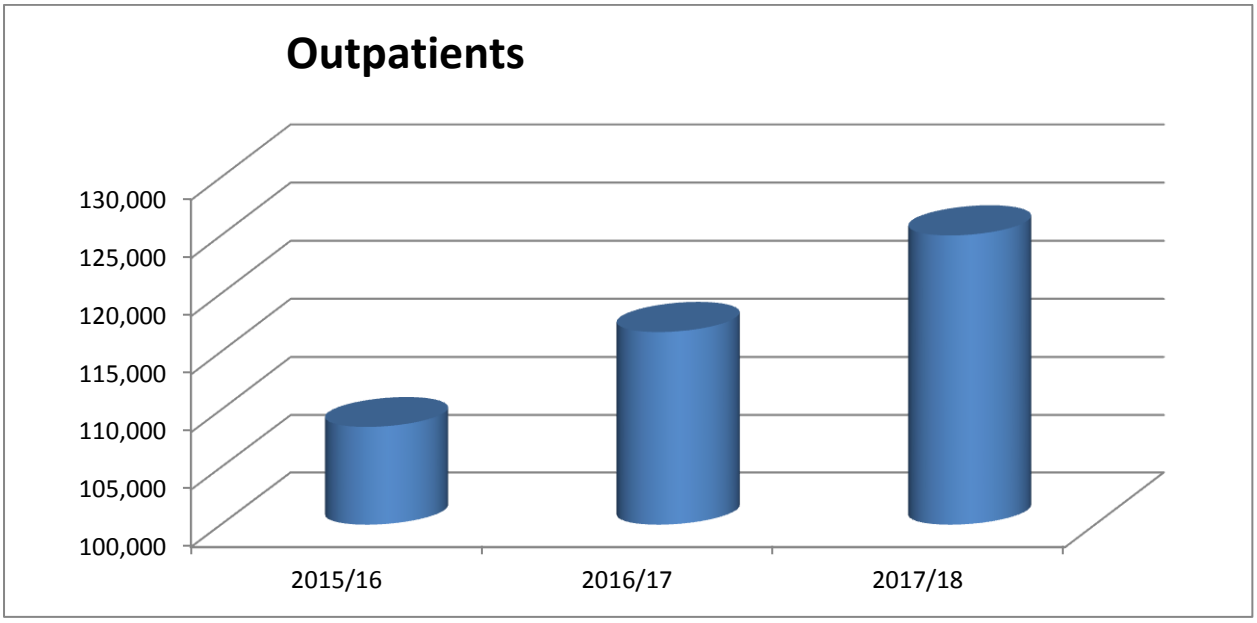
Summary of Activity

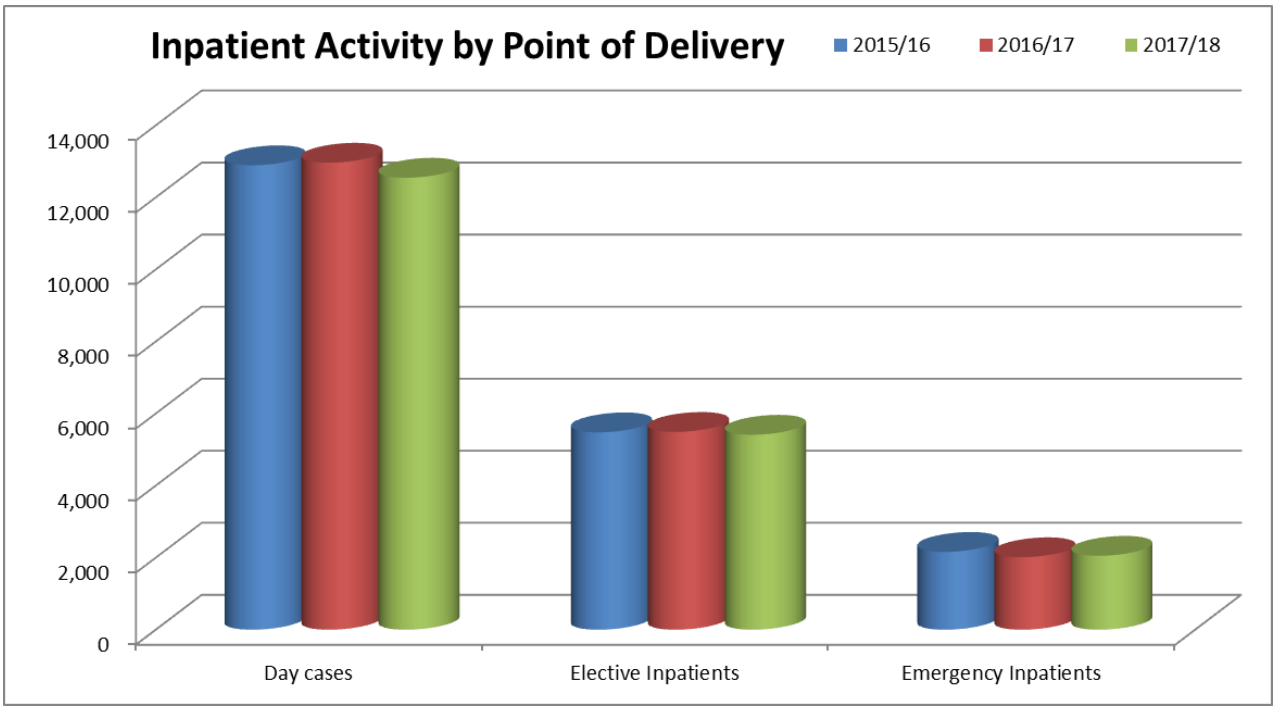
Table 8 shows activity for 2017/18 compared to previous years.

Table 8

	2013/14	**2014/15**	**2015/16**	**2016/17**	**2017/18**
Day cases	10,254	11,405	12,893	12,964	12,547
Inpatients	5,773	5,719	5,479	5,491	5,408
Outpatients	100,911	103,891	108,518	116,701	125,012
Key diagnostic tests	23,913	25,336	25,442	28,229	26,143


Summary of Annual Activity
Inpatients & Daycases
Key diagnostic tests
30,000
25,000
20,000
15,000
10,000
5,000
0
2015/16
2016/17
2017/18


Outpatients
130,000
125,000
120,000
115,000
110,000
105,000
100,000
2015/16
2016/17
2017/18



Bed Occupancy Rates

Bed occupancy is measured in line with the relevant national definition and reflects occupancy at midnight. This can vary by 1-3% from the measurement of occupancy levels at other times throughout the day. Overall for 2017/18 the average bed occupancy for the Trust's main wards (i.e. excluding Critical Care and the Complex Rehabilitation Unit (CRU)) was 83.98%, a decrease of 2.98% on 2016/17. Table 9 below gives the breakdown of occupancy rates for 2016/17 and 2017/18.

Table 9

Main Wards	Q1	Q2	Q3	Q4	Overall
2016/17	87.8%	88.1%	85.2%	86.6%	86.9%
2017/18	78.3%	84.4%	84.4%	89%	83.9%

Critical Care	Q1	Q2	Q3	Q4	Overall
2016/17	85.9%	82.3%	83.7%	80.9%	83.2%
2017/18	83.3%	85.9%	87.7%	83.5%	85.1%

CRU	Q1	Q2	Q3	Q4	Overall
2016/17	94.0%	93.0%	91.2%	89.4%	91.8%
2017/18	93.5%	81.8%	88.2%	86.2%	87.4%

2017/18: Referral to Treatment Target (RTT)

The Walton Centre has consistently achieved its access standards during 2017/18, with the most recent figures for Q4 showing a performance of over 94% against the 92% open pathways target.

Table 10 represents an overview of Trust performance against national priorities the single oversight framework published by NHS Improvement.

Table 10

Performance Indicator	2016/17 Performance	2017/18 Target	2017/18 Performance
Referral to treatment time, 18 weeks in aggregate, incomplete pathways	96.44%	92%	94%
All Cancers: 62 days wait for 1st treatment from urgent GP referral to treatment	100%	85%	100%
All Cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery	96.43%	94%	100%
All Cancers: Maximum waiting time of 31 days from diagnosis to first treatment	100%	96%	100%
All Cancers: 2 week wait from referral date to date first seen	99.66%	93%	99.59%
Incidence of Clostridium difficile	9	10*	7
Compliance with requirements regarding access to healthcare for people with a learning disability	Achieved	Achieved	Achieved
*Threshold set by Public Health England			

The Environment

The Trust has continually undertaken and monitored a number of measures during the year to reduce its impact on the environment. The Trust continues to use a confidential waste disposal service, whereby 100% of the shredded items are reproduced into other paper products.

3i Accountability Report – directors' report

Directors

The Board of Directors has collective responsibility for setting the strategic direction and organisational culture; and for the effective stewardship of the Trust's affairs, ensuring that the Trust complies with its licence, constitution, mandated guidance and contractual and statutory duties. The Board must also provide effective leadership of the Trust within a robust framework of internal controls and risk management processes. The Board approves the Trust's strategic and operational plans, taking into account the views of Governors; it sets the vision, values and standards of conduct and behaviour, ensuring that its obligations to stakeholders, including patients, members and the wider public are met. The Board is responsible for ensuring the safety and quality of services, research and education and application of clinical governance standards including those set by NHS Improvement, the Care Quality Commission, NHS Resolution and other relevant bodies. The Board has a formal Schedule of Matters Reserved for Board Decisions and a Scheme of Delegation. A copy of the Scheme of Reservation and Delegation is available from the Deputy Director of Governance:

- By telephone: 0151 556 3423
- By post:

  Ann Highton
  Deputy Director of Governance
  The Walton Centre NHS Foundation Trust
  Lower Lane
  Fazakerley, L9 7LJ

The unitary nature of the Board means that Non-Executive Directors and Executive Directors share the same liability and same responsibility for Board decisions and the development and delivery of the Trust's strategy and operational plans. The Board delegates operational management to its executive team and has established a Board Committee structure to provide assurances that it is discharging its responsibilities. The formal Schedule of Matters Reserved for the Board also includes decisions reserved for the Council of Governors as set out in statute and within the Trust's constitution.

During the period 1st April 2017 to 31st March 2018, the following were members of the Trust's Board of Directors:

Janet Rosser, Chair

Mrs Rosser was appointed as Chair of the Trust in April 2017. Prior to this, she was a Non-Executive Director and the Deputy Chair of the Trust.

After having a family, Mrs Rosser qualified as a lawyer in 1987 and trained with a North West firm in property and commercial law, spent some time lecturing undergraduate and post graduate students before moving to an international law firm spending ten years in the corporate department embedding new systems of working. She then moved on to work for a publishing house, writing and editing corporate based law books and updates. She is passionate about The Walton Centre and keen to ensure that it remains an outstanding Trust.

Non-Executive Directors

Ann McCracken, Non-Executive Director

Mrs McCracken was appointed in 2012 and is Deputy Chair and Senior Independent Director of the Board. She chairs the Quality Committee and is the Health and Wellbeing lead. She has worked in communications throughout her career from early days as a newspaper journalist to more recent times as Head of Communications for the North of England. She is now a Communications Consultant and also works with Citizens Advice. Mrs McCracken has held Non-Executive Director positions at the Royal Liverpool University Hospital and Liverpool Women's NHS Foundation Trust. Mrs McCracken's final term of office has been extended by one year to the end of May 2019.

Alan Sharples, Non-Executive Director

Mr Sharples was appointed in 2011 and is a former Director of Finance, Information and Commissioning at Alder Hey Children's NHS Foundation Trust. He has 33 years' experience of financial management in the public sector, 17 of which was at Board level. Mr Sharples is a former president of the North Wales branch of the Institute of Revenues, Rating and Valuation (IRRV), Vice-Chairman of the North Wales Local Authority Chief Finance Officers' Association and is a trustee of the charity Vision for Children. Mr Sharples' final term of office has been extended for a further year to the end of May 2019.

Seth Crofts, Non-Executive Director

Mr Crofts is the Pro Vice-Chancellor and Dean for the Faculty of Health and Social Care at Edge Hill University and is also a registered nurse in both Adult and Mental Health Nursing with 33 years of nursing experience. Mr Crofts is an experienced leader of health care education, has worked as a reviewer for the Quality Assurance Agency for Higher Education (QAA) since 2002 and been extensively involved in working to develop professional practice in higher education. He has made a major commitment to developing graduate employability and is currently involved in developing practice in health and social care organisations, with a specific interest in developing leadership skills in senior nurses. Mr Crofts was appointed as a Non-Executive Director at The Walton Centre in 2013, with his current term of office end due to end in October 2019.

Sheila Samuels, Non-Executive Director

Mrs Samuels joined the Trust in September 2015 and has a wealth of experience in public sector management and leadership. She has previously held Executive Director Board level roles in local government and the NHS. Since retiring in 2013 after 35 years public service, she has undertaken a number of consultancy assignments to support public sector and charitable organisations in addressing major organisational challenges. Mrs Samuels was appointed as Non-Executive Director in September 2015 and is currently in her first term of office.

Dr Peter Humphrey, Non-Executive Director

Dr Humphrey trained in Oxford, Southampton and London and qualified in medicine from Oxford University in 1972. He was appointed Consultant Neurologist at The Walton Centre in 1983 and went on to become Medical Director. Dr Humphrey had a major interest in cerebrovascular disease and set up the first one stop TIA clinic in the UK in 1983. Dr Humphrey has served as the Secretary of the Association of British Neurologists, President of the North of England Neurological Association and President of the British Association of Stroke Physicians. He is keen to ensure The Walton Centre retains an active research programme in order to continue as a leading research Neuroscience Centre. Dr Humphrey was appointed as a Non-Executive Director in August 2015 and is currently in his first term of office.

Executive Directors

Chris Harrop, Chief Executive (until 31st January 2018)

Mr Harrop qualified as a Public Chartered Accountant (Chartered Institute of Public Financial Accountants) at Liverpool John Moores University in 1994 and joined The Walton Centre as Director of Finance in 2004. With over 25 years NHS experience covering community, acute and specialised services Mr Harrop was appointed as the Trust's Chief Executive from 1 April 2014. Mr Harrop is also a qualified Executive and Business coach. Mr Harrop left the Trust on 31st January 2018.

Hayley Citrine, Chief Executive (from 1st February 2018) / Director of Nursing, Operations and Quality (until 31st January 2018)

Ms Citrine was appointed as Chief Executive from 1st February 2018. Prior to this, Ms Citrine joined The Walton Centre in 2014 as Executive Director of Nursing and Quality following a role as Acting Chief Nurse in her previous organisation. In 2016 the role was extended to include operations and performance as well as nursing and quality, widening her brief. Ms Citrine started her career in the NHS in 1985 and has worked as Deputy Director and Associate Director of Nursing for a number of years following previous experience in a variety of clinical posts at South Manchester University Hospitals Trust, Salford Royal Foundation Trust, Warrington & Halton Hospitals Foundation Trust and East Lancashire NHS Trust. During her career she has also experienced roles in governance and general management which has added to her breadth of knowledge.

Ms Citrine qualified in 1989, undertaken a wide variety of clinical training, holds three diplomas, a BA (Hons) in Health Studies and is a Master Practitioner in NLP. She has undertaken a variety of leadership development programmes through the Kings Fund, CASS Business School and NHS leadership programmes.

Dr Andrew Nicolson, Medical Director

Dr Nicolson completed his medical training in Manchester and neurology training mainly in the North West, before he was appointed as a Consultant Neurologist at The Walton Centre in 2005. He has a specialist interest in epilepsy, and remains part of the multidisciplinary team providing epilepsy services at the Trust. He has previously provided an outreach neurology service to The Royal Liverpool Hospital and Arrowe Park Hospital, and currently runs a community general neurology clinic in Wirral. He was Director of Medical Education 2007-13 and then Assistant Medical Director 2013-16. He was appointed as Medical Director from September 2016.

Mike Burns, Director of Finance

Mr Burns joined The Walton Centre in 2012 as Deputy Director of Finance after previously working for the Strategic Health Authority and Wrightington, Wigan and Leigh Foundation Trust. He qualified as a Chartered Management Accountant (CIMA) in 2001 after gaining a BSc (Hons) in Economics. Mr Burns' portfolio at the Trust includes Finance, Procurement, IM&T and Corporate Information. Mr Burns took up the post of Director of Finance in April 2016. His previous experience includes working in a range of sectors including consultancy, financial services, banking and retail.

Stuart Moore, Director of Strategy and Planning / Deputy Chief Executive

Mr Moore joined The Walton Centre in 2012. He began his career on the civil service training scheme at the Department of Health (DH) where he held a number of policy posts and was seconded to Sheffield Health Authority. He has worked in the NHS in Liverpool since 1996, having previously held a range of posts at the Royal Liverpool and Broadgreen University Hospitals NHS Trust, including Directorate Manager, Head of Planning & Performance and Acting Project Director. His responsibilities include estates and facilities management, governance, service improvement and the Neuro Network Vanguard.

Lisa Salter, Interim Director of Nursing and Quality (from 1st February 2018)

Mrs Salter completed her nurse training at the Royal Liverpool and Broadgreen Hospital and worked within the Nephrology Directorate. She progressed through different roles including, Lead for Nurse Recruitment and Head of Professional Nursing. In 2009, Mrs Salter moved to Liverpool Heart and Chest Hospital as Matron where she later became Assistant Director of Nursing for Patient Experience making changes for the benefit of both patients and staff.

Her final role at the Trust was Divisional Head of Nursing for Surgery and Quality before commencing her role at The Walton Centre Foundation Trust in June 2017 as Deputy Director of Nursing and Lead Nurse for Neurosurgery.

Mrs Salter qualified in 1994, holding a diploma in renal medicine, BSc Hons in Clinical Management and an MSc in Healthcare Leadership, the latter being as part of the NHS Leadership Academy. She has also completed several leadership and coaching programmes throughout her career to date.

Corporate Director

Mike Gibney, Director of Workforce

Mr Gibney, previously at Cheshire and Merseyside Commissioning Support Unit, has worked in charitable organisations and local government, including nine years in Social Services.

Mr Gibney joined the NHS four years ago, through the Gateway to Leadership Scheme. His role at The Walton Centre includes responsibility for HR, Training and Development, Communications and Fundraising.

Independence of Non-Executive Directors

All of the Trust's Non-Executive Directors are considered to be independent and there are no relationships or circumstances that are likely to affect any director's judgment as evidenced by their declaration of interests.

Appointment and Termination of Non-Executive Directors

Non-Executive Directors are appointed by the Council of Governors for a term of three years, at the end of this period, Non-Executive Directors are eligible for re-appointment for a further three years in compliance with the NHS Foundation Trust Code of Governance. Removal of the Chairman or another Non-Executive Director is in accordance with the Trust's constitution.

Balance, Completeness and Appropriateness

The Board of Directors is balanced and complete, having an appropriate mix of skills and experience in the areas of finance, operational management, governance, law, commerce, education, medicine, clinical research, diagnostics and nursing. There is a clear separation of the roles of the Chairman and Chief Executive, which have been set out in writing and agreed by the Board of Directors.

Board of Directors Performance Evaluation

During 2017/18, the Trust's Chair undertook a performance evaluation of the Non-Executive Directors and the Chief Executive Officer evaluated the performance of all Executive Directors. The performance evaluation of the Trust's Chair was undertaken by the Lead Governor and the Senior Independent Non-Executive Director and was reported at the Annual Members' Meeting in September 2017.

All directors have undertaken an annual self-certification in 2017/18 to confirm compliance with the requirements of the fit and proper persons regulations (FPPR).

Table 11 represents the attendance at meetings of the Board of Directors 01 April 2017 – 31 March 2018:

Table 11

	April 2017	May 2017 Extra-ordinary Board	May 2017	June 2017	July 2017	Sept 2017 Extra-ordinary Board	Sept 2017	Oct 2017	Nov 2017	Jan 2018	Feb 2018	Mar 2018
J Rosser	✓	✓	A	✓	✓	✓	✓	✓	✓	✓	✓	✓
M Burns	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
H Citrine	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
S Crofts	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
M Gibney	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
C Harrop	✓	✓	✓	✓	✓	A	✓	✓	A	✓		
P Humphrey	✓	✓	✓	A	✓	✓	✓	✓	✓	A	✓	A
A McCracken	✓	✓	✓*	✓	✓	A	✓	✓	✓	✓	✓	✓
S Moore	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A Nicolson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
L Salter											✓	✓
A Sharples	✓	✓	✓	✓	✓	A	✓	✓	✓	✓	✓	✓
S Samuels	✓	A	✓	✓	✓	A	✓	✓	✓	✓	✓	✓

KEY: ✓ = Present A = Apologies *Chaired

Director's Register of Interests

A register is kept of Directors' interests. Access to the register can be gained by contacting the Director of Finance:

- By telephone : 0151 556 3482 (Secretary)
- By post:

  Director of Finance
  The Walton Centre NHS Foundation Trust
  Lower Lane, Fazakerley
  L9 7LJ

The directors or governors do not hold any other significant interests or company directorships which may conflict with their management responsibilities.

Directors' Expenses

Expenses claimed by directors, in accordance with the Trust's constitution, are tabulated in table 12 below to the nearest £100.

Table 12

Name	2017/18 £'00	2016/17 £'00
M Burns	1	2
H Citrine	0	0
P Enevoldson (to 31/08/16)	N/A	1
M Gibney	12	6
C Harrop (to 31/01/18)	3	1
S Moore	6	4
A Nicolson (from 01/09/16)	0	0
L Salter (from 01/02/18)	0	N/A
J Wood (to 31/08/16)	N/A	1
S Crofts	0	0
K Hoskisson (to 31/03/17)	N/A	2
P Humphrey	0	0
A McCracken	2	1
J Rosser (to 31/10/16; from 01/04/17)	10	1
S Samuels	0	2
A Sharples	0	2

Disclosure to Auditors

So far as each director is aware, there is no relevant audit information of which the Trust's auditor is unaware and the Board of Directors has taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information, and to establish that the Trust's auditor is aware of that information.

Accounting Policies for Pensions and Other Retirement Benefits

Accounting policies for pensions and other retirement benefits are set out in note 4 to the accounts and the details of senior employees' remuneration can be found in Section 3ii of the Annual Report on Remuneration.

Provision of Goods and Services for the Purposes of the Health Service

The Trust has met the requirement as detailed in Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) i.e. that the Trust's income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

The Trust receives income for the provision of health services to Wales through the Welsh Assembly Government. There is a small proportion of private patient income (0.1% of total income) and research and

medical development income which are utilised to enhance the provision of the Trust's clinical services and the patient experience.

Better Payment Practice Code

The Better Practice Payment Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Table 13 below summarises the Trust's performance in 2017/18:

Table 13

Better Payment Practice Code - Measure of Compliance	2017/18	
	Number	£'000
Non-NHS Creditors		
Total Non-NHS trade invoices paid in the year	24,175	51,433
Total Non-NHS trade invoices paid within target	22,743	48,941
Percentage of Non-NHS invoices paid within target	94.1%	95.2%
NHS Creditors		
Total NHS invoices paid in the year	1,339	22,301
Total NHS invoices paid within target	1,074	19,751
Percentage of NHS invoices paid within target	80.2%	88.6%

In 2017/18 no interest has been paid by virtue of failing to pay within the 30 day period and no liability to pay interest has been accrued.

Disclosures required under schedule 7

Disclosures required under schedule 7 of the large and medium sized companies and groups (accounts and reports) regulations 2008 are included in the Annual Report on Remuneration in section 3ii.

The Trust has not received any political donations during the year 2017/18.

Enhanced Quality Governance Reporting

Quality governance and quality are discussed in more detail in sections 3vii and 4 of this document. There are no material inconsistencies between the Annual Governance Statement, the board statements required by the Risk Assessment Framework and any Care Quality Commission reviews.

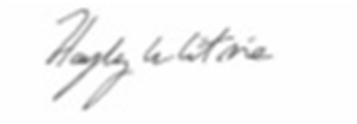
For each director at the time that this report is approved:

- So far as the director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware and
- The director has taken all the steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

'Relevant audit information' means information needed by the NHS foundation trust's auditor in connection with preparing their report.

Each director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above, and:

- Made such enquiries of his/her fellow directors and of the company's auditors for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.



Hayley Citrine, Chief Executive

25 May 2018

3ii Accountability Report – remuneration report

Annual Statement on Remuneration

There were no major changes made to very senior manager pay structure during the financial year from 1 April 2017 to 31 March 2018.

Senior Managers' Remuneration policy

Future Policy table

The table is contained in the report within section 3, and does not have any particular arrangements which are specific to any individual senior manager.

Directors' Contracts, Terms and Conditions

Executive and Corporate Directors' contracts are permanent on appointment and new Executive and Corporate Directors are subject to a period of six months' notice and are entitled to NHS redundancy payments should their posts be made redundant.

Policy on Payment for Loss of Office

The Trust has standard NHS contracts of employment.

The Trust's Remuneration Committee in March 2015 introduced a four point scale for each of the executive director posts.

Table 14 represents the Senior Manager * breakdown by male and female as at 31 March 2018:

Table 14

MALE	8
FEMALE	33
TOTAL	41

**Band 8b and above (excluding medical staff and senior clinical staff with no departmental management responsibility)*

Annual Report on Remuneration

Directors Remuneration

Executive and corporate directors' terms and conditions of service and salaries are determined by the Trust's Remuneration Committee. When determining the terms and conditions of executive and corporate directors the Remuneration Committee set pay in comparison to salaries in other foundation and specialist trusts across the local health economy.

Non-executive directors' remuneration is determined by the Governor Nominations Committee who make their recommendations to the Council of Governors.

The Trust's Policy on Pay

The Trust employs the majority of staff on national Agenda for Change or Consultant Contract Terms and Conditions. This is national policy and therefore a local Trust policy is not applicable. How the national policy is applied locally is agreed through the Trust's Staff Partnership Committee and Local Negotiating Committee (for medical staff). Director remuneration (for voting and non-voting directors) is agreed through the Trust's Remuneration Committee as outlined in the Remuneration Committee's terms of reference.

Where senior managers were paid in excess of £150,000[1] the Trust has reviewed the remuneration in relation to the duties performed and remuneration paid in similar organisations for similar roles and has concluded that the remuneration is fair and reasonable.

REMUNERATION REPORT

Fair Pay Multiple

The Trust is required to disclose the relationship between the remuneration of the highest paid director and the median remuneration of the Trust's workforce.

The median remuneration of the employees paid by The Walton Centre is £30,135 (2016/17: £29,333). The highest paid director is the Medical Director who received £173,868 remuneration (2016/17: £163,172). This is 5.7 times the median remuneration (2016/17: 5.7 times).

In 2017/18, 5 employees, all doctors, received remuneration in excess of the highest paid director (2016/17: 10 employees, all doctors). Remuneration ranged from £13,792 (2016/17: £11,637) to £194,529 (2016/17: £210,200). The lowest paid employee in 2017/18 was an apprentice.

Total remuneration (found in tables 15 and 16 below) includes salary, non-consolidated performance related pay and benefits in kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

[1] £150,000 is the threshold used in the Civil Service for approval by the Chief Secretary to the Treasury, as set out in guidance issued by the Cabinet Office. The Cabinet Office approvals process does not apply to NHS foundation trusts but is considered a suitable benchmark above which NHS foundation trusts should make this disclosure.

Table 15

Remuneration and Pension Entitlements of Senior Managers (subject to audit)

		1 April 2017 - 31 March 2018										1 April 2016 - 31 March 2017									
Name	**Position**	**Salaries and Fees** **£000** **(Bands of £5,000)**			**Taxable Benefits** **£** **(Nearest £00)**	**Pension Related Benefits** **£000** **(Bands of £2,500)**			**Total** **£000** **(Bands of £5,000)**			**Salaries and Fees** **£000** **(Bands of £5,000)**			**Taxable Benefits** **£** **(Nearest £00)**	**Pension Related Benefits** **£000** **(Bands of £2,500)**			**Total** **£000** **(Bands of £5,000)**		
Burns M	Director of Finance	110	-	115	0	35	-	37.5	145	-	150	105	-	110	0	42.5	-	45.0	145	-	150
Citrine H	Director of Nursing and Modernisation (to 31/08/16); Director of Nursing, Operations and Quality (from 01/09/16); Chief Executive (from 01/02/18)	120	-	125	0	62.5	-	65	185	-	190	115	-	120	0	50.0	-	52.5	165	-	170
Crofts S	Non-Executive Director	10	-	15	0	N/A	-	N/A	10	-	15	10	-	15	0	N/A	-	N/A	10	-	15
Enevoldson P	Medical Director (to 31/08/16)	N/A	-	N/A	N/A	N/A	-	N/A	N/A	-	N/A	85	-	90	0	N/A	-	N/A	85	-	90
Gibney M	Director of Workforce	90	-	95	0	15	-	17.5	105	-	110	90	-	95	0	82.5	-	85.0	170	-	175
Harrop C	Chief Executive (to 31/01/18)	130	-	135	0	32.5	-	35	165	-	170	155	-	160	200	110.0	-	112.5	265	-	270
Hoskisson K	Chair (to 31/03/17)	N/A	-	N/A	N/A	N/A	-	N/A	N/A	-	N/A	40	-	45	1,400	N/A	-	N/A	45	-	50
Humphrey P	Non-Executive Director	10	-	15	0	N/A	-	N/A	10	-	15	10	-	15	700	N/A	-	N/A	10	-	15
McCracken A	Non-Executive Director	15	-	20	400	N/A	-	N/A	15	-	20	10	-	15	500	N/A	-	N/A	10	-	15
Moore S	Director of Strategy and Planning; Director of Strategy and Planning/Deputy Chief Executive and Director reponsible for Operations and Performance (from 01/02/18)	105	-	110	0	25	-	27.5	130	-	135	105	-	110	0	32.5	-	35.0	140	-	145
Nicolson A*	Medical Director (from 01/09/16)	170	-	175	0	325	-	327.5	495	-	500	100		105	0	N/A	-	N/A	100		105
Rosser J	Non-Executive Director (to 31/10/16); Chair (from 01/04/17)	40	-	45	2,600	N/A	-	N/A	45	-	50	5	-	10	500	N/A	-	N/A	5	-	10

Salter L	Acting Director of Nursing and Governance (from 01/02/18)	15	-	20	0	12.5	-	15.0	25	-	30	N/A	-	N/A	N/A	N/A	-	N/A	N/A	-	N/A
Samuels S	Non-Executive Director	10	-	15	500	N/A	-	N/A	10	-	15	10	-	15	400	N/A	-	N/A	10	-	15
Sharples A	Non-Executive Director	15	-	20	700	N/A	-	N/A	15	-	20	15	-	20	900	N/A	-	N/A	15	-	20
Wood J	Director of Operations and Performance (to 31/08/16)	N/A	-	N/A	N/A	N/A	-	N/A	N/A	-	N/A	180	-	185	0	30.0	-	32.5	210	-	215

The salaries and fees for A Nicolson and P Enevoldson include remuneration for their clinical responsibilities:

A Nicolson £147,255 (2016/17: £85,489); P Enevoldson Nil (2016/17: £77,104).

*As A Nicolson became Medical Director on September 2016, the current increase in his pension related benefits largely reflects the fact that a full-year's entitlement in 2017/18 is being compared to a partial-year in 2016/17.

No directors received annual performance-related bonuses or long-term performance related bonuses in either period.

A further £6k was agreed to be paid to a former Director in 2017/18 which will be paid in 2018/19 due to a calculation error in relation to the original payment for loss of office made in 2016/17.

No payments have been made to people who have previously been Directors in the Trust in either period.

Table 16

Pension Benefits (subject to audit)

Name	Position	Real Increase in Pension at Pension Age (Bands of £2,500)			Real Increase in Pension Lump Sum at Pension Age (Bands of £2,500)			Total Accrued Pension at Pension Age at 31 March 2018 (Bands of £5,000)			Lump Sum at Pension Age Related to Accrued Pension at 31 March 2018 (Bands of £5,000)			Cash Equivalent Transfer Value at 31 March 2018 £'000	Real Increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2017 £'000	Employer's Contribution to Stakeholder Pension £'000
Burns M	Director of Finance	2.5	-	5.0	0.0	-	2.5	15.0	-	20.0	0.0	-	5.0	188	35	151	0
Citrine H	Director of Nursing and Modernisation (to 31/08/16); Director of Nursing, Operations and Quality (from 01/09/16); Chief Executive (from 01/02/18)	2.5	-	5.0	20.0	-	22.5	40.0	-	45.0	125.0	-	130.0	785	124	655	0
Gibney M	Director of Workforce	0.0	-	2.5	0.0	-	2.5	40.0	-	45.0	0.0	-	5.0	605	46	553	0
Harrop C*	Chief Executive (to 31/01/18)	0.0	-	2.5	0.0	-	2.5	55.0	-	60.0	145.0	-	150.0	1,021	71	926	0
Moore S	Director of Strategy and Planning; Director of Strategy and Planning/Deputy Chief Executive and Director reponsible for Operations and Performance (from 01/02/18)	0.0	-	2.5	0.0	-	2.5	40.0	-	45.0	110.0	-	115.0	778	64	706	0
Nicolson A	Medical Director	15.0	-	17.5	35.0	-	37.5	35.0	-	40.0	85.0	-	90.0	543	249	290	0
Salter L*	Acting Director of Nursing and Governance (from 01/02/18)	0.0	-	2.5	0.0	-	2.5	25.0	-	30.0	60.0	-	65.0	381	10	318	0

H Citrine and M Gibney opted out of the NHS Pension Scheme on the 31 January 2018.
As A Nicolson became Medical Director on September 2016, the current increase in his pension related benefits largely reflects the fact that a full-year's entitlement in 2017/18 is being compared to a partial-year in 2016/17.
The total accrued pension, lump sum and cash equivalent transfer values represent the total value for each Director. The real increases have been adjusted for directors not in post throughout the period to reflect only the increase attributable to their role as a Director (marked*).

Chief Executive
Date: 25 May 2018

3iii Accountability Report – staff report

Our People Matter – Walton Centre Staff

Key workforce strategies set out the Trust's commitment to providing world class HR – Recruitment Strategy, Organisational Development Strategy and the Coaching Strategy.

Education and Organisational Development

Supporting the Trust's strategic plan the organisation continues to be highly committed to promote excellence in education and training to ensure it delivers the highest calibre of health care staff for future NHS patients.

The role of the Education team is to support the organisation to provide education, training and development opportunities to develop current workforce and to support the talent of the future. The Trust retained its IIP Gold status in 2017 and the Trust's commitment to developing its staff was recognised. Education and organisational development initiatives from the last 12 months include:

- Cohorts 11 & 12 completed the PRIDE leadership programme, which forms part of the Trust collective leadership portfolio. The programme, which has been revised based on user feedback and organisational requirements, includes resilience, mindfulness, handling conflict, developing effective relationships, coaching skills and performance & motivation. Action learning sets were introduced to cohorts 11 & 12 for the first time following completion of the programme. Feedback for the programme remains excellent.
- To further support the Trust's coaching strategy and as part of the journey to embed a coaching culture within the organisation, an initial cohort of staff completed a coaching practitioner course in 2016 and the group gained their accreditation in 2017. The cohort have supported a number of "coachees" alongside qualified internal coaches who continued to support senior leaders. Staff have also been able to access external coaching when appropriate to support them with specific development. The coaching group will be "launched" to the organisation in 2018.
- Access to leadership development programmes provided by the North West Leadership Academy continue to be available to all staff. In 2017, the Leadership Academy announced plans to localise delivery of the Mary Seacole programme and the Trust nominated an internal facilitator to train and deliver on the revised programme.
- The Band 6 Collective Leadership Programme, which has a focus on developing "clinical expert" skills through bespoke training sessions, continues to support new and experienced ward staff. The focus has been to ensure all relevant staff receive the core clinical aspects of the Programme with the next steps being to deliver sessions which develop the leadership aspect of the role.

- The “next steps” of the Ward Manager Collective Leadership Programme was launched, with Ward Managers being offered individual coaching and 360 feedback via the Leadership Academy, as well as bespoke leadership development sessions.
- Training & Development supported key leads within The Rehab Network to develop a bespoke Rehabilitation module in partnership with a local university. The first cohort of attendees are currently completing the module.
- Organisational development support continues to be provided across the Trust, including team away days, team development and objective and priority setting.
- The Walton Centre continues to provide quality undergraduate medical student placements for 3rd and 5th year students, in partnership with Liverpool School of Medicine. Every 3rd year student attends the highly evaluated Neurology placement at the Trust and the innovative implementation of the formative assessment at the end of each student’s placement has been acknowledged as good practice by Liverpool University and adopted by other Trusts within the region. The undergraduate programme underwent a quality monitoring visit by Liverpool University in May 2017 and the support, commitment, culture and pastoral care provided by The Walton Centre was highly commended by the visiting team.
- The recommendations provided by Health Education North West following the Quality Monitoring visit in January 2017 continue to be embedded and anecdotal feedback from trainees supports the general positive theme of the report regarding the experience of the junior doctors’ whilst training at The Walton Centre.
- The review of the staff appraisal process continued with focus groups held to gain staff feedback on the current documentation and process and to understand general perception of the experience of appraisals. Staff feedback was fully taken into account to allow for the full redesign of the paperwork with the main focus becoming on how to “Have a Conversation”. Consultation continues regarding the revised paperwork and policy and the new documentation is due to be rolled out in 2018 once approved.
- Following the deep dive review of mandatory training, all changes have been implemented to ensure statutory/mandatory training requirements are supported and the Trust continues to deliver safe and effective care to its patients. The Trust has maintained good attendance for statutory and mandatory training with a revised training needs analysis agreed, supported by a new and revised reporting framework to help support delivery of safe and effective care to our patients.
- The Trust continues to support all staff with a range of education and development opportunities available to support service priorities and individual development. This includes professional qualifications, conferences and seminars, post registration accredited opportunities, apprenticeships, skills development and clinical skills training – including catheterisation, cannulation and venepuncture.
- The apprenticeship levy was introduced, with the Trust paying into the levy since April 2017. The levy has been introduced for organisations to explore different ways of engaging with new staff and also providing existing staff with the educational framework to develop in their roles. A training needs

analysis has been completed to understand current organisational demand for apprenticeships within our existing workforce as we look to finalise the available offerings.

- As part of a commitment to corporate and social responsibility, the Trust provides a quality work experience programme and co-ordinates the provision of elective placements, working closely with local schools and colleges. Work experience placements are highly valued and The Walton Centre supported 47 placements in 2017/18. The Trust is working in partnership with 4 other specialist Trusts in the region and in conjunction with Merseyside Youth Association in the employment of 4 Employment Mentors, who will be supporting organisations specifically in developing Entry Level Vocational Learning Developments for young people as well as the following groups: people with disabilities; young carers; looked after children; assessed as not being in education, employment or training (NEETS); veterans and their families.
- Schwartz Rounds continue to be part of the development available, offering staff from a range of disciplines to consider their experiences of providing care and explore any challenging emotional or social issues that they may deal with, as well as providing staff attending the sessions the opportunity to understand the challenges faced by our colleagues across the Trust. Feedback from the panels presenting at the sessions and from attendees has been excellent.
- As part of the national Talent for Care programme, focus groups were held for Bands 1- 4 staff to invite feedback on the support and development opportunities this staff group feel is available to them. In addition to amendments to the appraisal paperwork, suggestions for development included medical terminology, minute taking and IT skills. All development requests were considered and a programme of training has been offered, including:
    - Minute taking
    - Medical terminology
    - Training for emerging managers
    - Train the Trainer
    - Advanced Word
    - Advanced Excel
    - Time Management
    - Assertiveness

Future plans include developing an internal work-experience programme. Additional support has been provided to the Care Certificate programme, including the appointment of a Care Certificate Assessor.

Staff Survey

The 2017 survey was distributed between September and November 2017.

The Staff Survey is an important strand in the organisation's overall approach to staff engagement. Other elements include:

- Established staff communications and engagement methods including a weekly email bulletin to all staff, Walton Weekly; plus a monthly team brief meeting for all heads of department which is led by the Chief Executive.
- Quarterly clinical senates draw together clinicians to discuss clinical issues and are well attended from all specialties.
- Regular staff and patient listening weeks.
- Participation in Staff Friends and Family Test
- Regular staff engagement events i.e. Berwick sessions and Schwartz rounds

The Walton Centre NHS Foundation Trust had 574 staff take part in this survey with a response rate of 42% of all staff against a national average of 53% for specialist trusts in England.

Table 17 below represents the Staff Feedback data from the 2017 staff survey which identifies the key findings and informs future actions.

Table17

Positives

- **Overall staff engagement score**

2017 Score	4.00
2016 Score	4.02
2017 National Average	3.95
Comparison to National Average	**Better**

- **Organisation and management interest in and action on health and wellbeing**

2017 Score	3.98
2017 National Average	3.73
Comparison to 2016 and national average	**Same as 2016 score and best score for acute specialist Trust**

- **Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse**

2017 Score	52%
2017 National Average	47%
Comparison to 2016 score and national average	**Decreased by 1% from 2016 score and better than average**

- **Effective team working**

2017 Score	3.91
2016 National Average	3.79

Comparison to 2016 score and national average	**Better than 2016 score and best score for acute specialist Trust**

- **Percentage of staff satisfied with the opportunities for flexible working patterns**

2017 Score	59%
2017 National Average	54%
Comparison to 2016 score and national average	**Better than 2016 score and better than national average**

- **Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**

2017 Score	20%
2017 National Average	23%
Comparison to 2016 score and national average	**Same as 2016 score and better than national average**

Negatives

- **Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months**

2017 Score	19% decrease from 21% in 2016
2017 National Average	7%
Comparison to National Average	**Worse**

- **Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or public in the last 12 months**

2017 Score	23% decrease from 27% in 2016
2017 National Average	21%
Comparison to National Average	**Worse**

- **Percentage of staff experiencing physical violence from staff in last 12 months**

2017 Score	3%
2017 National Average	1%
Comparison to National Average	**Worse**

- **Percentage of staff agreeing that their role makes a difference to patients/service**

2017 Score	89%
2017 National Average	91%

Comparison to National Average	Worse

- **Percentage of staff appraised in last 12 months**

2017 Score	83%
2017 National Average	88%
Comparison to National Average	**Worse**

Areas of improvement from the previous year are as follows:

- Effective team working
- Staff experiencing harassment, bullying or abuse from patients, relatives or the public
- Staff experiencing physical violence from patients, relatives or the public
- Percentage of staff satisfied with opportunities for flexible working
- Percentage of staff working extra hours.

An action plan has been developed to address the issues which arose from the previous year relating to the following areas;

- Patient Care and Experience
- Appraisals and support for development
- Violence, harassment and bullying
- WRES

The results of the staff survey are variable but it is important to recognise that they are mainly positive in nature.

6.2 Future Priorities and Actions

The key priority areas to address inevitably need to be those identified in the bottom ranking scores. These can be explicitly profiled in existing staff engagement techniques and this will allow more prescriptive engagement exercises such as Staff Listening Weeks and the Chief Executive's schedule of big conversations. However, the Trust will consider the results in their entirety and identify any areas that can be improved upon. The results can also be interpreted by staff group or department which will enable the organisation to take specific action where required.

The Trust's HR team visit wards/departments to gather additional feedback regarding staff survey results. This information is fed into staff communications.

Staff Profile

On 31st March 2018 the Trust employed 1292.11 whole time equivalents made up of the following groups in table 18 below:

Table 18

Staff Group	WTE	Headcount
Prof scientific and technic	**52.90**	**58**
Clinical services	**212.29**	**240**
Administrative and clerical	**339.03**	**374**
Allied health professionals	**138.82**	**155**
Estates and ancillary	**7.37**	**11**
Healthcare scientists	**20.24**	**22**
Medical and dental	**124.51**	**130**
Nursing and midwifery registered	**396.64**	**429**
Total	**1291.8**	**1419**

- Female staff = 1107
- Male staff = 312

Trade Union Facility Time

Relevant union officials

The total number of Trust employees who were relevant union officials during the relevant period are noted in table 19

Table 19

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
8.00	**8.00**

Percentage of time spent on facility time

The number of employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time is noted in table 20.

Table 20

Percentage of time	*Number of employees*
0%	
1-50%	**8.00**
51%-99%	
100%	

Percentage of pay bill spent on facility time

The percentage of the Trust's total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period is noted in table 21.

Table 21

Total cost of facility time	**£24,254**
Total pay bill	**66.4 million**
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	**0.04%**

Paid trade union activities

The number of hours spent by employees who were relevant union officials during the relevant period on paid trade union activities are noted in table 22.

Table 22

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	**20.5%**

Staff Engagement

Regular staff and patient listening weeks have continued, with teams of staff carrying out surveys and holding discussions with individuals and teams throughout the Trust to strengthen existing surveys and feedback methods. In 2017/18, the Friends and Family Test continued, facilitated via email and sent to a random sample of staff each quarter. All Trust staff are given the opportunity to participate in the survey over the year.

The Trust continues to have very positive working relationships with Staff Side, through the Staff Partnership Committee, which includes medical representation. The Trust also has a Local Negotiation Committee for medical staff. These committees confer with staff representatives to consult and negotiate on workforce policies, procedures and terms of conditions of employment. The Trust's workforce policies and procedures are negotiated and agreed through these forums.

Staff Health and Wellbeing

The established programme of health and wellbeing activities continues to be available to staff. The programme has been expanded throughout the year to include additional activities in direct response to

staff feedback/requests, including the introduction of a mindfulness programme and participation in a “back class” managed by a neighbouring Trust. In particular, there is a strong focus on ensuring activities are available for difficult to reach groups including front line ward based staff. This has included the introduction of a health and wellbeing app.

The Trust’s Health and Well Being programme is supported by a core group of staff including a non-executive director as Board lead and a Senior Physiotherapist as Clinical lead.

A range of after work exercise classes continues to prove popular, with zumba, pilates, circuit training, yoga, netball and a successful football team consisting of staff from across the Trust and contracted staff, organised by some of the Trusts junior doctors. Two health and wellbeing days were held during 2017 and staff were able to take advantage of general health checks and flu vaccinations.

During 2017 the Trust was re accredited with the Investors in People Health and Wellbeing gold standard.

Human Rights, Equality Diversity and Inclusion (ED&I)
The Walton Centre has always recognised and valued the fact that its workforce is made up of individuals with a large diversity of backgrounds, perspectives and characteristics however 2017/18 has marked a welcome increase in the amount of effort and focus the Trust is putting into this area. During 2017/18, there have been a number of improvements, changes and initiatives that demonstrate the higher energy levels at the Trust regarding ED&I. The Trust has also invested in the creation of a new post of Equality and Inclusion Lead to help move the ED&I agenda forward.

Equality and Diversity Objectives
Trust has continued to work towards its current equality and diversity objectives, which are:

- Improve data collection and equality profiles for both inpatients and outpatients
- Improve data collection and equality profiles for all staff members
- Ensure all staff members are paid equally for equal work
- Continue to use Equality Impact Assessments to monitor policies and procedures and introduce this for all service developments and organisational change episodes
- Increase involvement with the local community and in local support groups for both patients and staff

The Trust has recently published its ED&I 5 Year Vision.
This vision sets out the way forward for The Walton Centre to improve ED&I for both patients and staff. This vision has come from both staff and patients sharing what good practice looks like and how we will know when we have achieved it, supported by a detailed strategic action plan. This will be delivered by the Operational ED&I Group, who will be held to account by the ED&I Steering Group. It will be monitored through the Quality Committee with an annual review of the vision and action plan progress in the same

manner the Quality & Patient Strategy is currently monitored. This vision will guide the Trust towards making systematic improvements around ED&I in this year and in coming years.

ED&I Champions

The Trust has created new ED&I Champions recruited from staff to create a higher profile for ED&I and to drive positive culture change towards the Trust's equality commitments:

- We are committed to making ED&I a priority. We want to be a workplace that inspires leadership at all levels, with all staff, where everyone's voice is heard.
- We are committed to creating an inclusive culture, where staff and patients believe there is strength in difference. We want to celebrate and actively embrace diversity.
- We are committed to ensuring that staff and patients have good experiences at the Trust, and feel comfortable "bringing their whole self" to The Walton Centre.
- We are committed to ensuring our care with, and for, all patients is meaningful to them, that ED&I is part of everyone's role, and is an integral part of our health and wellbeing approach.

One example where the ED&I Champions are already making a positive difference is in their work to foster a greater awareness of key cultural dates and events. One of the important actions for this in 2018 is the Trust's planned Ramadan Awareness Event. Further initiatives will be identified and implemented throughout this and coming years.

On 31 March 2018 the Board of Directors comprised of:

- Three male and three female non-executive directors (including the Chair);
- Three male and two* female executive directors (and one male corporate director).

*one female director is currently in an 'acting' role.

Table 23 (a-f) represents the diversity of the Trust's workforce as a whole as of 31st March 2018. Total percentages have been rounded to the nearest whole number.

Table 23a Sex

Gender	Headcount	Percentage
Female	1107	78.01%
Male	312	21.99%
Grand total	**1419**	**100%**

Table 23b Age

Age range	16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61+	Grand Total
Female	1	71	144	155	132	125	141	136	127	75	**1107**
Male	1	19	28	42	35	50	50	42	29	16	**312**
Grand total	**2**	**90**	**172**	**197**	**167**	**175**	**191**	**178**	**156**	**91**	**1419**

Table 23c Ethnicity

Ethnicity	Headcount	Percentage
A White - British	1217	85.76%
B White - Irish	25	1.76%
C White - Any other White background	32	2.26%
CP White Polish	2	0.14%
CY White Other European	3	0.21%
D Mixed - White & Black Caribbean	0	0%
E Mixed - White & Black African	2	0.14%
F Mixed - White & Asian	6	0.42%
G Mixed - Any other mixed background	3	0.21%
H Asian or Asian British - Indian	59	4.16%
J Asian or Asian British - Pakistani	2	0.14%
L Asian or Asian British - Any other Asian background	12	0.85%
LH Asian British	1	0.07%
LK Asian Unspecified	1	0.07%
M Black or Black British - Caribbean	2	0.14%
N Black or Black British - African	10	0.70%
P Black or Black British - Any other Black background	2	0.14%
PC Black Nigerian	0	0%
R Chinese	2	0.14%
S Any Other Ethnic Group	16	1.13%
Undefined	6	0.42%
Z Not Stated	16	1.13%
Grand total	**1419**	**100%**

Table 23d Religion

Religion	Headcount	Percentage
Atheism	142	10.01%
Buddhism	4	0.28%
Christianity	874	61.59%
Hinduism	27	1.90%
Not disclosed	145	10.22%
Islam	15	1.06%
Judaism	2	0.14%
Other	95	6.69%
Sikhism	0	0%
Undefined	115	8.10%
Grand total	**1419**	**100%**

Table 23e Disability

Disability	Headcount	Percentage
Not disabled	987	69.56%
Not declared	55	3.88%
Unknown	329	23.19%
Disabled	48	3.38%
Grand total	**1419**	**100%**

Table 23f Sexuality

Sexual Orientation	Headcount	Percentage
Bisexual	9	0.63%
Gay	15	1.06%
Heterosexual	1142	80.48%
Not disclosed	114	8.03%
Lesbian	5	0.35%
Undefined	134	9.44%
Grand total	**1419**	**100%**

Table 23g Marriage & Civil Partnership

Marital Status	Headcount	Percentage
Civil partnership	12	0.85%
Divorced	87	6.13%
Legally separated	13	0.92%
Married	627	44.19%

Single	600	42.28%
Unknown	70	4.93%
Widowed	10	0.70%
Grand total	**1419**	**100%**

Table 23f Staff Groups

Staff Group	Headcount	Percentage
Staff - registered medical practitioners	130	9.17%
Staff- non clinical	385	27.13%
Staff - registered nurses	429	30.23%
Staff - other staff	475	33.47%
Grand total	**1419**	**100%**

ED&I Training for Staff

The Trust has conducted extra ED&I training for the ED&I Champions to enable them to work more effectively in their new roles. The Trust has also continued to implement its previous ED&I related training initiatives such as the mandatory three yearly Equality, Diversity and Human Rights Training, ensuring that all Trust staff are maintaining awareness of equality and remain up to date with changes in legislation.

Cultural Ambassadors Programme

The Walton Centre is also part of a pilot programme with the RCN around Cultural Ambassadors. The Trust has recruited some of our Black and Minority Ethnic (BME) staff to receive training to be able to support colleagues through various Human Resources (HR) Processes to ensure fairness e.g. Disciplinary, Grievance and Capability processes. There is also potential to widen their programme out into supporting fairness in recruitment processes.

Navajo Chartermark and Disability Confident Employer

The Trust is proud to announce that in March 2018 the Trust successfully underwent a reaccreditation process to keep up our eligibility to use the Navajo Chartermark. This is an equality mark sponsored by InTrust Merseyside & Sefton Embrace and supported by the LGBTI Community networks across Merseyside. It is a signifier of good practice, commitment and knowledge of the specific needs, issues and barriers facing lesbian, gay, bisexual, and transgender (LGBT) people in Merseyside. Navajo looks at employment practices and how services are inclusive for LGBTI people. The Trust has also renewed its commitment to the Department for Work and Pensions, Disability Confident Employer Scheme, which commits the Trust to take positive actions to ensure that we have equitable and accessible recruitment processes relating to disability.

Gender Pay Gap

The Trust has met its Gender Pay Gap reporting obligations and the results are published on the Trust's website. The Trust has taken note of the results and will be making use of the data to inform action planning for the coming year

The Trust Workforce Race Equality Standard (WRES)

WRES April 2017. This report showed a disappointing lack of progress across most of the measures. A particular area of concern was the finding that the percentage of BME staff experiencing harassment, bullying or abuse from staff in last 12 months had significantly increased, and the similar measure in respect of experience of discrimination remains far too high. Following analysis of the WRES, discussion at Board level and consultation, the Trust's ED&I Steering Group was set up and ED&I Champions created, the Trust had put in place a number of actions to try and improve the experience of BME employees. Tackling bullying, harassment and discrimination will form part of the work plan for the EDI Champions in 2018. The Trust is also looking forward to producing and publishing the Workforce Disability Equality Standard (WDES) in 2018/19.

Reciprocal Mentoring

The Trust had successfully completed the first round of the Reciprocal Mentoring programme. The Reciprocal Mentoring scheme had been established in conjunction with two other local Trusts. The aim of the programme was to support employees from minority groups to further their development, whilst also improving the senior leaders understanding of what it means to be a BME employee within the Trust. Planning for the 2018 round of Reciprocal Mentoring had commenced.

Equality Delivery System

The Trust's Equality Delivery System (EDS 2) review is currently being undertaken for 2018 in conjunction with Healthwatch and local community groups. The Trust is not seeking to increase its grades on any of the sub-goals in 2018, as the emphasis for this year's EDS is the work that the Trust is doing with other Merseyside trusts to focus on improving areas which are identified as real barriers by organisations who represent the views of people within each protected characteristic. This approach will enable real progress to be made in areas that make a real difference, whilst continuing to support the Trust with its duties under the Public Sector Equality Duty.

Equality Impact Analysis

The improved Equality Impact Assessments/Analysis (EIA) is being developed further, following user feedback, to increase the level of guidance and support for staff completing the EIA. The electronic form is currently being used for the CIP process which contains both a quality impact assessment and an equality impact assessment. This means that the responsible manager must complete both sections before any CIP can be fully considered. These steps will help the Trust to ensure that it pays due regard to its obligations under the Public Sector Equality Duty of the Equality Act 2010.

Engagement

Finally, relationships have continued to be built with all local Healthwatch groups, with equality becoming a standing item on the Patient Experience Group agenda. Involvement with other local networks and charities has included regular engagement with the Brain Charity, epilepsy patients and Navajo.

Learning Disability Group

The Trust has a Learning Disability Steering Group that feeds into the Trust's Safeguarding Group which in turn reports to the Board of Directors via the Patient Safety Group. The Learning Disability Steering Group meets quarterly and has developed good links with the community learning disability teams in the local areas. Members of the Trust's Learning Disability Steering Group also attend the Trust's Safeguarding Group meetings.

The chair of the Learning Disability Steering Group is the Matron for Safeguarding who is also a member of the Liverpool and Sefton Acute Trusts Liaison Learning Disability Group.

Community and Social Responsibilities

The Walton Centre is committed to working in partnership with our local communities, supporting people to develop appropriate skills and experience required to enter the employment market. We support a number of projects which we believe assist our local population including; taking a proactive approach to providing meaningful work experience in the workplace across a range of departments – in 2017/18 the Trust supported 57 work experience students. The Trust has continued to support internships during the school summer holidays and has participated in the career ready mentoring programme with a local school. The Trust also participates in career fairs, career talks to local schools and colleges and organises health and wellbeing activities. The Trust is currently working in partnership with the Merseyside Health Sector Career & Engagement Hub to develop internal Health Career Ambassadors to encourage young people to choose a career in the NHS from a range of disciplines. The Trust is also part of a collaborative approach in North Merseyside for apprenticeships, to offer a range of opportunities linked to this important agenda. In collaboration with other specialist Trusts and alongside Merseyside Youth Association, a group of NHS Employment Mentors commenced in post in January 2018. Their roles will focus on working with local communities, education providers, employment agencies and the Trust to further develop access to work experience, qualifications and career routes in to the NHS.

Reputation and Fundraising

Communications work continued to support the Trust's strategy and promote the Trust's vision of Excellence in Neuroscience through the proactive use of print and broadcast media, the Trust's magazine and website and the Trust's social media accounts. The Communications team also worked to promote the Trust's Vanguard programme, The Neuro Network, to staff, patients and other stakeholders.

This year the Trust appeared frequently in print and other media. A highlight was coverage of the iMRI scanner and new theatres development launch event attended by Marina and Kenny Dalglish which attracted local news coverage in papers and ITV News, including video footage shot inside the hospital's new theatres. Another highlight was the coverage of the Organ Donation Week celebrations by Made in Liverpool television. The team produced four editions of the members' magazine Neuromatters which is sent to over 5,000 members as well as being available on site for staff and visitors.

The Trust's social media accounts continued to grow, and provide a valuable engagement tool for members of the public and staff. This year the team added a new Instagram account alongside the established Facebook and Twitter accounts to reach an expanded audience. During the period April 2017-March 2018, the Trust's Facebook page grew by 1,350 likes (a 35% increase), the Twitter account by 1,135 followers (a 16% increase), and the Instagram account by 450 followers. The most successful posts during the year included news about the visit by LFC goalkeeper Simon Mignolet to the MS service (post seen 85,000 times on Twitter), and a Trust overview video about our values and services (post seen by 46,000 individuals on Facebook).

Around 150 members of staff attended the annual Staff Awards event, which recognised the achievements of staff who had been nominated by patients and their colleagues, as well as the Trust as a whole.

For the Trust's reaccreditation with Investors In People Gold Standard the team produced a new poster campaign, social media content, banners, and media releases. The team also supported the annual 'Walton Willow' memorial celebration during Organ Donation Week which was attended by hundreds of patient relatives and staff. The team also supported the Trust's annual flu vaccination campaign which successfully met the national target for workforce vaccinations.

The team supported recruitment events at the Trust with social media content including videos and staff interviews, banners, and other media releases, and a variety of internal events, engagement sessions, staff-focused campaigns, and health and wellbeing opportunities.

During the year under review the Charity has continued to go from strength to strength; community support grew steadily, with further increase in the number of supporters using on-line fundraising platforms such as Justgiving and Virgin Money Giving to facilitate their sponsored events and maximise gift-aid opportunities. Events included sponsored runs, cycle rides, sky dives and extreme challenges such as 'Tough Mudder' and bungee jumping. The Charity has also been chosen as Charity of the Year for 2018 by two corporate organisations, as voted for by their staff – this will help greatly in not only raising funds but also awareness.

In addition to raising awareness and unrestricted funds, the Charity also continued to raise funds for specific purposes such as the Home from Home Fund and the Sid Watkins Innovation Fund. Donations to the Home from Home Fund ensure that the Trust can continue to provide the facility free of charge to

relatives whose loved ones are receiving critical care at the hospital; and The Sid Watkins Innovation Fund supports innovation and research in the field of neurological health care.

A number of events were organised by the Charity during this time including the Golf Day and the Jan Fairclough Ball, which caters to our corporate supporters. More community focussed events such as the abseil and the annual Hope Mountain Hike were both once more heavily supported by staff as well as patients and their families. In addition to the events organised by the Charity team, there was a high profile event organised by the Bentley Drivers Club in aid of the Sid Watkins Fund. The event took place at Aintree Racecourse with a gala dinner at Knowsley Hall.

The Charity has also been involved in developing a process through which ideas/requests can be identified and considered as potential future fundraising projects. The process links in with the Trust's newly established Medical Innovation Group, which was established to help create an organisational culture where all members of staff are encouraged to think creatively to enable practical innovations to improve patient care. Some of the ideas will become projects and/or programmes that will be supported by the Charity. Specific focus during the year under review has been on complex rehabilitation.

Consultancy

During the year, the Trust made use of external, objective advice and assistance to support the development of strategy, structure and management of the Trust's purposes and objectives. Total consultancy expenditure was £195,000 which included on-going Vanguard project delivery, Trust valuation services and an independent review of clinical services.

Reporting high paid off-payroll arrangements

The Trust does not routinely utilise any off payroll staff for the delivery of main stream services. However, where there are skills shortages, time limited arrangements are entered into by the Trust, with regular review undertaken by the relevant director. Where the engagement lasts for more than six months, the Trust seeks assurance that the appropriate HMRC regulations are being followed.

The Trust has not had any off-payroll engagements with board members or any other senior officials with significant financial responsibility during the period. Other off-payroll arrangements are reflected in tables 24, 25 and 26:

Table 24

All off-payroll engagements as at 31 March 2018 (where the worker is paid more than £245 per day and has been in post for more than six months)	
Number of existing arrangements as at 31 March 2018	1
Of which:	
Number that have existed for less than one year at the time of reporting	0
Number that have existed for between one and two years at the time of reporting	0

Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	1

The Trust has undertaken a risk assessment of the off-payroll engagements outlined above and off-payroll arrangements are reviewed through the relevant committee. Where necessary, assurance has been sought that the individual is paying the correct amount of income tax and National Insurance.

Table 25

All new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018 (where the worker is paid more than £245 per day and has been in post for more than six months)	
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018;	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the Trust's payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

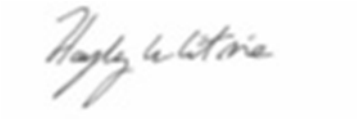
Table 26

All new off-payroll engagements of board members, and/ or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	
Number of off-payroll engagements of board members, and/ or senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/ or senior officials with significant financial responsibility' during the financial year. This figure includes both off-payroll and on-payroll engagements	0

There have been no off-payroll engagements of Board members, or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018.

Enhanced Quality Governance

Enhanced quality governance patient care and stakeholder relations reporting are discussed in detail in section No. 3i of this report.



Hayley Citrine, Chief Executive

25 May 2018

3iv Accountability Report – the disclosures set out in the NHS Foundation Trust Code of Governance

Statement of Compliance with the Code

The Walton Centre NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance is based on the principles of the UK Corporate Governance Code issued in 2012.

The Chair, Deputy Director of Governance and Assistant Corporate Secretary reviewed the Trust's compliance with the NHS Foundation Trust Code of Governance (the Code) and prepared a report for the Trust's Board meeting who considered this report at its meeting on 25 May 2018 and agreed that the Trust complies with the main and supporting principles and statutory requirements of the Code. The Trust's disclosures in respect of those Code provisions which the Trust is mandated to provide in this annual report are detailed at table 27 below:

Table 27

PROVISION	SUPPORTING EXPLANATION	CHAPTER
A1.1	Refer to : Board of Directors Refer to: NHS FT Code of Governance Disclosures	2.0 4.0
A1.2	Refer to: Board of Directors, NHS FT Code of Governance Disclosures and Remuneration Report	2.0, 4.0, 3.0
A5.3	Refer to: NHS FT Code of Governance Disclosures	4.0
B1.1	Refer to: Board of Directors	2.0
B1.4	Refer to: Board of Directors	2.0
B2.10	Refer to: Remuneration Report	3.0
B3.1	Refer to: Board of Directors	2.0
B5.6	Refer to: NHS FT Code of Governance Disclosures	4.0
B6.1	Refer to: Board of Directors	2.0
B6.2	Refer to: Board of Directors	2.0
C1.1	Refer to: Forward from the Chairman and Chief Executive, Annual Governance Statement and Independent Auditor's Report and	1.0, 9.0, 11.0
C2.1	Refer to: Annual Governance Statement	9.0
C2.2	Refer to: Annual Governance Statement	9.0
C3.5	N/A	N/A
C3.9	Refer to: NHS FT Code of Governance Disclosures	4.0
D1.3	N/A	N/A
E1.5	Refer to: NHS FT Code of Governance Disclosures	4.0
E1.6	Refer to: NHS FT Code of Governance Disclosures	4.0
E1.4	Refer to: NHS FT Code of Governance Disclosures	4.0

The Trust is also compliant with the following provisions:
A 1.4, A1.5, A1.6, A1.7, A1.8, A1.9, A1.10, A3.1, A4.1, A4.2, A4.3, A5.1, A5.2, A5.4, A5.5, A5.6, A5.7, A5.8, A5.9
B1.2, B 1.3, B2.1, B2.2, B2.3, B2.4, B2.5, B2.6, B2.7, B2.8, B2.9, B3.3, B5.1, B5.2, B5.3, B5.4, B6.3, B6.4, B6.5, B6.6, B8.1

C1.2, C1.3, C1.4*, C3.1, C3.3, C3.6, C3.7, C3.8.
D1.1, D1.2, D1.4, D2.2, D2.3
E1.2, E1.3, E2.1, E2.2

*Provision C1.4 requires the Board of Directors to notify NHSI and the Council of Governors and consider whether it is in the public's best interest to bring to the public's attention, any new major developments which are not public knowledge; the Trust is compliant with the requirement of this provision. All significant financial and performance challenges are included on the Board Assurance Framework which reports through Audit Committee, Business Performance Committee and Trust Board.

Copies of the NHS FT Code of Governance can be downloaded at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf

The Council of Governors

As detailed in the Trust's constitution, the Council of Governors consists of 17 elected governors, four staff governors and 12 appointed partnership governors. The Council of Governors meet in public four times a year; this provides the opportunity for governors to express their views and raise any issues so that the Board of Directors can respond accordingly.

The Board of Directors and the Council of Governors enjoy a strong and developing working relationship. Mrs Janet Rosser chairs both and acts as a link between the two. Each is kept advised of the other's progress through a number of systems, including informal updates, meeting agendas and minutes, email correspondence, attendance of directors at the Council of Governors meetings and attendance by governors at the Board of Directors meetings.

The Council of Governors meet with the Trust's non-executive directors on a quarterly basis, which provides the opportunity for detailed discussion regarding the role of the non-executive directors and their individual and collective responsibilities as directors of The Walton Centre.

The Council of Governors is responsible for:

- Appointing and, if appropriate, removing the chair and other non-executive directors
- Deciding the remuneration and allowances, and the other terms and conditions of office, of the chair and the other non-executive directors.
- Approving the appointment of the chief executive.
- Appointing and, if appropriate, removing the Trust's external auditor, and
- Receiving the Trust's annual accounts, any report of the auditor on them and the annual report.

Governors also hold the non-executive directors individually and collectively to account for the performance of the Board of Directors; represent the interests of the members of the Trust as a whole and of the public; approve significant transactions; approve applications by the Trust to enter into a merger, acquisition,

separation or dissolution; decide whether the Trust's private patient work would significantly interfere with the Trust's principal purpose and must approve any proposed increases in private patient income of 5% or more in any financial year. In addition, amendments to the Trust's constitution must be approved by the Council of Governors.

The Board of Directors consults the Council of Governors when preparing the Trust's forward plans.

The Council of Governors is composed of the following:

- Four public governors from the administrative county of Cheshire
- Eight public governors from the administrative county of Merseyside
- Three public governors from the administrative counties of North Wales
- Two public governors for the Rest of England and Wales
- Twelve partnership governors and
- Four staff governors.

The period of office for an elected governor is three years after which a governor is eligible for re-election. An elected governor may not hold office for more than nine consecutive years. The period of office for a partnership governor is three years after which a governor is eligible for re-appointment. A partnership governor may not hold office for more than nine consecutive years.

Ms Katie Clarke-Day held the role of Lead Governor from January 2016 to January 2018.

Table 28 gives details of each seat on the Council of Governors and its occupant(s) during the period 1 April 2017 – 31 March 2018:

Table 28

Seat	Name of Governor		Constituency	Date Appointed	End of Tenure
1C	Austin	Jonathan	Cheshire	2015	2018
2C	Cheesman	Colin	Cheshire	2015	2018
3C	Ferguson	Louise	Cheshire	2015	2018
4C	Hubbard	Melissa	Cheshire	2015	2018
1EW	Clarke-Day	Katie	E & W	2014	Resigned 2018
1EW	-	-	E & W	-	-
2EW	Duckers	Stephen	E & W	2014	Resigned 2017
2EW	Lewis	Michael	E & W	2017	2020
1M	Comerford	Ged	Merseyside	2016	2019
2M	Brown	Doreen	Merseyside	2015	2018
3M	Cahill	Tony	Merseyside	2013	2019
4M	Clark	Alan	Merseyside	2015	Resigned 2017

Seat	Name of Governor		Constituency	Date Appointed	End of Tenure
4M	Griffiths	Alan	Merseyside	2017	2020
5M	Desmond	Jonathan	Merseyside	2017	2020
6M	Owens	Bobby	Merseyside	2015	Resigned 2018
6M	-	-	Merseyside	-	-
7M	Paton	Joe	Merseyside	2015	2018
8M	Strong	Barbara	Merseyside	2017	2019
1W	Felda	Urtha	North Wales	2014	Resigned 2017
1W	Holmes	Mark	North Wales	2017	2020
2W	Burgen	Andy	North Wales	2016	2019
3W	Kitchen	John	North Wales	2015	2018
1S	Gerrans	Emily	Staff	2015	2018
2S	Lowe	Amanda	Staff	2015	2018
3S	Davies	Rhys	Staff	2016	2019
4S	Moreno	Isabel	Staff	2016	2019
1P	Austen-Vincent	Ruth	Partnership	2015	2018
2P	Clegg	Peter	Partnership	2017	2020
3P	Heron	Susan	Partnership	2015	Resigned 2017
3P	Brant	Paul	Partnership	2017	2020
4P	Mellor	Nanette	Partnership	2017	2020
5P	Pereira	Ella	Partnership	2017	2020
6P	McCabe (nee Quayle)	Shirley	Partnership	2015	Resigned 2017
6P	-	-	Partnership	-	-
7P	Allen	Jackie	Partnership	2017	Resigned 2017
7P	Howard	Stella	Partnership	2018	2021
8P	Thomas	Kevin	Partnership	2009	Resigned 2017
8P	Felda	Urtha	Partnership	2017	2020
9P	Vaughan	Jan	Partnership	2017	2020
10P	-	-	Partnership	-	-
11P	Rothwell	Derek	Partnership	2017	2020
12P	-	-	Partnership	-	-

The Trust's current Governors are noted below in table 29:

Table 29

Constituency	Name of Governor
Public - Cheshire	Louise Ferguson
Public – Cheshire	Colin Cheesman
Public – Cheshire	Jonathan Austin
Public – Cheshire	Melissa Hubbard
Public – Merseyside	Tony Cahill
Public – Merseyside	Doreen Brown
Public – Merseyside	Jonathan Austin

Constituency	Name of Governor
Public – Merseyside	Alan Griffiths
Public – Merseyside	Ged Comerford
Public – Merseyside	Joe Paton
Public – Merseyside	Barbara Strong
Public – Merseyside	*Vacant*
Public – North Wales	Mark Holmes
Public – North Wales	Andy Bergan
Public – North Wales	John Kitchen
Public – Rest of England and Wales	Michael Lewis
Public – Rest of England and Wales	Vacant
Staff – Nursing	Amanda Lowe
Staff – Medical	Rhys Davies
Staff – Clinical	Emily Gerrans
Staff – Non Clinical	Isabel Moreno
Local Authority Governor (Sefton Metropolitan Council)	*Vacant*
Local Authority Governor (Liverpool City Council)	Paul Brant
Partnership Governor (Cheshire & Merseyside Neurological Alliance)	Ruth Austen-Vincent
Partnership Governor (Liverpool University)	Professor Peter Clegg
Partnership Governor (MS Society, Isle of Man)	Vacant
Partnership Governor (The Brain Charity)	Nanette Mellor
Partnership Governor (North Wales CHC Joint Committee)	Stella Howard
Partnership Governor (Merseyside & Cheshire Clinical Network)	Jan Vaughan
Partnership Governor (Healthwatch)	*Vacant*
Partnership Governor (North Wales Neurological Conditions Partnership)	Urtha Felda
Partnership Governor (Liverpool CCG)	Derek Rothwell
Partnership Governor (Edge Hill University)	Ella Pereira

There are dedicated correspondence methods which makes it simpler for members and prospective members to contact Governors:

- By email : governors@thewaltoncentre.nhs.uk
- By telephone : 0151 0151 556 3477
- By post:

  Governors

  C/O Executive Offices

  The Walton Centre NHS Foundation Trust

  Lower Lane

  Fazakerley

  L9 7LJ

Governors Appointments and Elections

All public and staff governors are appointed by an election process which is administered by Electoral Reform Services (ERS) on behalf of the Trust. Members are invited to self-nominate and the election process is held in accordance with the Trust's Constitution. Public governors are elected for a period of three years beginning and ending at an Annual Members Meeting. Partnership governors are nominated by their respective organisations. Their term of office is also three years. In the summer of 2017, elections to the Council of Governors were held according to the Trust's constitution. Results were as reported in table 30 below:

Table 30

Seat	**Turnout**	**Governor Elected**
Public : Merseyside	10.2%	Barbara Strong
		Alan Griffiths
		Jonathan Desmond
		Alan Griffiths (Casual Vacancy)
Public : North Wales	13.4%	Mark Holmes
Public: Rest of England	9.7%	Katie Clarke-Day
		Michael Lewis
Staff: Non Clinical	UNCONTESTED	Isabel Moreno

Governors Register of Interests

A register is kept of governors' interests. Access to the register can be gained by contacting the Deputy Director of Governance:

- By telephone : 0151 556 3423
- By post:

  Deputy Director of Governance

  The Walton Centre NHS Foundation Trust

  Lower Lane

  Fazakerley

Council of Governors meetings

Table 31: represents the Chair & Governors attendance 01/04/17 – 31/03/18

Table 31

Name of Governor	**15/06/17**	**12/09/17**	**14/12/17**	**13/03/18**
Janet Rosser Chair	✓	✓	✓	✓
Alan Clark	✓			
Alan Griffiths		x	x	x

Amanda Lowe	x	x	x	x
Andy Burgen	✓	✓	✓	✓
Barbara Strong	✓	✓	✓	✓
Bobby Owens	x	✓	✓	x
Colin Cheesman	✓	✓	✓	x
Derek Rothwell		✓	✓	✓
Ella Pereira	✓	✓	✓	✓
Emily Gerrans	x	✓	x	✓
Ged Comerford	✓	✓	x	x
Isabel Moreno	✓	✓	✓	✓
Jan Vaughan	x	x	x	x
John Kitchen	x	✓	✓	x
Jonathan Austin	x	x	✓	x
Jonathan Desmond		✓	✓	✓
Katie Clarke-Day	✓	✓	✓	
Louise Ferguson	✓	✓	✓	x
Mark Holmes		✓	✓	x
Melissa Hubbard	x	✓	x	x
Michael Lewis		x	x	x
Nanette Mellor	x	✓	x	✓
Paul Brant		✓	✓	x
Peter Clegg	✓	x	x	x
Rhys Davies	x	✓	x	x
Rick Grainger	x	✓		
Ruth Austin-Vincent	✓	✓	x	✓
Shirley McCabe	✓	✓		
Stella Howard				✓
Stephen Byron	x	x	x	x
Stephen Duckers	✓	✓		
Tina Wilkins	x	✓		
Tony Cahill	x	x	x	✓
Urtha Felda	✓	✓	x	x

38 individuals acted as governors between 01 April 2017 and 31 March 2018.

Table 32 shows the number of additional days/or events attended by the Governors:

Table 32

Trust Assurance Meeting	30
Audits/Inspections	7
Engagement - Governors	11
Engagement - Membership	26
Engagement - Stakeholders	4
Engagement - Trust	22
Networking	2
Sub Committee Membership	50
Training	7
Total	**153**

Governor Training

All Trust Governors were invited to attend a Governor Training Day held at the Trust hosted by GovernWell (NHS Providers) in March 2018. The topics covered included an Introduction to the NHS; NHS Finances and Business Skills; Quality Matters; Governance and the role of the governor; Effective Questioning and Challenge; and Member and public engagement. Positive feedback was provided by those Governors in attendance.

Governor Expenses

In accordance with the Trust's constitution, Governors may claim expenses for attendance at Council of Governor meetings and whilst representing members or the Trust at other events and meetings. In 2017/18 the total amount claimed was £2,535.74 as seen in table 33:

Table 33

Name of Governor	**Expenses Claimed (£) 2017/18**
Jackie Allen	52.90
Andy Burgen	477.90
Alan Clark	39.80
Katie Clarke-Day	417.60
Stephen Duckers	6.95
Louise Ferguson	459.00
Mark Holmes	408.10
Stella Howard	106.55
Michael Lewis	118.90
Shirley McCabe	316.89
Isabel Moreno	17.00
Barbara Strong	114.15

Council of Governors meetings: table 34 represents Directors and Non-Executive Directors attendance.

Table 34 - 1st April 2017 to 31st March 2018

Name of Director or NED	**15/06/17**	**12/09/17**	**14/12/17**	**13/03/18**
M Burns	✓	✓	✓	✓
H Citrine	A	✓	✓	✓
M Gibney	✓	✓	A	✓
C Harrop	✓	✓	✓	
S Moore	✓	✓	A	✓
A Nicolson	A	✓	✓	A
L Salter				✓
Alan Sharples	✓	✓	✓	✓
Seth Crofts	✓	✓	A	A
Ann McCracken	✓	✓	✓	✓
Sheila Samuels	A	A	✓	✓
Dr Peter Humphrey	✓	✓	✓	✓

✓ = Attended A = Apologies

Developing an Understanding: Board of Directors and Council of Governors

The Board of Directors has taken steps to ensure the Board's directors, and in particular non-executive directors, develop an understanding of the views of governors and members about the Trust. Ms Janet Rosser chairs both the Board of Directors and the Council of Governors, with the support of the Deputy Director of Governance and the Assistant Corporate Secretary, who are the link between the two. The full Council of Governors meets four times a year and these meetings are attended by non-executive directors, the senior independent director, the Chief Executive and when required executive and corporate directors. Governors meetings provide the opportunity for the governors to perform their statutory duties, express their views, and raise any issues so the Board of Directors can respond. Governors also attend meetings of the Board of Directors.

The Trust recognises the importance of governors being accessible to members. Council of Governors meetings are public meetings and agendas and minutes from the meetings, together with details of how members can contact governors, are publicised on the Trust's website. Annual Members Meetings are held which are open to the public.

Photographs of the Trust's governors are displayed in a prominent place in the reception of the Trust's main building together with a notice which informs that members can contact governors via the Trust's Deputy Director of Governance:

- Telephone : 0151 556 3423
- By post:
  Ann Highton, Deputy Director of Governance
  The Walton Centre NHS Foundation Trust
  Lower Lane
  Fazakerley, L9 7LJ

Information regarding the Trust's governors is also displayed on the Trust's website: www.thewaltoncentre.nhs.uk.

Governors participate in the Trust's annual Open Afternoon and listening weeks where they meet, and receive feedback from patients, staff, Trust members and members of the public which have enabled them to represent the interests of these stakeholders. Governors communicate feedback from members at the Council of Governor meetings and meetings held with non-executive directors.

Membership

At the end of March 2018, the Trust's membership stood at 7,426 compared to 7,565 in March 2017. The Trust's membership is available to employees of the Trust and members of the public, aged 16 years and

over, who live in the public constituencies of Cheshire, Merseyside, North Wales or the Rest of England & Wales. Table 35 provides a breakdown of the Trust's membership by constituency:

Table 35

Numbers by Constituency and Catchments	
Public Cheshire	872
Public Merseyside	2,585
Public North Wales	1,457
Public Rest of England and Wales	1,162
Public Out of Trust Area	7
Public Totals	**6,083**
Staff - Registered Nurse	383
Staff Registered Medical Practitioners	150
Staff Other Clinical Professional	458
Staff - Non-Clinical	352
Staff Total	**1,343**
TOTAL MEMBERSHIP	**7,426**

The Trust's Membership Strategy can be found at:
http://www.thewaltoncentre.nhs.uk/uploadedfiles/Trust%20Board/Membership%20Strategy%20Final.pdf
The Walton Centre NHS Foundation Trust is a public benefit organisation and its objective, with respect to membership, is to recruit, retain and develop a sizeable, representative and active membership which is engaged with the objectives of the Trust. Information for prospective members is posted on the Trust's website.

The Trust is committed to building a membership representative of both the population it cares for and the staff who work for the Trust. Membership is therefore open to any individual who is eligible to be a member of the public or staff constituencies. To ensure effective member engagement the Trust produces a quarterly newsletter called Neuromatters. Copies are posted/emailed to public members and are prominently displayed around the Trust to encourage membership. The newsletter is also available on the intranet, website and via social media.

During 2017/18, members have continued to receive quarterly newsletters from the Governors called *Connect*. These editions are available on the Governors page of the Trust's website.

During 2017/18 the Trust and Governors undertook the following membership engagement activities:

- Annual Members Meeting
- Governor take-over day on the Trusts' Twitter and Facebook social media platforms
- Articles in Neuromatters, membership magazine
- Patient engagement and listening events at Satellite Clinics
- Patient Listening Weeks
- Staff Listening Weeks
- Participation in Berwick Sessions
- Participation in Swartz Rounds

There is a dedicated email account which makes it simpler for members and prospective members to contact the Membership Manager: membership@thewaltoncentre.nhs.uk

Committees of the Board of Directors

The Trust's Board of Directors has a number of committees and their proceedings are reported to the full Trust Board.

1. Audit Committee
2. Walton Centre Charity Committee
3. Nomimations and Remuneration Committee
4. Business Performance Committee
5. Quality Committee
6. Research Development and Innovation Committee

1. Audit Committee

The Audit Committee is a committee of the Non-Executive Directors (excluding the Chairman) and is chaired by Alan Sharples.

The Committee met on five occasions during 2017/18.

Meetings of the Trust's Audit Committee and attendance have been represented in table 36 as follows during the reporting period 01 April 2017 to 31 March 2018:

Table 36

	April 2017	May 2017	July 2017	Oct 2017	Jan 2018
Alan Sharples	✓	✓	✓	✓	✓
Ann McCracken	✓	✓	✓	✓	✓
Seth Crofts	✓	✓	✓	✓	✓

The Role of the Audit Committee:

The Audit Committee critically reviews the governance and assurance processes upon which the Board of Directors places reliance. Three Non-Executive Directors are members of the Audit Committee, reflecting the importance that the Board places on the Audit Committee to enable effective Non Executive challenge, including triangulation of the work of the Board's Assurance Committees (Business Performance Committee and Quality Committee) across all aspects of the Trust's business.

Principal Review Areas in 2017/18

The narrative below sets out the principal areas of review and significant issues considered by the Audit Committee during 2017/18 reflecting the key objectives of the committee as set out in its terms of reference.

- ***Internal Control and Risk Management***

The Committee has reviewed relevant disclosure statements for 2017/18 and other appropriate independent assurance together with the Head of Internal Audit Opinion, external audit opinion and considers that the 2017/18 Annual Governance Statement is consistent with the Committee's view on the Trust's system of internal control.

Reviews undertaken in 2017/18 included:

Review Title	**Assurance Level**
ESR (HR / Payroll Interface)	High
Combined Financial Systems	High / Significant
CIP/QIA	Significant
IG Toolkit	Significant
Activity Data (Cyclical Review) – cancer targets	Significant
Volunteers	Significant
NICE – Use of Antimicrobials	Significant
Serious Untoward Incidents	Significant
Patch / Vulnerability Management	Limited
Assurance Framework Opinion	Met
Audit Committee Effectiveness	N/A – Effectiveness report issued
Business Performance Committee Effectiveness	N/A - Effectiveness session facilitated and report issued
Well-Led Assessment	N/A - Outcome report issued

Where limited assurance was received, the committee deliberated the report with follow up audits/review of action plans and invited the relevant management lead to attend the next Committee meeting to provide a progress update on recommendations.

Governance, Risk Management and Internal Control

The work of the Audit Committee in 2017/18 has been to review the effectiveness of the organisation and its systems of governance, risk management and internal control through a programme of work involving the scrutiny of assurances provided by internal audit, external audit, local anti-fraud officer, Trust managers, finance staff and the clinical audit team along with reports and reviews from other external bodies.

An annual work programme is set at the start of the year along with agreement of the internal audit and anti-fraud work plans, with provision to meet contingency requirements.

Review of the Work of the Auditors

The Audit Committee undertook a review of the work of both internal and external auditors during the year, with the Audit Committee receiving a report at its July 2017 meeting, which was approved by the Committee.

The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities, both clinical and non-clinical, that supports the achievement of the Trust's objectives.

In addition, the Committee monitors the integrity of the financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reports and the judgments contained in them.

In particular, the Committee reviews the adequacy of:

- All risk and control related disclosure statements, in particular the Annual Governance Statement and declarations of compliance with the CQC outcomes, together with any accompanying Director of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors.
- Underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements.
- Policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements.
- Policies and procedures for all work related to fraud and corruption.

In carrying out this work, the Committee primarily utilises the work of internal audit, external audit and other assurance functions and also makes requests of, and receives reports and assurances from, directors and managers as appropriate and by using an effective assurance framework / Trust-wide risk register to guide its work and that of the audit and assurance functions that report to it.

Internal Audit

Throughout the year, the Committee has worked effectively with MIAA, the Trust's appointed internal auditors, to ensure that the design and operation of the Trust's internal control processes are sufficiently robust.

The Committee has given considerable attention to the importance of follow up in respect of internal audit work in order to gain assurance that appropriate management action has been implemented. The latest follow up report received by the Committee in January 2018, noted that a number of recommendations still needed to be implemented. Given the delays in implementation of the actions, the Committee tasked management to escalate to relevant leads in order to bring an updated position to a forthcoming Audit Committee in accordance with the Committee work plan.

The Committee has considered the major findings of internal audit and where appropriate has sought management assurance that remedial action has been taken. 'Limited assurance' was assigned to the Patch / Vulnerability Management review in 2017/18. On this occasion, the Committee requested sight of the full report including management response and attendance at the meeting by the relevant lead. This has continued to strengthen the Committee's response to major audit findings in 2016/17 and has ensured that any control weaknesses are understood by the Audit committee and are quickly addressed.

The Committee reviewed and approved the internal audit plan and detailed programme of work for 2017/18 at its April 2017 meeting. This included a range of key risks identified through discussion with Management and Executives and review of the Trust's Board Assurance Framework. Reviews were identified across a range of areas, including combined financial systems, IM&T, Performance, Clinical Quality, Workforce, Governance and Risk.

Mersey Internal Audit Agency (MIAA) has supported the non-executive directors over the year through the provision of networking events, policy advice, and Insight updates.

MIAA routinely reviews the papers received by the Board of Directors and minutes of Board meetings to pick up on areas of potential risk for inclusion in the audit programme.

Anti- Fraud

The Committee reviewed and approved the anti-fraud work plan for 2017/18 at its April 2017 meeting noting coverage across all mandated areas of strategic governance, inform and involve, prevent and deter and hold to account. During the course of the year the Committee regularly reviewed updates on proactive anti-fraud work.

External Audit

The Committee routinely received progress reports from the external auditor, including an update on the annual accounts audit timetable and programme of work, updates on key emerging national issues and developments which may be of interest to Committee members alongside a number of challenge questions in respect of these emerging issues which the Committee provided a management response to at every quarterly meeting.

The value of external audit services for the year was £47,000 (including VAT). In addition to this, £8k was incurred for other auditor remuneration; £6,000 for the Quality Account and £900 for the review of the Technology Strategy Board Grant, plus VAT.

During 2017/18, the auditor has not been engaged in any non-audit activity.

The Trust's external auditors, Grant Thornton UK LLP, were appointed by the Council of Governors in April 2017 following a formal procurement exercise for a contract period of three accounting years, with an option to extend for a further accounting year.

The audit committee included a number of significant accounting issues and treatments in its consideration of the Trust's financial statements for the year ended 31 March 2018. During the year the committee critically addressed the issues around the appropriateness of the Accounting Policies that have been adopted and was satisfied that the policies were reasonable and appropriate. As part of the full year reporting process the external auditors, Grant Thornton, consider the key areas of accounting judgement and disclosure. For each of these areas, the audit committee critically review and assess the policies and judgements that have been applied, the consistency of policy application from year to year and the appropriateness of the relevant disclosures made, together with the compliance with applicable accounting standards. The key areas of accounting judgement and disclosure are shown in the Trusts final accounts. The committee has been able to place reliance upon work undertaken by the External auditors as part of the work that they undertook to enable them to develop their Audit Opinion.

The following additional significant issues have been discussed by the Audit Committee during 2017/18:

- the accuracy of income recorded in relation to patient care activities, in particular income related to additional NHS contract activity;

- the risk of management over-ride of controls (which includes an understanding of accounting judgements applied);
- Valuation of property, plant and equipment.

Other Assurance Functions

The Committee has routinely received reports on Losses and Special Payments, Bad Debts and Tender Waivers.

The Committee has reviewed and agreed the updated Standing Financial Instructions and Scheme of Reservation and Delegation for Board approval.

Members of the Committee have met privately with the internal and external auditors, without the presence of any Trust officer.

Financial Reporting

The Committee has reviewed the accounting policies and annual financial statements prior to submission to the Board and considered these to be accurate. It has ensured that all external audit recommendations have been addressed.

Review of Audit Committee Effectiveness

Last year, the Audit Committee undertook its annual self-assessment, including a review of its Terms of Reference, via a facilitated workshop session by MIAA on the 19th May 2017 and subsequently produced a report and action plan. Of the actions identified, MIAA was subsequently satisfied that these had been addressed.

2. Walton Centre Charity Committee (WCCC)

The role of the WCCC is to ensure the charity is managed and administered in accordance with the requirements of the Charity Commission and that the charity produces audited Annual Accounts. It ensures that the charity has an investment policy in place; this is reviewed at least annually and that the Committee ensures that it receives at least an annual report from its investment managers / advisors.

The Committee also ensures that items of expenditure are approved, in line with the objectives of the fund and are charitable in nature and that the charity can demonstrate public benefit for its expenditure. It establishes the strategy, policies, budget, spending priorities and criteria for spending decisions for each fund. The strategy and policy must comply with charity law and the specific objectives of each fund.

In addition, the WCCC oversees all fundraising activities relating to the charity, approves new fundraising appeals and monitors fundraising targets, and reviews the Trust's Fundraising Strategy prior to approval by the Trust Board.

In October 2017, following the recommendation from the WCCC, the Trust Board approved the transfer of the Charity's investments from Investec Fund Management to the CCLA Ethical Investment Fund (50%) and the Ruffer LLP Charity Assets Trust (50%) and authorised the WCCC to act on its behalf in transferring the investments.

3. Nominations and Remuneration Committees

The Trust has in place two Nominations and Remuneration Committees – one for nominations and remuneration for Non-Executive appointments (including the Chair) and the other with nominations and remuneration for Executive appointments.

Remuneration Committee

The Trust has established a committee of Non-Executive Directors in order to ensure effective governance in respect of the appointment, remuneration, allowances and other terms / conditions of office of the chief executive, other executive directors, corporate directors and senior managers not covered under Agenda for Change terms and conditions. The Committee regularly reviews the structure, size and composition (including the skills, knowledge and experience) required of the Board of Directors and makes recommendations to the Board with regard to any changes. It also gives full consideration to, and makes plans for, succession planning for the chief executive and other executive directors taking into account challenges and opportunities facing the Trust and the skills and expertise needed. The Committee also considers any matter relating to the continuation in office of any executive director at any time including the suspension or termination of services of an individual as an employee of the Trust.

Members of the Remuneration Committee for 2017/18 were:

- Janet Rosser (Chair)
- Alan Sharples
- Ann McCracken
- Seth Crofts
- Dr Peter Humphrey
- Sheila Samuels

The Remuneration Committee convened seven times during the reporting period as detailed in table 37.

Table 37

	27/04/17	29/06/17	28/09/17	17/11/17	30/11/17	25/01/18	29/03/18
J Rosser	✓	✓	✓	✓	✓	✓	✓
A Sharples	✓	✓	✓	✓	✓	✓	✓
A McCracken	✓	✓	✓	✓	✓	✓	✓
S Crofts	✓	✓	✓	A	✓	✓	✓
P Humphrey	✓	A	✓	✓	✓	A	A
S Samuels	✓	✓	✓	A	✓	✓	✓

KEY: ✓ = Present A = Apologies

The Director of Workforce and the Chief Executive provide advice to the Remuneration Committee, as and when required.

Governors' Nominations Committee

There is also a Governors' Nominations Committee which is responsible for considering nominations and remuneration for non-executive directors.

Current members of the Committee are:

- Janet Rosser, Trust Chair
- Louise Ferguson, Nominations Committee Chair and Public Constituency Governor
- Colin Cheesman, Public Constituency Governor
- Ella Pereira, Stakeholder Governor

The Governors' Nominations Committee had no reason to convene during the reporting period.

Health and Safety Performance, Occupational Health and Staff Sickness Absence

Health and Safety

The total number of RIDDOR (Reporting of Injuries Diseases and Dangerous Occurrences Regulations) reportable accidents sent to the Health and Safety Executive (HSE) during the financial year of 2017/18 was 16 compared to 10 in 2016/17.

Occupational Health/Health and Wellbeing

The Trust continues to support a programme of health and wellbeing initiatives for staff and is continually looking to develop and expand these. A small multi-disciplinary health and wellbeing group has continued to meet.

Two staff health and wellbeing days take place each year and the Trust regularly takes on board staff feedback and reviews its offers to staff. A back care programme introduced in 2016 to support staff with MSK conditions has continued to expand and develop over the past year.

The Trust's Health and Wellbeing Occupational Health Service continues to be provided by a service level agreement with Aintree University Hospital with key performance indicators monitored via quarterly review meetings. This year, the Trust has had a very successful flu campaign, which was a collaboration between the Trust and Occupational Health Service. Following a tendering process the Trust's onsite counselling service is provided by the Network of Staff Supporters (NOSS). Staff can access the service themselves or via their manager.

Sickness Absence (Table 38)

Staff sickness absence	2016/17	2017/18
Days Lost (Long Term)	14,383	19,967
Days Lost (Short Term)	6,683	7,795
Total Days Lost	21,066	27,762
Average Staff Service Years	6.7	6.9
Average Working Days Lost	14.8	16.1
Total Staff Employed in Period (Headcount)	1397	1419
Total Staff Employed in Period with No Absence (Headcount)	491	492
Percentage Staff with No Sick Leave	39.03%	37.30%

Number of Individuals Who Retired Early on ill-health Grounds during the Period of Reporting

During the period 1 April 2017 to 31 March 2018 there was one* early retirement from the NHS Trust on the grounds of ill-health.

**At the time of production, one further application was pending for 2017/18.*

Policies and Procedures with Respect to Countering Fraud and Corruption

The Trust has an Anti-Fraud, Bribery and Corruption policy in place and does not tolerate fraud, bribery and corruption. The aim is to eliminate all NHS fraud, bribery and corruption as far as possible. The Trust is committed to taking all necessary steps to counter fraud, bribery and corruption. To meet its objectives, it has adopted the four-stage approach developed by the NHS Protect:

1. **Strategic Governance**
   This section sets out the standard in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

2. **Inform and Involve**
   This section sets out the requirement in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS.

3. **Prevent and Deter**
   This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensure that opportunities for crime are minimised.

4. **Hold to Account**
   This section sets out the requirement in relation to detecting crime and investigating crime. Prosecuting those who have committed crime and seeking redress.

During the financial year 2017/18 the Trust's Anti-Fraud Specialist (AFS) completed a wide range of work across the main key areas of activity as outlined by the NHS Counter Fraud Authority (NHS CFA) and agreed within the work plan approved by the Audit Committee. The plan was substantially delivered, with one piece of work carried over to 2018/19 in respect of conflict of interests.

The Trust has a Standards of Business and Personal Conduct Policy. During 2017/18 the Trust has implemented a new Managing Conflicts Policy in line with national guidance, which has superseded the Hospitality, Gifts and Sponsorship Policy.

An anti-fraud work plan is agreed with the Director of Finance and approved by the Audit Committee and the anti-fraud specialist is a regular attendee at Audit Committee meetings to provide an update on the on-going programme of proactive work to prevent any potential fraud and investigatory work into reported and suspected incidents of fraud.

Compliance with the Cost Allocation and Charging Requirements set out in HM Treasury and Office of Public Sector Information Guidance

The Walton Centre NHS Foundation Trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance. The Trust complies with the Approved Costing Guidance issued by NHS Improvement in February 2016. The Trust's Finance Department works with all departments within the Trust to use the activity information available within the Trust and an established NHS costing package to appropriately allocate expenditure to services and patients. The Trust was a pilot site for the national costing transformation programme that is being

introduced by NHS Improvement and work began on this in January 2017. The Trust was also an early implementer of a Costing Transformation Programme introduced by NHS Improvement in 2016/17.

Contracts

The Trust has many contracts for goods and services with numerous suppliers in the private and public sectors. Whilst all are important the following are regarded as essential to the daily operation of the business and would be difficult to change at short notice:

- The close proximity of Aintree University Hospital means that the Trust can benefit from economies of scale by using their infrastructure to provide some of its support services. There is a service level agreement in place to cover these services which include Pharmacy Services as well as many estates functions including the provision of utilities and emergency maintenance.
- The EBME service has undergone a full tender exercise recently and the contract has been awarded to Royal Liverpool and Broadgreen University Hospitals NHS Trust until March 2021 (the contract was previously held with Aintree University Hospital until March 2018).
- St Helens & Knowsley NHS Trust provide the Trust with Payroll services; this is covered under contract until September 2018.
- The Trust's Patient Information System is provided by Silver Link and is under contract until April 2019.
- The Radiology Picture Archive and Communication System (PACS) and information system has been awarded as part of a consortium of local NHS bodies. The information element has been awarded to HSS (until June 2020) and the PACS element to Care Stream (until June 2023).
- ISS Mediclean provides hotel services including cleaning, portering, security and patient meals. This service underwent a full tender exercise in 2016 and a four year contract was awarded until March 2020.
- Laundry services for the Trust are provided by ISS Mediclean and are under contract until September 2018, with an option to extend for a further 12 months.
- Decontamination services are provided by Steris and are under contract until 2023, with a potential break clause in the contract in 2019.
- Neuropathology and mortuary services are provided by Liverpool Clinical Laboratories (LCL), with a contract in place until July 2018.

Policies applied to contracts for goods and services: Procurement and Tendering Policy, Sustainability Policy and Supplier Representative Policy.

Policies applied to contracts for goods and services:

- Give full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.
- Facilitate the continuing employment of, and arranging training for, employees who became disabled during the period.
- Facilitate the training, career development and promotion of disabled employees.

Any applicant who wishes to declare their disability on their application form will be given a guaranteed interview by the Trust providing they meet the minimum criteria for the vacancy. All candidates are asked in their invite to interview if they require any reasonable adjustments to be made for their interview and these are always accommodated wherever possible. Once appointed, and throughout an employee's employment, where necessary the Trust's Occupational Health Department will be consulted to advise on any reasonable adjustments which need to be made. Although NHS Jobs 2 is a web-based system application forms are also available in other formats upon request. To ensure improved monitoring, the HR Department have an established central log to record where staff have been supported with reasonable adjustments.

3v Accountability Report – regulatory ratings

2017/18: NHS Improvement Performance and CQC Ratings

NHS Improvement award Foundation trusts regulatory ratings based on self-certification received from trusts in their annual plan, in-year monthly submissions and any exception reports, including any reports from third parties such as the Care Quality Commission (CQC). The ratings for The Walton Centre Foundation Trust over the last two years are summarised in the tables below. Ratings awarded at the start of the year are based on the expected performance at the time of the annual risk assessment in our annual plan. The quarterly ratings are based on actual performance reported to NHS Improvement, via quarterly in-year submissions. NHS Improvement moved to the Single Oversight Framework in October 2016.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are placed in a segmentation rating from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place. Information for the prior year and first two quarters of 2016/17 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHS Improvement's guidance for annual reports.

Segmentation

This segmentation information is the Trust's position as at 31st March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Following a review of the Trust's financial position The Walton Centre Foundation Trust was placed in segment 1. This is the lowest level of oversight with no potential support needs having been identified resulting in maximum autonomy within the Single Oversight Framework.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to provide an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score shown in the table below.

Table 39

Area	Metric	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	1	1	1	2	2	2
	Liquidity	1	1	1	1	1	1
Financial efficiency	I&E margin	1	1	1	2	1	2
Financial controls	Distance from financial plan	1	2	2	1	1	1
	Agency spend	1	1	1	1	2	3
Use of Resource Risk Rating		**1**	**1**	**1**	**1**	**1**	**2**

Governance Rating

NHS Improvement use a combination of methods to assess governance issues at NHS foundation trusts and to gain assurance of their standards of governance. Trusts are rated green where there are no concerns, red where they are under formal regulatory investigation or 'under review' where concerns have been identified by the trust or its regulators which require further investigation. Table 40 reflects trust performance during the year.

2017/18 Performance

Table 40

	Annual Plan 2017/18	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Finance and Use of Resource rating	1	1	1	1	1
Governance rating	Green	Green	Green	Green	Green

Overview of Trust performance against national priorities from the Department of Health's

Operating Framework

Table 41

Performance indicator	2017/18 Target	2017/18 Performance	2016/17 Performance
Incidence of MRSA	0	**1**	1
Screening in-patients for MRSA	95%	95.26%	97%
Incidence of Clostridium difficile	<=10*	7	9
All Cancers: Maximum wait time of 31 days for second or subsequent treatment: surgery	>=94%	100%	96.43%
All Cancers: 62 days wait for 1st treatment from urgent GP referral to treatment	>=85%	100%	100%
All Cancers: Maximum waiting time of 31 days from diagnosis to first treatment	>=96%	100%	100%
All Cancers: 2 week wait from referral date to date first seen	>=93%	99.62%	99.66%

3vi Accountability Report - statement of accounting officer's responsibilities

Statement of the chief executive's responsibilities as the accounting officer of The Walton Centre NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

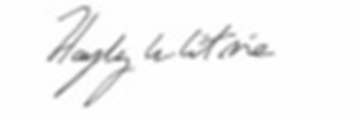
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require The Walton Centre NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Walton Centre NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Signed 

Chief Executive Date: 25 May 2018

3vii Accountability Report – annual governance statement

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives; whilst safeguarding the public funds and departmental assets for which I am personally responsible and in accordance with the responsibilities assigned to me. I am also responsible for ensuring that The Walton Centre NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in NHS Foundation Trust Accounting Officer Memorandum.

The Trust is required to register with the Care Quality Commission (CQC). Its current registration status is 'Registered without Conditions'. Within the year 2017/2018 there have been no CQC inspections. The quarterly engagement meetings between the CQC and the Trust have continued to be held throughout the year. These have been attended by the CQC Engagement Manager, the Director of Nursing and the Deputy Director of Governance and where there had been a specific topic for discussion the relevant specialist was invited. The CQC has held two focus groups during the year which have included all levels of staff within the area.

Within the year Hayley Citrine was appointed as the new Chief Executive Officer and the Deputy Director of Nursing was appointed as the "Acting Director of Nursing".

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the Trust strategies, policies, aims and objectives of The Walton Centre NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Walton Centre NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

There have been no significant control issues identified.

Capacity to handle risk

The Board of Directors collectively takes a proactive role in providing leadership to the organisational risk management process. The Trust has a Risk Management Strategy which was approved by the Quality Committee in October 2016. The Risk Management Strategy identifies the objectives in table 42:

Table 42

Objective No	Objective Description
Objective No 1	Define the organisations risk appetite
Objective No 2	Ensure a single and comprehensive risk management process
Objective No 3	Increase the coverage and utilisation of appropriate risk assessments throughout the Trust
Objective No 4	Increase the use of Trust wide data to inform the risk management process
Objective No 5	Enhance the knowledge and skills base of staff in risk management across the Trust, thereby also further encouraging an open and transparent reporting culture
Objective No 6	Strengthen the system of assurance regarding risk through to Board level

Compliance with the objectives of the strategy is monitored by the Quality Committee and was last presented in October 2017.

The Trust also has a Risk Management Policy which sets out the roles and responsibilities of the chief executive, executive directors, executive director with responsibility for risk, and the managerial roles key to the co-ordination of risk management throughout the organisation. The policy clearly states that all Trust employees have a responsibility for the management of risk; it also describes the systems of governance process for the management of risk.

The following committees of the Board of Directors have delegated powers for the responsibility of monitoring high-level risks within their terms of reference:

- Quality Committee
- Business Performance Committee
- Audit Committee

The Quality Committee is chaired by a Non-Executive Director and in order to ensure appropriate challenge, part of its constitution includes attendance by two other Non-Executive Directors. The terms of reference of the committee require it to act as a scrutiny committee, providing assurance to the Trust Board that adequate and appropriate checks and balances are in place, and that controls which arise from risk assessment and mitigation processes are robust. The Quality Committee is also responsible for the review of the Trust Risk Register which is formed by those risks which are held on the operational risk registers and are rated as 12 and above. Also included in the Quality Committee Terms of Reference is the quarterly review of those risks on the Board Assurance Framework for which it has designated responsibility.

The Business Performance Committee is chaired by a Non-Executive Director; and in order to ensure appropriate challenge, part of its constitution includes attendance by two other Non-Executive Directors.

The committee's responsibilities relating to risk management require the scrutiny of those risks on the Board Assurance Framework for which it has designated responsibility. The committee provides assurance to the Trust Board that the systems and processes are robust and, if required, has the capacity to escalate issues to the Trust Board. During the year 2017/18, the Business Performance Committee has requested detailed reports on specific risks included on the Board Assurance Framework; this has enabled the committee to provide assurance to the Trust Board that those adequate checks and balances were in place.

The Audit Committee is chaired by a Non-Executive Director, and its membership is constituted of two other independent Non-Executive Director members. Governors of the Trust are invited to observe the committee and are required to act as a link between the Audit Committee and the Council of Governors, thus ensuring transparency and promoting engagement. The Audit Committee has oversight of the system of risk management and assurance, including the Board Assurance Framework. It has a cycle of business that requires attendance by members of the senior management team to provide assurance in relation to the effective design and operation of systems of control that fall within their respective portfolios.

The Patient Safety Group reports into the Quality Committee. The Terms of Reference of the Patient Safety Group reflect the scrutiny and oversight function of the operational elements of risk and governance throughout the organisation. Divisional risk registers are presented to, and scrutinised by, the group on a rotational basis; at meetings where divisions are not scheduled to fully review their registers, an exception report informs the group of new risks and those which have been archived. This process ensures cross divisional challenge and a Trust-wide consistency in the grading of risks, which in turn, provides a standardised organisational risk profile. The Patient Safety Group is also responsible for the scrutiny of serious untoward incidents, root cause analyses, safety alerts and related action plans.

Monthly multidisciplinary divisional governance and risk meetings are held in each of the divisions, all of which have core agenda items which include the review of risk registers, complaints, incidents and health and safety issues. The Chair's reports from these groups report into the Quality Committee.

A Harm Free Care Board which is comprised of lead nurses and members of the governance department meet each week to continually review risk registers, monitor progress of root cause analysis investigations and complaints.

The Trust holds quarterly Council of Governors Steering Group meetings which act as a forum for discussion and engagement with the governors. The steering group also agrees the agenda for the quarterly Council of Governors meetings. The Council of Governors meetings enable governor consultation and provides an oversight and scrutiny function. Development of the Council of Governors is referenced in section 3iv.

2017 saw the implementation of a Trust-wide safety huddle for all staff groups to raise and discuss safety concerns affecting patients, visitor and staff. Meeting are held each weekday morning for approximately 20 minutes to support excellent communication and champion safety.

The Board Assurance Framework is reviewed and monitored each quarter by the Executive Team, the board committees and the Trust Board. This scrutiny allows the Board of Directors to satisfy itself that risks which threaten the achievement of strategic objectives are under prudent control and fall within the Board's risk appetite. The Audit Committee reviews the framework each quarter ensuring that the correct governance process has been followed. The Quality Committee and the Business Performance Committee review the specific risks for which they have delegated responsibility.

To ensure that the Trust's approach to managing risk is successfully implemented and maintained, staff at all levels are provided with appropriate risk management and incident report training which is appropriate to their role and responsibility within the organisation. Training includes, but is not limited to: incident reporting, health and safety, risk management, fire safety, infection control and prevention, information governance, root cause analysis, complaints management, equality and diversity, safeguarding children and vulnerable adults, conflict resolution and basic life support. Other risk management training is provided on a formal and ad hoc basis as part of the corporate learning and development programme.

A training needs analysis has been developed which is managed by the training and development function and is monitored through the performance management process. This identifies the initial and on-going mandatory training requirements for all employees. All new starters attend a mandatory induction programme which covers all areas of risk management.

The Trust is an accredited centre for the Institution of Occupational Safety and Health (IOSH) Managing Safely course for senior staff. This is an internationally recognised certificate of competence.

Training in the use of Datix is provided to all staff. There is also an accessible, specialist system lead based centrally with the Risk Management Team.

All staff can access the Datix system to report an incident online. Line managers quality check the data before the information is validated and referred to the appropriate person in the organisation. Escalation is based on the risk rating score of the issue reported. The Trust continually strives to improve its risk management performance by capturing good practice and lessons learned from a wealth of sources including complaints, litigation, incidents, audits and reviews. To facilitate the learning of lessons from incidents, the Trust uses the following processes: a regular Lessons Learned newsletter, inclusion in monthly assurance reports to the specific wards and departments, inclusion in the quarterly governance and risk report and inclusion in the monthly Team Brief and weekly email bulletin to staff, Walton Weekly.

The Trust has developed a root cause analysis action and assurance tracker. This records proposed actions from investigations and holds the evidence to demonstrate that any recommended action has been

taken. The tracker is reviewed each week at the Harm Free Care Board and the monthly divisional governance and risk meetings.

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 are identified through the daily scrutiny of the Datix system. Relevant incidents are identified and entered onto a tracker which manages Trust compliance to the Duty of Candour regulations. All patients, and in some circumstances relatives, who fall into the duty of candour requirements are offered an apology by the relevant clinician as soon as possible and this is recorded in the patient records. The patient or relative will then receive a letter offering an apology which is signed by the Chief Executive. The letter of apology also includes an offer for the relative/family/carer to contribute to the subsequent investigation and enquires whether the recipient would like to receive a copy of the final root cause analysis investigation.

The Trust has robust policy development and management processes in place which ensures that documents which support patient care are fit for purpose and are approved and ratified by a nominated group/committee. Strategies and policies relating to risk management are kept under review throughout the year. All risk and control related policies have an equality impact assessment completed as required by the Trust's document control arrangements. Any proposed cost improvement plans undergo a quality impact assessment to ensure that any changes in funding to services or schemes do not increase risk unexpectedly or negatively impact on patient safety, patient experience or clinical effectiveness of the service.

The Trust's Risk Management team is a component of a wider governance department which integrates all components of risk for effective control and greater efficiencies.

The Risk and Control Framework: Risk Management

Risks are identified, assessed and recorded by senior managers who input information from risk assessments onto Datix, an electronic web based risk management solution. Formal risk management reports and registers are managed at divisional governance meetings and reviewed with local departmental managers.

The Board of Directors recognises the value of taking a strategic, proactive and comprehensive approach to the assessment and the control of risk. The Trust appreciates the variety of significant benefits which can be achieved from improving patient care and the safety of the working environment for its staff, which assist in reducing levels of financial risk and loss for the organisation as a whole. The Board of Directors consider the nature and extent of the risks facing the organisation, the amount and type of risk identified, the likelihood that the risk might materialise and the ability to control the impact of the risk. At the beginning of each year, the Board scores the risk of failure to achieve its strategic objectives and identifies a target score for that risk. The target score may be at the same level (where the Board has an appetite for that risk) or lower (where the risk score is intolerable and must be mitigated to a lower level).

The Board's appetite toward compliance with statutory legislation is to refrain from risks which may prevent compliance. On this basis the risk appetite aligned to the strategic priorities should not be taken into consideration for compliance related decisions.

The Board has set a risk appetite of Cautious / Moderate. This reflects the environment that the organisation is currently operating in and the need to be innovative when considering options for improvement. This does not indicate that the Board is seeking to undertake 'risky behaviour'.

To ensure consistency in process, all risk assessments are completed using the ISO 3100 Risk Management Standard and evaluated using a 5x5 risk grading matrix which is described in the Trust Risk Management Policy. All risk assessments, including information on evaluation and control, are recorded on Datix and supported by action plans which are rigorously monitored at the weekly Harm Free Care Group, monthly Divisional Governance Groups, and the Patient Safety Group. Lessons learned from risk assessments and serious untoward incidents are shared via the monthly ward and department assurance reports, the monthly divisional governance reports, the quarterly Governance and Risk Report, the Incident Feedback, Team Brief, Trust Safety Huddle, Walton Weekly and through email bulletins to all staff.

The Trust's Strategic Objectives for 2017/18 were:

1. Improving quality by focusing on patient experience and clinical effectiveness
2. Sustaining and developing our services
3. Research and innovation for patient care
4. Developing our hospital
5. Recruiting, retaining and developing our workforce
6. Maintaining our financial health

In response to feedback from the executive team, the Board Assurance Framework has been subject to a complete review during the year 2017/2018. As at 31 March 2018, the Board Assurance Framework identified eight risks to the strategic objectives. All risks have robust controls and treatment plans to mitigate the risk as far as reasonably practicable. Therefore, the level of risk will decrease once risk treatment is effective.

Compliance to the UK Corporate Governance Code is explained in section 3iv of this document, compliance with the single oversight framework found in section 3v.

Development of the Council of Governors is referenced in section 3iv.

Major Risks: The major risks both in year and future are listed in table 43. These will be continually monitored through the year and updated as necessary.

Table 43

Strategic Objective	Risk Description and Rating	Mitigating Actions
6	Failure to achieve the CIP financial plans in accordance with the Strategic Plan due to conflicting pressures/challenges without adequate mitigations Risk Rating: 16	• Financial savings plan • Quality Impact Assessment • Mitigation/sustainability options plans • Dedicated finance savings program manager in post • Review of short-term affordability (capital program) • Business intelligence – work has begun on developing a suite of operational and financial real time information which will look to incorporate PLICS information • Corporate divisions meet with Directors of Finance and Workforce on a fortnightly basis to identify savings in year and plan for next financial year
6	Failure to deliver financial stability in the medium term due to changes in the NHS economic Environment e.g. tariff changes Risk Rating: 9	• Contracts for 17/18 agreed with major English Commissioners which are both in line with plan submitted to NHSI in December 2016 • Engagement with business partners • Proactive management of recharging for non-contracted activity • Review of SLA with main providers • Mitigation Plans and CIP contingency planning have been developed and presented at Trust Board • Agency Spending Review – to manage within agency cap and to reduce over expenditure
6	Failure of WHSSC to pay tariffs at HRG4+ levels Risk Rating: 16	• Issue been discussed with NHSI regarding the non-payment of HRG4+ • Collaboration. NHS Trusts and FT's are being impacted and are therefore working with NHSI to find a solution to the issue • Further discussion regarding the outcome of the escalation between all parties
1	Due to external pressures on the system, the Trust will be forced to take patients outside of the specialty Risk Rating: 12	• Communication with NHSE to advise when system pressures are increased and anticipate pressure to take patients outside of specialty • Reviewed and improved operational process • Policies, Procedures and Guidelines to identify patient flow accepted to support system pressure
	Failure to secure satisfactory	• Stakeholder management to ensure commissioners and other stakeholders are aware

2	arrangements for continuation of Neuro Network Vanguard service models following cessation of national funding in March 2018 Risk Rating: 16	and supportive and their needs are met, through face to face contact, collaborative working and written and electronic materials • Formal evaluation of the Program to demonstrate quality and activity/financial benefits, overseen by North West Coast CLAHRC as External Lead Evaluator, with input from Edge Hill University and Evaluation Group, chaired by a CCG director and with other commissioner representation. • Management plan developed and agreed with Executive Team and implemented for managing staff potentially at risk, including financial plan provision in 2018-19 • Updated in March 2018 • Work stream established to develop an agreed financial model and financial flow and other mechanisms for consideration by commissioners as part of contracting round, overseen by Finance sub-group involving Deputy Finance Directors from all Commissioners and Finance Director of the STP
2	Failure to deliver patient activity due to demand and competing operational pressure Risk Rating: 12	• Service Improvement Programme. Established an infrastructure. Program board and projects defined and operational • Waiting list incentives • New Theatres (including Emergency theatre capacity) • Additional bed capacity available on Caton Ward • Divisional performance monitoring reviews (weekly) • SPC charts. 2% tolerance limits – early warning alert • Outpatient referrals –& Extended scope practitioners triage (reduced demand) • Succession Planning assessment and implementation
2	Failure to meet Neurosurgery and Pain RTT targets required by NHS Improvement and NHS England Risk Rating: 12	• Waiting list initiatives and overtime offered weekly to mitigate staff shortage and increase capacity to meet the demand of RTT targets • Service Improvement Program • Workforce. Job Planning .Monitor annual leave of consultants • Continuous validation and if required amend patient pathways to ensure accuracy • Monitor Performance of RTT on a weekly basis as a minimum • Established specific processes for the management of Warrington patients • Expand bed capacity (reduce length of stay

5	Inability to manage the impact of the reduction in numbers of Junior Doctors Risk Rating: 12	• Ongoing recruitment campaigns as appropriate • Existing Recruitment Strategy • Existing Organisational Development Strategy with strong emphasis on staff support including expanded coaching offer • Ongoing service improvement/continuous improvement work programme to improve efficiency, reduce agency spend and promote compliant working patterns
1	Inability to maintain Registered and Unregistered Nursing safe staffing levels resulting in sustained bed closures Risk Rating: 12	• Policies/Strategies • Escalation. Matron of the Day - Daily escalation identifies staffing and patient acuity, moves staff to ensure best use of staffing for patient need • Training and Education • Ward establishment monitoring (weekly) • Vacancies monitored weekly • Working with NHSI to target staff retention
1	Failure to deliver patient safety due to limited treatment options for CPE infected neuro patients/outbreak of CPE colonise, action and effective management. Risk Rating: 12	• Infection control policies (Monitored through Infection Control Work Plan, reviewed to ensure compliance with national guidance) • Ward rounds - Antibiotic Ward Round (Infection control, microbiology and medical representation) • Screening - Risk assessment for 'high risk' patients (as defined in PHE guidelines) • Incident reporting and monitoring
1	Compromising patient safety due to failure to prevent and breaching annual PHE threshold for C-Difficile. Risk rating: 12	• Infection control policies (Monitored through Infection Control Work Plan), reviewed to ensure compliance with national guidance • Environmental scores monitored monthly with any underperformance addressed immediately (ward and domestics services) • Cleaning schedules reviewed in collaboration with ISS, external company hygiene solutions and infection control • Cases of CDT following a full RCA that deemed unavoidable are presented to commissioners for external verification. • All CDT cases now typed
2	Risk of uncertainty regarding the future of Warrington Spinal surgery and potential impact on The Walton Centre's finances, Patient Experience	• Staffing. Extra capacity introduced via WLIs • Triaged follow-up referrals with an Extended Scope Practitioner (ESP) to signpost patients to correct clinician • Established specific processes for the management of Warrington patients - • Monthly meeting with WCCG, WCFT to monitor

	activity and reputation Risk rating: 16	transfer • Use of Inter provider transfer forms to ensure clear patient pathways (clock/start stops) • Regular updates and communications shared with NHSI, NHSE and CQC through contract and other meetings
1	Potential for harm caused to patients due to unnecessary treatment being commenced or treatment delayed as a result of an inaccurate EMG test Risk rating: 16	• Supervision provided • Communication and support to patients provided • Review of all tests undertaken • Management of additional activity and impact on general waiting times • Communications by Medical Director, CEO, Director of Nursing, Operations & Quality to NHSI, NHSE, CQC & the Medical Directors of Acute Trusts of the review
2	Failure of Low Carbon Steel heating pipework due to premature corrosion Risk rating: 20	• Established working group to: develop and action tracker & determine and co-ordinate actions • Escalation plan for out of hours leaks agreed with AUHT • Risk based methodology for replacement works priority • Use of specialist engineering advice

The Trust submitted the annual business plan (including operational plan) to NHS Improvement by the required deadline, following Board approval.

The Trust declared a position of compliance to the following three licence conditions; this is evidenced through the Audit Committee in April and May 2018 and the Trust Board May 2018.

Condition G6: The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution;

Condition FT4: The provider has complied with required governance arrangements;

Condition CoS7: If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service.

In respect of the principal risks to compliance with the NHS FT condition 4 (FT Governance), The Walton Centre has a Board of Directors and has established a committee structure with associated reporting lines, performance and risk management systems. Each committee is chaired by a non-executive director and has an associated executive team member as its executive lead.

The Board of Directors and Board Committees receive timely and accurate information to assess risks to compliance with the Trust's provider licence, and have the requisite degree and rigour of oversight over the Trust's performance. To assure itself of the validity of its annual governance statement required under NHS FT Condition 4 (8) b, the Board of Directors receives an annual assurance statement and associated

evidence. The Board of Directors approve quarterly reports for submission to the sector regulator NHSI, regarding its principal risks to compliance with its Governance and Continuity of Service ratings

Mersey Internal Audit Agency completed 13 reviews of the systems of internal control during the year. Four achieved high assurance, eight achieved significant assurance and one of the reviews received limited assurance. The review that achieved limited assurance had been supported by robust action plans in order to address the recommendations.

The Trust was subject to a full "Well Led" self-assessment as required by NHSI in 2015 and completed a subsequent initial self-assessment against the NHSI Well Led framework in 2018; this review was facilitated by an external reviewer. The Trust will undergo a second full self-assessment in December of 2019.

Emergency Preparedness Resilience and Response (EPRR)

The NHS England Core Standards for Emergency Preparedness Resilience and Response (EPRR) are the minimum standards which NHS organisations and providers of NHS funded care must meet. The Trust is required to follow the EPRR framework and delivery of the NHS England Core Standards. These are the minimum standards which NHS Organisations and providers of NHS funded care must meet and provide assurance around EPRR to the Commissioning Board. In 2017/18 the Trust has continued to invest both time and resources in its emergency preparedness, resilience and response. The 2017/18 self-assessment against the NHS England Core Standards shows that, of the 45 applicable standards, the Trust is fully compliant.

In 2017/18, the Trusts EPRR arrangements were revised taking into account the learning from the Manchester Arena and Westminster Bridge incidents. This learning has resulted in a clear improvement of the Trust's emergency preparedness, as demonstrated by:

1. The Trust achieving full compliance against all of NHS England's core standards for EPRR.
2. The Trust Major Incident Plan and associated action cards were revised with input from Consultant Surgeons/Anaesthetists.
3. A review of on call arrangements and associated training for Tactical and Strategic Commanders.
4. Training for On-call managers.
5. A successful clinically led Major Incident exercise - Brave Defender II.
6. Continued joint working with Aintree Major Trauma Centre and participation in a joint exercise in February 2018.
7. Continued review and testing of Business Continuity Plans.

A new EPRR work programme for 2018/19 will be overseen by the Trust's Resilience Planning Group and, if completed in full, will enable the Trust in 2018/19 to achieve full compliance against all of NHS England's core standards for EPRR.

Review of economy, efficiency and effectiveness in the use of resources

The Trust has a very well established mechanism for setting financial plans and ensuring that these are met. The Trust has also undertaken a detailed review of its income and expenditure budgets prior to setting its annual plans for 2018/19. The financial position is reviewed in detail at the Trust's Business Performance Committee meetings and at the Board of Directors meeting. A full description of all key activity, income and expenditure variances is covered in that report along with a full analysis of capital expenditure against plan, cash flow and the Trust's Use of Resource risk rating.

The Board of Directors has been proactive in identifying and agreeing financial risks and mitigations and this process is on-going. The Trust has a well-established system for identifying and managing financial risk. Internal audit has played a key role in providing assurance that financial systems are operating adequately and the Trust is continually striving to improve the effectiveness of its financial controls.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all obligations in relation to equality, diversity and human rights legislation are complied with.

The Foundation Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the obligations for the Trust under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Information Governance

With regard to information security risks, the Trust has a nominated Senior Information Risk Officer (SIRO) at executive level who has nominated responsibility for information risk. The Trust has maintained a minimum level 2 score across all of the 45 standards within the Information Governance toolkit and has scored 85% (green) compared with 86% (green) in the previous year. Information Governance training is provided as part of induction for all new staff and refresher training forms part of the Trust's mandatory training programme. The Trust has successfully gained accreditation against the ISO27001 (2013) standard in relation to Information and IT security. The Trust once again received 'Significant Assurance' from Mersey Internal Audit following a review of its Information Governance (IG) toolkit evidence for the

seventh year in succession. During the period of reporting, there have been four serious incidents, three involving confidentiality and the other a third party Information Security breach which were scored at Level 2 using the Information Governance Reporting tool which were duly reported to the Information Commissioner Office (ICO). The Trust has received notification from the ICO that no further action by them was necessary due to the remedial action taken by the Trust.

Annual Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

A number of steps have been put in place to assure the Board that the quality report gives a balanced view, and that there are appropriate controls in place to ensure data quality such as:

- The Trust Board has a good balance of skills and knowledge to provide appropriate challenge to data.
- The Trust supports a collective leadership approach which ensures a balance in the decision making process.
- Policies ensure that the quality of care provided is consistent and adheres to the Walton Way Values.
- There is a clear governance structure which facilitates the movement of information from ward to board.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive directors, senior managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Trust has a governance structure which ensures that the effectiveness of the system of internal control is fit for purpose.

The Board of Directors has a clear idea of its responsibilities and the Directors have a suitable balance of knowledge, skills and experience which enables robust challenge of the systems of internal control.

The Audit Committee acts independently from the executive ensuring that stakeholders are properly protected in relation to financial reporting and internal control

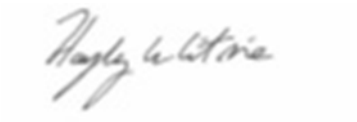
The Quality Committee has continued to improve the process of internal control through the introduction of two initiatives; “what quality means to you” which requires divisional representatives to present to the committee on issues within their areas and presentations relating to the Darzi Principles. Both of these initiatives provide a more detailed perspective on the internal control processes to inform the committee. Furthermore MIAA reviewed the Quality Committee’s compliance with its terms of reference and noted good compliance.

The clinical audit function continues to develop since being devolved in to the divisions and provides robust assurance on outcomes through its governance links.

The Trust’s internal auditors play a major part in challenging and providing assurance against the systems of internal control.

Conclusion

No significant internal control issues have been identified during the reporting year.



Chief Executive, 25 May 2018

4 Quality Report

Please refer to the Trust's Quality Account (enclosed at the end of this report) for a detailed analysis of the following:

Care Quality Commission Registration

The Trust is required to register with the Care Quality Commission (CQC). Its current registration status is 'Registered without Conditions'.

Quality Governance

4.1 Quality Governance

The Trust developed and implemented a Quality and Patient Safety Strategy in 2015, replacing the previous Quality Governance Strategy. The Quality and Patient Safety Strategy is a three year strategy, with an overarching aim to ensure Excellence in Neurosciences. It builds on previous progress through the Quality Governance Strategy and other patient safety initiatives and action plans taking the next steps for The Walton Centre a highly specialist tertiary centre going 'from good to great'.
The Strategy sets out the way forward for the three years using the five foundations which we have agreed following consultation with The Walton Centre's staff. These are based in particular from the learning from the Berwick Review and also the King's Fund's work in relation to collective leadership and culture in the NHS.

The five foundations are:

Foundation 1 - Leadership at all levels
Foundation 2 - Culture of continuous learning
Foundation 3 - Patient engagement
Foundation 4 - Build capacity and skills
Foundation 5 - Measurement to predict

It is a key enabling strategy of the overall Trust Strategy with several of its objectives, underpinning the quality elements, development of the Trust's services and The Walton Centre's workforce. In turn, the Quality and Patient Safety Strategy has its own supporting strategies in particular the Patient Experience Strategy. Furthermore it is closely linked with the Organisational Development Strategy.

Quality information is monitored at departmental, divisional and at board level. It includes patient safety, clinical effectiveness and patient experience information and is considered by the Quality Committee and the Board of Directors at their meetings. The Board is satisfied that, to the best of its knowledge and using its own processes and having had regard to Monitor's Quality Governance Framework, that the Trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to our patients.

To ensure compliance with the Care Quality Commission registration regulations, each regulation is part of a planned schedule of reviews which work alongside internal quality inspections. The Nursing Assessment and Accreditation System is an example of this and wards are currently classed as having a "green" status (good).

This year, the Trust has continued to develop the Board Assurance Framework (BAF) and review and refine the committee structures reporting to the Board of Directors. The Governance Department has continued to review and enhance its staffing structures with key appointments and further strengthening of health and safety and business continuity plans within the Trust which have had external scrutiny.

The Trust is committed to delivering outstanding care for patients and monitors quality and safety on a daily basis. Safety is reviewed each morning at the Trust safety huddle, which allows staff to escalate any concerns relating to patient, visitor or staff safety. Themes are shared with Trust Board quarterly.

Quality and safety is discussed at various committees, which then provide chairs reports to Trust Board following each meeting. Key performance indicators are provided to committees so that improvements and key risks can be viewed and risk mitigated. Where improvements have been observed, lessons to be shared are also managed trust wide.

The Quality Accounts for 2017/18 were all achieved with the feedback received from our specialised commissioners and Healthwatch.

The Patient Experience Team have been recognised by Healthwatch for their engagement with patients and this is noted within the Quality Account feedback. Engagement information is shared with the Patient Experience Group and is also escalated to Trust Board with key themes of improvement work.

The Board of Directors consulted with patients, governors, commissioners, Healthwatch and other external agencies to ascertain and agree the Trust's Quality Account improvement priorities for 2018/19. The Trust continues to monitor services across the three domains of quality: patient safety, clinical effectiveness and patient experience, reporting progress on the improvement priorities to the Quality Committee and to the Board of Directors on a regular basis.

Quality priorities are monitored and performance managed by the Board of Directors and by the Quality Committee. Operational groups within the Trust are made aware of their responsibilities in relation to quality priorities and report to Board committees. The Trust's Internal Auditor, Mersey Internal Audit Agency (MIAA), are fully involved in the process to provide regular review and assurance via the Audit Committee.

In addition, quarterly meetings to review quality assurance reports take place with the Trust's commissioners, ensuring external scrutiny and performance management.

Further details with regards to the Trust's statement in relation to quality governance can be found in the Annual Governance Statement included earlier in this report. Further information can also be found within the Quality Accounts section of this document.

Membership

At the end of March 2018, the Trust's membership stood at 7,426 compared to 7,565 in March 2017. The Trust's membership is available to both employees of the Trust and also patients, carers, volunteers and members of the public, aged 16 years and over, who live in the public constituencies of Cheshire, Merseyside, North Wales or the Rest of England & Wales. Table 44 provides a breakdown of the Trust's membership by constituency:

Table 44

Numbers by Constituency and Catchments	
Public Cheshire	872
Public Merseyside	2,585
Public North Wales	1,457
Public Rest of England and Wales	1,162

Numbers by Constituency and Catchments	
Public Out of Trust Area	7
Public Totals	**6,083**
Staff - Registered Nurse	383
Staff Registered Medical Practitioners	150
Staff Other Clinical Professional	458
Staff - Non-Clinical	352
Staff Total	**1,343**
TOTAL MEMBERSHIP	**7,426**

The Trust's Membership Strategy can be found at: www.thewaltoncentre.nhs.uk/173/being-a-member. The Walton Centre NHS Foundation Trust is a public benefit organisation and its objective, with respect to membership, is to recruit, retain and develop a sizeable, representative and active membership which is engaged with the objectives of the Trust. Information for prospective members is posted on the Trust's website.

The Trust is committed to building a membership representative of both the population it cares for and the staff who work for the Trust. Membership is therefore open to any individual who is eligible to be a member of the public or staff constituencies. To ensure effective member engagement the Trust produces a quarterly newsletter called Neuromatters. Copies are posted/emailed to public members and are prominently displayed around the Trust to encourage membership. The newsletter is also available on the intranet, website and via social media. During 2016 the Trust introduced a Governors email newsletter called 'Connect' which is sent quarterly to all members who have elected to receive email communications. The newsletter is also available on the website Governors page.

During 2017 the Trust and Governors undertook the following membership engagement activities:

- Annual Members Meeting
- Governor take-over day on the Trusts' Twitter and Facebook social media platforms
- Articles in Neuromatters membership magazine

- Patient engagement and listening events at Satellite Clinics
- Patient Listening Weeks
- Staff Listening Weeks
- Berwick Sessions
- Swartz Rounds

There is a dedicated email address which makes it simpler for members and prospective members to contact the Membership Manager: membership@thewaltoncentre.nhs.uk

4.2 Patient Experience

To demonstrate our commitment to continually improving the patient experience, we have a Patient Experience Strategy to focus on ensuring our patients remain at the centre of everything we do. This strategy ensures that patients are involved and receive an experience that not only meets, but also exceeds, their physical and emotional needs and expectations.

Based on feedback from patients and staff, the strategy has been used to underpin the Trust strategic aims around the Walton Way values, encompassing excellent patient experience and design actions to help the Trust achieve its strategic objective of:

"We treat our patients and colleagues with caring, respect, dignity, openness and pride. This is The Walton Way"

This will encompass the areas of improvement that patients have informed the Trust about, as well as being based on "what does excellent patient experience look like?" The purpose of this Strategy is to:

- Raise standards and expectations of patient, family and carer experience at The Walton Centre
- Define the action required by staff throughout The Walton Centre to improve patient experience
- Provide a framework of action for priorities and to clarify responsibility for action
- Ensure the current national drivers and standards for patient experience, together with The Walton Way underpin our ambition
- Ensure the Patient Experience Strategy contributes effectively to the Quality Strategy and ultimately to the strategic objectives of the Trust.

Further information on the progress in relation to patient experience can be found within the Quality Account section of this document.

The Patient Experience Strategy is available at: http://www.thewaltoncentre.nhs.uk/169/trust-publications.html

4.3 Patient Care

The nursing workforce is reviewed on a 6-monthly basis in line with national guidance using various tools and data is triangulated with nurse sensitive indicators to ensure that staffing is appropriate and safe. The senior nursing team provide leadership across clinical areas and ensure that there is a continued focus on nursing standards, the environment, patient safety and enhanced patient and family experience. As part of their work, the team review staffing on a shift by shift basis to ensure that changes in acuity and occupancy are considered and managed accordingly, in line with The Walton Centre outstanding status. The last staffing report was presented to the Trust Board in November 2017.

Where staff have requested to do long days instead of single shifts, this has allowed greater flexibility with staffing numbers to support enhanced levels of care and enable staff to have an improved work-life balance.

The nursing establishment planned versus actual results are reviewed by the Director of Nursing and Governance and are presented to various Committees prior to their monthly submission to NHS England and the Trust website. The unify return is cross referenced with friends and family data, registered nurse to patient ratio, nurse sensitive indicators and occupancy rates.

In 2017, there has been a significant focus on effective recruitment and retention of registered nurses to ensure that staffing is to its optimum. Work has been conducted alongside NHS Improvement and focussed on recruitment, support of staff in the workplace, equality, diversity and inclusion and retention. As a consequence the Trust has seen the turnover of registered nurses reduce significantly.

The Trust has worked hard in 2017/18 to support the reduction of healthcare acquired infections and has seen considerable reductions. The Trust has however had one MRSA bacteraemia in-year against a zero trajectory; a full root cause analysis has been carried out with lessons learned shared Trust-wide. The annual trajectory of Clostridium Difficile was 10 cases for Public Health England (PHE), with the Trust reporting seven cases this year.

Clostridium difficile continues to remain a challenge for the Trust going forward however work continues to support this reduction.

The Trust has also successfully managed Carbapenemase-producing Enterobacteriaceae (CPE) infections. The Trust screens all high risk patients on admission and undertakes regular screening in the areas containing high risk patients in the Trust. The Trust introduced a more timely and accurate screening medium, 'PCR', to allow the reduction in disruption of activity and to provide a better patient experience for patients who need to be screened following contact with an infected patient or on admission. This has allowed patients to be managed more effectively throughout the hospital.

The Walton Centre observed a 28% reduction in catheter associated urinary tract infections (CAUTI) by introducing catheter diaries to support the clear communication of catheter management.

Quality indicators are monitored via the Quality Committee which is chaired by a Non-Executive Director.

4.4 Commissioning for Quality and Innovation Payment Framework (CQUIN)

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009 with the principle that a proportion of healthcare providers' income was conditional upon demonstrating improvements in quality and innovation in specified areas of patient care. This means that a proportion of The Walton Centre's income is dependent on achieving quality and innovation goals.

The anticipated CQUIN income that the Trust expects to receive for 17/18 is £1.6m. This is subject to final validation around Q4 CQUIN delivery. For the first time, CQUIN schemes were instigated for two years with the following goals agreed for both 2017/18 and 2018/19:

- Clinical Utilisation Review
- Critical care Timely Discharge (4 hr Target)
- Spinal Networks
- Medicines Optimisation
- Digital Maturity
- Health and Wellbeing
- Advice and Guidance

- E-Referrals

Further details of the agreed goals for 2017/18 and for the following 12 month period are available on request from enquiries@thewaltoncentre.nhs.uk.

The Quality Committee reports directly to the Board of Directors on issues of quality governance and risks that may affect patient experience, patient outcomes or patient safety. This Committee also has responsibility for reviewing the Trust's Quality Accounts. Review and planning events involving patients, staff, governors and Healthwatch identified the areas of focus in respect of quality for the forthcoming year. Key performance indicators and priorities relating to quality were identified and their performance is monitored by various Committees and the Board of Directors on a monthly basis. The development of the Trust's Quality Account and reporting have also been agreed by the Board of Directors and the Trust's Council of Governors has been fully involved in the development of the Trust's quality priorities. External overview has been provided by the Trust's lead commissioner and opinion on the draft report has been sought from Healthwatch. The Overview and Scrutiny Committee, specialist commissioners and Healthwatch have had the opportunity to review the Quality Account.

Patient Experience and Complaints Handling

The Patient Experience Team provides help, advice and support to patients and their families, as well as helping to resolve concerns quickly on a patient's behalf. This can be prior to, during or after their visit to the Trust. The Patient Experience Team can be contacted by telephone or can visit a patient on a ward or at one of our Outpatient clinics. Where concerns cannot be easily resolved or are of a more serious nature, the Patient Experience Team are responsible for dealing with complaints on behalf of patients and their families. We pride ourselves in working with patients and staff throughout the Trust to resolve complaints in a timely way and to explain our actions and to evidence how services will be improved as a result of a complaint.

Our positive approach to managing and resolving complaints was recognised by Rob Behrens, Parliamentary and Health Service Ombudsman when he visited the Trust in June 2017. We were the first NHS organisation Mr Behrens visited after coming into post. He commented *"The Walton Centre's strong commitment to patient experience was particularly evident; the senior leadership, the complaints teams and frontline staff I spoke to were committed to continuous improvement and saw responding to patient feedback and*

complaints as central to this. The Trust had also focused on staff health and wellbeing as they saw a link between mistakes and staff feeling stressed and unable to cope."

Trend Analysis and Lessons Learned

Every complaint is investigated and each complainant receives a detailed response from the Chief Executive. We ensure those responses are open and transparent, and provide assurance that where mistakes have been made, those are rectified and we learn the lessons. Outcomes from complaints are reported monthly to committees within the Trust, and to the Executive Team. Longer term trends are reported to the Patient Experience Group, the Board and Council of Governors. Trends and actions taken are also discussed in detail in the Governance and Risk Quarterly report, the monthly divisional governance and risk group meetings and Quality Committee.

Examples of lessons learned from complaints during 2017/18 include revision to the rapid discharge pathway, improvements to accessibility of patient information, improvements to the patient administration system, improvement to the radiology reporting process, and reflection for teams and individual staff members.

Complaints Activity

We use feedback from people who have used the complaints process to help us improve our responsiveness and service. Following the restructure of the Patient Experience team in 2016/17, we reviewed our processes, making them more accessible to patients and families. We have developed a person centred approach so that complainants are kept involved and updated at each stage of the investigation, with regular contact from members of the Patient Experience Team.

The number of complaints received 01 April 2017 – 31 March 2018 are noted in table 45.

Table 45

	Quarter 1 April–June 17	**Quarter 2** July–Sept 17	**Quarter 3** Oct– Dec 17	**Quarter 4** Jan–Mar 18
Number of complaints received	27	34	41	30

The Trust received 132 complaints during 2017/18, compared with 102 complaints received in 2016/17.

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

make contact with the patient or relative once a complaint is received to agree the best way of addressing their concerns. This individualised approach has led to many patients or relatives wishing to resolve their concerns informally rather than pursuing the formal complaints procedure.

Patient Experience Strategy and Patient and Public Engagement

The Trust has a Patient Experience Strategy that underpins the Trust strategic aims around the Walton Way values. During the course of the current three year strategy, the Trust has maintained its position as one of the leading organisations for providing excellent patient experience.

During 2017/18 there has been significant engagement with patients, families and carers to identify what matters to them and what represents an excellent patient experience for them. This has been central to the Vanguard programme and the engagement activity has been enhanced working with the MS Society, Neurological Alliance, Brain Charity, Healthwatch Sefton, Liverpool and Knowsley.

Building on these improvements to engage with patients, families and stakeholders during the current strategy, the Trust is in a good position to further develop this in incorporating patient and family voice into the new Trust Vision and Strategy.

Volunteers

Following the introduction of the Volunteer Coordinator role in 2016, the volunteer service has continued to grow at the Trust. At the end of Quarter 3, we had 65 volunteers contributing almost 900 hours per month on average. In addition to the Neuro Buddy role, volunteers have been providing a valuable service in roles relating to research, Meet and Greet, trolley service, befriending, infection prevention and control, administrative duties and assisting the Pain Management Programme.

There is extensive support for volunteers and close monitoring of volunteer activity. This was reflected in the MIAA audit of the volunteer service conducted during 2017/18. MIAA audited the processes in line with national guidelines and established practice and rated the Trust's volunteer service as 'Significant Assurance'.

National Inpatient Survey

The results of the 2016 National Inpatient Survey (published in May 2017) highlighted that The Walton Centre maintained its position as one of the leading trusts for patient experience.

Overall, the Trust was ‘better than most other trusts’ in seven areas and ‘the same’ in three others, which was an improvement on the previous year. The Trust was not ‘worse than most other Trusts’ in any of the questions asked. The Trust was better than most other trusts when it came to patients’ experience of:

• Waiting for a bed on a ward
• The hospital and ward
• Doctors
• Nurses
• Care and treatment
• Overall views of care and services
• Overall experience

It was ‘about the same’ as other trusts on patient experience of waiting lists; operations and procedures, and leaving hospital.

Statistics show The Walton Centre is consistently achieving positive results in this survey year on year. Figures from the past four years show a steady increase with more and more questions showing that The Walton Centre has been rated as being among the best performing Trusts nationally.
For the full survey results for The Walton Centre visit www.cqc.org.uk/cqc_survey/3

The 2017 survey results will be presented to the Patient Experience Group, Quality Committee and Trust Board, once received, and an action plan developed to support any areas that require improvement.

Research and Innovation

The Trust continues to recognise the importance of Research and Innovation during 2017/18. The Neuroscience Research Centre (NRC) aims to:

- Work collaboratively to facilitate high quality clinical and healthcare research;
- Support the development and adoption of innovation;
- Reduce the timeline for study set up;
- Ensure its quality management systems and processes are fit for purpose and compliant with statutory regulations;
- Align its functions to Walton Way values and behaviours.

The NRC continues to work with clinicians to embed the Trust's Research, Development and Innovation Strategy so that research and innovation are integral to the Trust's day-to-day activities, making research and innovation everyone's business.

The NRC has recruited 1039 patients in 2017/2018. There are currently 85 clinical studies on-going at The Walton Centre and participation in clinical research demonstrates the Trust's commitment to improving the quality of care.

The Trust continues to recruit patients and relatives to the Genome Medicine Centre in Liverpool, which is part of the Government's flagship 100,000 Genome Project.

During 2017/18, the Trust has worked in partnership with the following networks and organisations to attract NIHR funding to deliver clinical research and share research outputs and innovations to inform service transformation and improvement:

- Clinical Research Network: North West Coast (CRN)
- Liverpool Health Partners (LHP)
- The Innovation Agency, the North West Coast Academic Health Science Network, (NWC AHSN)
- North West Coast Collaboration for Leadership in Applied Health Research and Care (NWC CLAHRC)
- Local Universities
- Other NHS trusts and NHS organisations
- Pharmaceutical companies (industry)

The Trust was shortlisted in four categories in the North West Research & Innovation Awards for 2018 and won the Clinical Research Rising Star of the Year award.

Clinical Audit

During 2017/18, eight national audits and three confidential enquiries covered NHS services provided by the Trust.

National Audits

Adult Critical Care (ICNARC / Case Mix programme)

The case mix programme is an audit of patient outcomes from adult critical care units. Data is collected on all patients admitted to Horsley Intensive Care Unit and submitted securely. The data sent is compared with outcomes from similar patients and analysed. The Trust receives quarterly data analysis reports which identify trends over time and shows how it compares to other units. These reports are discussed at the ICNARC Review Group Meetings and aim to assist with decision-making, resource allocation and local quality improvement. An audit of re-admissions for subarachnoid haemorrhage patients is currently being undertaken.

Trauma Audit and Research Network (TARN)

TARN audits the pathway and outcomes of patients admitted to the Trust as a result of a traumatic injury. Data collected for patients admitted is submitted securely and clinical reports are published by TARN three times a year specifically focusing on head and spinal injuries, orthopaedic injuries and thoracic and abdominal injuries. These reports along with monthly performance and activity reports are discussed at the quarterly internal trauma services meeting and the monthly Aintree University Hospital / Walton Major Trauma Clinical Assurance meeting. They are also discussed at the Major Trauma Centre Collaborative Board (MTCC). TARN, since October 2014, are working alongside Quality Health to collect Major Trauma Patient Reported Outcome Measures (PROMs), measures are collected before the patient's discharge and TARN follow up 6 months post injury. PROMs performance reports are published quarterly and are fed back in the quarterly internal trauma services meeting**,** any patients experiencing severe-extreme problems 6 months from injury are discussed in the trauma-rehab MDT to see what further care can be provided. The provision of this accurate and relevant information is vital to help doctors, nurses and managers improve their services. The Trust will continue to submit data to TARN and will review individual cases as appropriate

Falls and Fragility Fractures Audit Programme – National Audit of Inpatient Falls 2015-2017

This audit is funded through the Healthcare Quality Improvement Partnership (HQIP) and is carried out by the Clinical Effectiveness and Evaluation Unit (CEEU) of the Royal College of Physicians. The Falls Workstream is currently contracted to deliver the first National Audit of Inpatient Falls (NAIF), a clinically led, web-based audit of inpatient falls prevention care in acute hospitals in England and Wales. NAIF aims to improve inpatient falls prevention through audit and quality improvement. Round two of the audit was undertaken in May 2017

and the report was published November 2017. The report has been reviewed by the Falls Prevention Steering group and a work plan has been produced.

National Emergency Laparotomy Audit

NELA is being carried out by the National Institute of Academic Anaesthesia's Health Services Research Centre (HSRC) on behalf of the Royal College of Anaesthetists (RCoA), The audit aims to enable improvement of the quality of care for patients undergoing emergency laparotomy. The Trust does not perform many of these procedures but it continues to submit data for the cases it does have securely. The Trust submitted 100% of the applicable cases in the data collection period.

Specialist Rehabilitation for Patients with Complex Needs Following Major Injury

The audit will provide a national comparative assessment of the organisation, quality, outcomes and efficacy of specialist rehabilitation services provided for adults with complex needs following major injury (physical injury caused by events such as road traffic accidents, falls, etc.) It aims to drive improved and equitable access to specialist rehabilitation services. Walton Centre NHS Foundation Trust is submitting data securely via the TARN database. Findings are discussed at regional and local trauma group meetings.

The Sentinel Stroke National Audit Programme (SSNAP)

The clinical audit collects a minimum data set for stroke patients in England, Wales and Northern Ireland in every acute hospital, and follows the pathway through recovery, rehabilitation, and outcomes at the point of 6 month assessment. Originally The Walton Centre NHS Foundation Trust was not required to submit data to this audit, however, following changes made to include thrombectomy data the Trust has started to submit information for the patients who have had a thrombectomy procedure at The Walton Centre. Data collection is on-going and the audit results are published quarterly. The process for collecting SSNAP data is currently under review and actions have been identified to improve data submission.

National Comparative Audit of Blood Transfusion (NCABT)

The National Comparative Audit of Blood Transfusion is a programme of clinical audits which looks at the use and administration of blood components in NHS and independent hospitals in England and North Wales.

Schedule of audits 2017:-

1. Audit of O negative red cells Winter / Spring 2018 – not applicable to WCFT

2. Audit of red cell & antiplatelet transfusion in adult haematology patients – not applicable to WCFT
3. TACO audit – applicable to WCFT

The Trust submitted 100% of the cases to the TACO audit and is awaiting the publication of the report.

National Neurosurgery Audit Programme (NNAP)

The Neurosurgical National Audit Programme (NNAP) was established by the Society of British Neurological Surgeons in 2013 as part of a major quality improvement initiative. The programme aims to support neurosurgical units in the UK and Ireland to improve patient care, outcomes, safety, and experience by providing high quality, robust audit data that is analysed and presented in a consistent and clinically relevant way. The analysis of audit data found that The Walton Centre NHS Foundation Trusts is one of the busiest units in the country, with very good performance / outcomes and low mortality rates.

National Confidential Enquiries (NCEPOD)

The purpose of NCEPOD (National Confidential Enquiry into Patient Outcome and Death) is to assist in maintaining and improving standards of medical and surgical care for the benefit of the public by reviewing the management of patients. This involves undertaking confidential surveys and research and by publishing and generally making available the results of such activities, in order to maintain and improve quality of patient outcomes. There were three studies The Walton Centre was eligible to participate in during 2017/18.

Perioperative Diabetes

The aim of this study is to identify and explore remediable factors in the process of care, in the peri-operative management of surgical patients with diabetes across the whole patient pathway from referral for surgery, (elective) or admission to hospital (emergency) to discharge from hospital.

This will include:

- To examine organisational structures, processes, protocols and care pathways in hospitals from pre-admission through to discharge or death
- To identify avoidable and remediable factors in the management of patients

The patient identifier spreadsheet was completed and submitted to NCEPOD within the set timeframe. NCEPOD selected 6 cases from The Walton Centre to be included in the study. A Consultant and Anaesthetist questionnaire was completed for each case and submitted

within the set timescale along with copies of the patient notes. The report is due to be published in winter 2018.

Cancer in Children, Teens and Young Adults

The aims of this study are to review the process of care of children, Teens and Young Adults under the age of 25 years who died/ or had an unplanned admission to critical care within 30 days of receiving systemic anti-cancer therapy in order to:

- Look at the decision making and consent process around the prescription of Systemic Anti-Cancer Therapy (SACT) in this group of patients.
- Explore remediable factors in the quality of care provided to patients during the final line of therapy.
- Look at preventable causes of treatment-related mortality in young people's cancers.
- Look at the configuration of the service and organizational structures in place for the safe delivery of SACT to children, teenagers and young adults.

The Data request and Organisational Questionnaire have been completed and submitted to the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) within the set timeframe. The report is due to be published September 2018.

Chronic Neurodisability, focusing on cerebral palsy study

The aim of this study is to identify the remediable factors in the quality of care provided to children and young people with chronic disabling conditions, focusing in particular on cerebral palsies.

This will include:

- To examine the interface between different care settings
- To examine the transition of care

There are 10 Organisational Questionnaires for this study; however, only 4 of these are applicable to the Trust. The relevant questionnaires have been completed and submitted to NCEPOD within the required timeframe. The report is due to be published in March 2018.

Local Audits

During 2017/18, the Trust also participated in 100 local clinical audits. All action plans received are discussed, monitored and signed off by the Clinical Audit Group. The Clinical Audit Teams for each Division produce a monthly clinical audit activity status report which includes recommended actions from all completed projects for each division and the progress made towards implementation. These reports and actions are monitored monthly at the Divisional Governance and Risk meetings.

An annual clinical audit event is also held at the Trust for staff to share their work and learning from audits undertaken for the purpose of service improvement and improving clinical knowledge.

Never Events

During 2017/18 the Trust reported 3 Never Events. The requirements of the Duty of Candour regulations were followed in all instances ensuring openness and transparency. All incidents were subject to thorough investigation with root cause analysis being completed; lessons learnt were shared within the divisions.

Conclusion

The Trust had made continuous improvements during 2017/18, meeting all of its financial and operational targets. This was a significant achievement, given the ongoing challenges faced by the NHS. The Chair and Chief Executive paid tribute to the hard work and dedication of staff and the many supporters of the Trust, including volunteers, support groups, charitable groups, fundraisers, members, governors, current and previous patients.

The Walton Centre NHS
NHS Foundation Trust

Quality Account

2017 – 2018

Part 1 Statement on Quality from the Chief Executive

We are delighted to share the Quality Account 2017 / 2018 for The Walton Centre NHS Foundation Trust which demonstrates our commitment to deliver quality care to our patients that we serve, enabling, “Excellence in Neuroscience”. This report details our performance over the last year whilst also highlighting our key priorities for 2018 / 2019.

The Walton Centre NHS FT has continued to work in collaboration with our stakeholders in both 2017/2018 priorities and those identified for the fore-coming year with the Council of Governors, patient representatives, specialist commissioning and members of Healthwatch. In addition, the Quality Account incorporates information relating to compliance with national audits, complaints and information relating to research governance and data quality.

2017 / 2018 has been an exciting year, with significant changes noted across our Executive and senior leadership teams and our aim of delivering quality care in relation to patient safety, clinical effectiveness and patient experience has remained our priority. As the new Chief Executive Officer, I stand firm to supporting the quality agenda and enabling our staff to achieve this. We have taken various approaches to the delivery of quality care, by working with various teams across the hospital as well as across the region of Cheshire and Merseyside to ensure that quality care is delivered in the right place, at the right time.

The Trust has a robust performance management framework, developed with Commissioners and with the Welsh Health Specialised Services Committee. NHS England (Cheshire and Merseyside) as specialist commissioner undertakes the lead in performance managing the Trust against its statutory and NHS plan targets as part of the local health economy review process and regular contract quality performance meetings have taken place.

Since achieving our CQC outstanding rating in April 2016, The Walton Centre NHS FT has continued to strive for and deliver on the quality agenda for patients. The quality priorities for 2017/2018 have been achieved and are detailed within this Quality Account. In addition, this year we have achieved:

- A positive visit from the Parliamentary and Health Service Ombudsman in June 2017 recognising the Trust’s commitment to continuous improvement
- Shortlisted as a finalist for the Health Service Journal for epilepsy management for pregnant women – outcome awaited

- Creation of an Instagram account to increase opportunities of how patients communicate with us
- Reduction in complaints from 2016/2017
- Commencement of a vision to enable a culture of equality, diversity and inclusion for staff to support our patients and their families
- Re-secured our achievement of Investors In People Gold standard
- Sky view ceiling system installed in Intensive care
- Introduction of a Trust safety huddle
- Re-introduction of a patient advice telephone line
- Commissioning an in-theatre intra-operative magnetic resonance imaging (MRI) scanner for use in complex surgery
- Opened two new theatres
- Piloted the introduction of open visiting times to support patient & family centred care
- Delivery of a new Renishaw Neuromate Robotic Arm to allow greater precision in minimally invasive surgery

These initiatives are reported on within this report in further detail. Such quality initiatives are discussed and debated through various Committees, including, the Audit Committee, the 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 sub groups to the Quality Committee include Patient Safety Group, Clinical Effectiveness and Service Group, Infection Prevention and Control Committee and Patient Experience Group and items are discussed in detail to gain assurance and enable lessons to be identified and shared Trust-wide.

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.

Staff within The Walton Centre NHS FT strive to deliver outstanding care and this is recognised by their achievements of 2017 / 2018 whilst working in partnership with our patients and their families to meet and exceed their expectations. The commitment to patient safety, clinical effectiveness and patient experience is appreciated and has enabled our successes.

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 Acting 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 2016/17. Consultation with patients, governors, commissioners, Healthwatch and other external agencies also informed the Board when focusing our priorities for 2017/18.

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 2017/18.

2.1 Improvement Priorities for 2017 – 2018 - 'How well have we done?'

In February 2018, the Board of Directors undertook a full review of quality indicators used by the Trust for the previous financial year and acknowledged the work implemented to ensure each indicator was on target to be achieved. At this review, quality priorities were identified and agreed for 2018/19. 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 involved in the Trust during 2017/18, providing regular reviews and assurance via the Audit Committee. 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: Development of a Surgical and Medical Acute Response Team (SMART) Database

The Trust identified that one of the objectives to focus on during 2017/18 was the development of a database to capture the attendances of the SMART Team across the wards and their impact in the recovery and stabilisation of the deteriorating patient.

The SMART team now have a database that has been capturing all the activity regarding the deteriorating patients and this has been evidenced in returns for 2017/18.

The data collected is utilised to identify the number of cardiac arrests, patients with sepsis and attendances to support tracheostomy patients. The data is also utilised to support the Trust in the annual peer review undertaken by the Critical Care Network, providing evidence to inform quality of care and delivery of safe patient care Trust wide.

The SMART team regularly feedback at Professional Nursing Forum, Infection Prevention and Control Committee and through the Tracheostomy Steering Group regarding changes in care delivery to ensure best practice.

Outcome: Achieved

A robust database is now in place which captures the activity of the SMART Team, enabling reports to be generated to assist in reviews of service and care planning.

An average of 60 patients per month were discharged from Critical Care of which 100% received a follow up visit from The SMART Team. An average of 260 visits are now completed per month by the SMART Team to patients who have transferred from Critical Care to the wards. This provides patients and their families with valuable support physiologically, psychologically and physically. This has had a significant supportive impact collectively on patients, families and staff.

Priority 2: Carbapenemase Producing Enterobacteriaceae (CPE) Screening and Case Management

CPE bacteria normally live harmlessly in the bowel, however, if they enter into other areas such as the bladder or bloodstream, they can cause infection.

Infection caused by a CPE can be difficult to treat as these bacteria can produce enzymes which destroy most available antibiotics.

Screening for CPE is carried out to identify those patients who have acquired a CPE infection or who may be carriers of CPE (colonised). The Trust screens high risk patients as per care pathway.

Outcome: Achieved

Patients are screened by polymerase chain reaction (PCR) in line with national guidance. A CPE care pathway has been developed for the Trust. Implementation of the pathway provides a clear treatment plan for patients enabling the Trust to audit infection prevention and control strategies and improve patient experience. Isolation of patients is known to be a key area that many patients find difficult to adapt to the restrictions required. The pathway allows earlier identification of the need for additional psychological support and provides the opportunity for the patient to discuss and plan their care with the multi-disciplinary team. The screening programme has allowed early detection of patients colonised with CPE which enables staff to implement appropriate infection prevention precautions and improve patient flow through the Trust.

Priority 3: Develop Mental Capacity Act (MCA) Champions

An MCA Champion is someone who will receive comprehensive training regarding the Mental Capacity Act 2005 (MCA). The purpose of this training was to enable staff caring for patients to have the correct level of knowledge regarding MCA to ensure their safety.

Outcome: Achieved

The Trust has a fully trained cohort of Mental Capacity Act Champions who are available to provide leadership and support to staff and patients.

2.1.2 Clinical Effectiveness

Priority 1: **Same Day Admissions**

Same day admission describes the process whereby patients are admitted to hospital and have surgery on the same day. The move toward same-day surgery has been increasing over the year and has focused on limiting inpatient hospitalisation, reducing ancillary services and decreasing length of stay.

Outcome: Achieved

The Trust has implemented same day admission and have achieved a significant reduction in the number of patients being admitted the day before surgery.

Priority 2: Improved Discharge Process

The Trust identified that the discharge process needed to be improved to ensure patients were safely discharged to their place of care at a reasonable hour. This had a positive impact on patients awaiting admission to the Trust to ensure an enhanced experience.

Timely discharge is important for good patient experience and discharge has been a key theme from our engagement events. In order to support this initiative the Trust identified a 10% target for patients being discharged by midday.

Outcome: Achieved

At least 10% of patients discharged from the Trust by noon on their day of discharge.

Priority 3: Surgical site infection

A surgical site infection occurs post surgery in the part of the body where the surgery was undertaken. The Trust monitors and reports infection rates that occur post surgery and notes a very low rate of surgical site infections compared to national data from other organisations.

Shunt surgery has a higher incidence than other areas in the Trust and a review of process and practice in relation to this surgery, may identify further areas to focus on to reduce incidence.

Outcome: Achieved

A retrospective audit of shunt infections identified between April 16 – December 17 was undertaken. During this period there were 11 recorded infections related to shunt surgery. The audit confirmed adherence to the Trust policy and no identification of clinical practice that was a cause for concern. The Trust continues to review surgical site infections and will take appropriate measures to address any inconsistencies identified in collaboration with the surgical teams.

2.1.3 Patient Experience

Priority 1: Explore the development of a Nurse Bank

The options available for the sourcing of temporary staff are numerous. At times it can be difficult to ensure the Trust is using the approach which best fits the individual organisational need. The Trust always aims to utilise substantive employees as effectively as possible before looking to fill vacant shifts through external organisations.

The Trust has negotiated a bank exclusive contract with NHS Professionals (NHSP). This exclusive contract is essentially for current leavers or recent leavers from the Trust. Successful candidates work as bank staff in this Trust only. This provides another opportunity to enrol more staff as bank only and reduce agency use.

The development of the Trust bank allows permanent substantive staff to work extra shifts at a competitive rate; thus ensuring excellent standards are delivered, continuity of patient experience and care and a reduction in the reliance on agency staffing. Whilst we have been doing this we have also been focussing our attention on recruitment and retention to reduce the reliance upon bank and agency staff.

Outcome: Achieved

Continue to report staffing requirements bi-annually and discuss ad-hoc requirements due to patient acuity with the NHS Professionals.

Priority 2: Development of a Neuro Buddy Service

Patients with neurological conditions may experience various emotions, including fear, anger or sadness. A group of volunteers have become ‘Neuro Buddies’ who support both patients and visitors across the Trust when they feel most vulnerable.

Patients and their carers often say that talking to someone else who has been affected helps them feel less like they are on their own and more confident about coping with the situation they are in - Neuro Buddies offer people a chance to do that.

Outcome: Achieved

Twenty three Neuro Buddies are currently acting in the capacity of volunteers across the Trust.

A case study of a Neuro Buddy was presented to the Patient Experience Group as a patient/volunteer story to highlight the benefits of the service for patients, volunteers and staff. Feedback included:

- From a Neuro Buddy: *"I have been a patient here and wanted to give something back as I was so grateful for how the Walton Centre helped me. It is such a rewarding role and gives me such an opportunity to help patients, as I know what it feels like to be in their position."*
- From a patient: *"This is something over and above what I was expecting when I came into hospital. They made me feel so relaxed and calm."*
- From a staff member: *"They have has been fantastic at communicating with patients that have needed emotional support. They are very respectful of the patients' anxieties and worries and have a natural ability to engage."*

Priority 3: Launch 'John's Campaign' for Dementia

Johns Campaign is an initiative to welcome and support family members of people with dementia according to patient's needs and not be restricted by visiting hours. Involving a family carer from the moment of admission to hospital until the moment of discharge has been proven to enable the delivery of quality of care and improved outcomes.

Outcome: Achieved

The Trust has implemented Johns Campaign and this is championed by the Safeguarding Matron who visits each ward when patients with dementia are admitted to the Trust.

2.2 What are our priorities for 2018 - 2019

In December 2017, the Board of Governors undertook a full review of quality indicators 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 2018/19 with the Quality Committee, Healthwatch 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 have identified lead/s who have agreed milestones throughout the year. Monthly meetings are held to review progress.

How progress to achieve these priorities will be reported:

Updates are reported 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 1: Reduce Falls

There is a genuine desire to reduce falls to enhance patient experience. Whilst falls can have a physical harm, psychological elements can also be affected. Falls with no harm can affect patient confidence.

Reason for Prioritising:

Whilst lots of work has been undertaken in respect of falls, a different review and understanding of themes is required. This includes a number of patients with capacity who are at risk of falls but choose to mobilise unassisted.

Outcome Required:

To have a real-time discussion with patients and staff when a fall has occurred in order to learn lessons and share this with colleagues.

Priority 2: Invest in staff training for patients with challenging behaviour

Extensive work has been undertaken to support patients with challenging behaviour. Staff have highlighted that they frequently experience abuse, both verbally and physically from patients and their families which is also highlighted in the staff survey.

Reason for Prioritising:

The Trust believe it is essential to support our patients and staff within the work place and consequently have arranged for enhanced training to be delivered by Advancing Quality Alliance (AQuA). It is envisaged that such support will have a positive impact on staff in improving their experience in being better able to manage difficult situations.

Outcome Required:

To develop and implement a bespoke training programme for staff from various disciplines who have contact with patients with challenging behaviour.

Priority 3: Reduce missed doses of critical medication year on year

The Trust has a list of medicines that are classed as critical that must be given when prescribed to maintain safe and effective care. On occasions critical medicines are omitted for a variety of reasons and in some cases this is avoidable.

Reason for Prioritising:

By raising staff awareness of the issue and identifying and addressing specific causes, we can reduce omissions and thereby improve patient safety.

Outcome Required:

A year on year reduction in missed doses of critical medicines.

2.2.2 Clinical Effectiveness

Priority 1: Extend Health and Wellbeing Programme to improve staff resilience and mindfulness

As an organisation with Investors in People Gold we are committed to ensuring the psychological wellbeing of our staff. As the pressure within the NHS increases, it is essential that our staff are able to manage accordingly whilst maintaining good health.

Reason for Prioritising:

Research shows that supporting staff in the work place to achieve excellent health and wellbeing, results in a better staff and patient experience.

Outcome Required:

Review current health and wellbeing activities and providing opportunities within the workplace and ensure the more difficult to reach areas i.e. ward areas are encompassed.

Priority 2: Reduce non-clinical cancelled operations year on year

It is the aim of the Trust to reduce non-clinical cancellations year on year.

Reason for prioritising:

Cancellations have a negative effect on patient experience. Patients coming into hospital may need to make arrangements for support on discharge, make alternative plans for childcare and provide employers with prior notice of absence therefore cancelling operations can have a significant practical impact on our patients, in addition to the obvious emotional and psychological impact.

Several work-streams such as building on our Clinical Utilisation Review (an electronic tool to monitor whether patients are in the right bed at the right time), timely decision-making, monitoring and management of beds and completion of tablet prescribing to take home will all help our aim to reduce our non-clinical cancellation rate for patients.

Outcome Required:
A reduction in the non-clinical cancellation rate year on year.

Priority 3: Safety Huddle

The safety huddles address issues which have occurred over the past 24 hours and gives an opportunity to raise potential safety issues for the forthcoming 24 hour period, related to patients, visitors and staff.

Reason for prioritising:
The safety huddles have been in place for over a 6 month period which now offers the opportunity to review issues which have been raised such as IT systems, estates issues, infection prevention, staffing and bed occupancy. It is important to ascertain if there are any themes, where the hot spots may be within the organisation and what are the ways of best practice for sharing learning.

Outcome Required:
Undertake six monthly reviews of the Safety huddles to determine themes of concerns, ensuring the sharing of best practice and lessons learnt. Produce bi-annual report of themes and present this to the Quality Committee.

2.2.3 Patient Experience

Priority 1: Improve how we provide information to patients

Patients and families are increasingly using social media as a key source of information to find out about their condition and their care and providing feedback and opinion.

Reason for prioritising:

Information needs to be easily accessible through various media forms that are appropriate to patient and family requirements and increasing opportunities for feedback.

Outcome Required:
Development of social media to increase accessibility of patient information and opportunities for how patients may provide feedback through social media.

Priority 2: Initiate enhanced training on oral hygiene

As a specialised centre for neurology and neurosurgery, we care for patients who have various complex conditions. As a result of some of these conditions, many patients require ventilation (sometimes for prolonged periods of time), a tracheostomy and/or have dysphagia (difficulty in swallowing) which at times means a patient has to remain nil by mouth for a period of time.

These patients are particularly vulnerable to having poor oral hygiene due to changes in secretions, dry mouth and impaired swallow. As well as this, many of our patients have cognitive and mobility difficulties, meaning it is difficult for them to clean their teeth efficiently.

Reason for prioritising:
To enhance the standard of mouth care across the Trust which would result in improved patient mood, dignity and assist in potentially reducing hospital acquired pneumonia/ventilator associated pneumonia rates that could be associated with poor oral hygiene.

Outcome Required:
The aim of this priority is to implement the “Mouth Care Matters” project in order to enhance the standard of mouth care in the Trust.

Priority 3: Improve the way we listen and act on patient, family and carer feedback

Patient, family and carer feedback is important to us and it is essential that we triangulate information received and use all information gathered.

Reason for Prioritising:
The Patient Experience Team are keen to review ways in which we gather this information to ensure that all patient groups are heard e.g. via the introduction of patient panels.
Involving a family member or carer from the moment of admission to hospital until the moment of discharge has been proven in delivering enhanced quality care and improved outcomes.

Outcome Required:

Develop engagement activities to facilitate meaningful two way communication so that patients, families and carers have a voice in the care and services provided.

2.3 Statements of Assurance from the Board

During 2017/18, 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 2017/18 represents 91.5% of the total income generated from the provision of the relevant health services by The Walton Centre for 2017/18.

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 seven 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 2017/2018, 8 national clinical audits and 3 national confidential enquiries 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 the Trust was eligible to participate in.

The national clinical audits and national confidential enquiries that The Walton Centre was eligible to participate in during 2017/2018 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)
- Specialist Rehabilitation for Patients with Complex Needs Following Major Injury
- The Sentinel Stroke National Audit Programme (SSNAP)
- Falls and Fragility Fractures Audit Programme (FFFAP)
- National Comparative Audit of Blood Transfusion (NCABT)
- National Neurosurgery Audit Programme (NNAP)

2.3.4 National Confidential Enquiries

- Cancer in Children, Teens and Young Adults
- Chronic Neurodisability, focusing on cerebral palsy
- Perioperative Management of Surgical Patients with Diabetes

The national clinical audits and national confidential enquiries that The Walton Centre participated in and for which data collection was completed during 2017/2018 are listed 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%
Neurosurgery		
National Neurosurgery Audit Programme (NNAP)	Yes	100%
National Comparative of Blood Transfusion (NCABT) – Management of patients at risk of transfusion associated circulatory overload (TACO)	Yes	100%
Getting It Right First Time (GIRFT) – Surgical Site Infection Audit	Yes	100%
Older people		
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	Yes	N/A – No cases to submit
Rehabilitation		
Specialist Rehabilitation for Patients with Complex Needs Following Major Injury	Yes	100%
National Confidential Enquiry into Patient Outcome and Death		
Cancer in Children, Teens and Young Adults	Yes	N/A - NCEPOD did not require clinician questionnaires for this study
Chronic Neurodisability, focusing on cerebral palsy study	Yes	100%
Perioperative Management of Surgical Patients with Diabetes	Yes	100%

The reports of 6 national clinical audits were reviewed in the reporting period 1st April 2017 to 31st March 2018 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 • Undertake an audit of re-admissions for Subarachnoid haemorrhage patients • Development and implementation of action plan regarding infections
Severe Trauma - Trauma Audit & Research Network (TARN)	• The Trust will continue to submit data to TARN and will review individual cases as appropriate
National Emergency Laparotomy Audit (NELA)	• The Trust will continue participating in the NELA audit by submitting data for patients who undergo emergency laparotomy

	• Recommendations from the Third Patient Report have been reviewed and work is in progress to address gaps identified • Review and amend Sepsis policy as appropriate • Review of emergency surgical pathways
The Sentinel Stroke National Audit programme (SSNAP)	• Review procedure for collecting data included in the SSNAP dataset and ensure all doctors involved are aware of the process • Ensure data needed for SSNAP is included in EP2
Specialist Rehabilitation for Patients with Complex Needs Following Major Injury	• Findings discussed at regional and local trauma group meetings • Follow patients in specialist clinics • Early referral to rehab network for early identification and input • Therapy team: submit as many cases as possible • Continue best practice
Falls and Fragility Fractures Audit programme – National Audit of Inpatient Falls	• Findings have been reviewed by the Falls steering group and a work plan has been produced

2.3.5 Participation in Local Clinical Audits

The reports of 100 completed local clinical audits were reviewed by the Trust in 2017/18 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
Assessment of quality of care for patients with migraine in a general neurology clinic	• Raise awareness of issues below via presentation at consultant audit meeting • Copy patients into clinical correspondence unless inappropriate • Provide patients with further reading material or support information • Improve documentation regarding analgesia use, risk of medication overuse headache
To evaluate patient satisfaction with physiotherapist led botulinum toxin clinics	• Currently no referrals from the rehabilitation consultants:- Liaise with neurology operational manager about the on-going issues regarding the clinic codes and where activity is tracked to. • Feedback service evaluation to the rehabilitation consultants and discuss referral pathways • Continue to encourage all consultants who deliver botox to refer into the clinics • Continue liaising with consultants for appropriate patients • Continue attending guided injection clinic once a month to improve skills and techniques and therefore be able to take more patients
Monitoring and safety in prescription of corticosteroids – re-audit	• Ensure checklist easily accessible on Trust intranet • Send email to clinicians to remind them of the recommendations and location of checklist • Consider poster for clinic rooms

Service Evaluation on the use of Botulinum Toxin in acute patients with spasticity	• Early detection and injection of patients with spasticity / multi-disciplinary team spasticity ward round every 2 weeks • Unclear documentation of goals and outcomes / Pro-forma – for clear documentation in the notes for indication and outcome of botulinum toxin injections • To ensure that the action plan is happening / Prospective study of large number of patients with spasticity who require botulinum toxin injections
Review of inpatient falls on Complex Rehabilitation Unit and consider impact (if any) of single side rooms	• Present findings to staff via divisional governance and risk meetings, hub operational meetings and at Professional nursing forum • Share good practice findings with staff and identify gaps in practice relating to non-compliance with policy post falls actions • Discuss with Information team to request for falls since admission to be auto-populated
Meal time choices audit	• The development of picture menus • Development of textured menus • Speech and Language Therapy and Dietitians are producing new guidance on advice given for textured diets and dietary supplementation. • Feedback re: stock issues and feedback from audit
Outcome of enteral tube feeding during rehabilitation pathway	• Time taken to assess percutaneous endoscopic gastrostomy feeding tube removal – Data provided to senior members of the therapy team for ongoing discussion • Feedback of results to wider therapy team – arrange hub in service training
Retrospective evaluation of neurotrauma clinic	• Findings presented to the Society of British Neurological Surgeons, International Brain Injury Association conferences • Publication – manuscript under preparation
Audit of patients with multiple examinations – May 2017	• No action required
Audit of voice recognition software in radiology – May 2017	• Careful checking of wording within reports prior to verification, proof reading of reports, clear enunciation for optimal accuracy • Ensure correct placement of the microphone as this may cause certain words to be incorrectly recognised by the software • Agenda item to be added to Consultants meeting to discuss issues above and detailed in the Minutes
Nutrition and lifestyle factors amongst patients with a history of haemorrhage	• Provide dietetic advice to overweight / obese patients • Liaise with neurovascular specialist nurse regarding providing dietetic advice within group education sessions that are to be set up in near future for Allied Health Professionals to educate and support neurovascular patients
Audit of assessment of thrombectomy data as a	• Reliably capture patient journey, preferably electronically • Ensure clinical follow up with the vascular clinic

measure of outcome in ischaemic stroke intervention	• Arrangement of monthly multi-disciplinary team to discuss all the thrombectomy cases
To determine whether current Cz/Fz montage is as clinically effective as C1/C2 whilst performing a lower limb somatosensory evoked potential	• Sensitivity to be set at the same on both scalp montages – implement this as the basic settings on the somatosensory evoked potential protector machine • All clinical physiologists performing somatosensory evoked potential to review any responses present on C1-C2 – Data to be shown to all clinical physiologists performing somatosensory evoked potential • Discuss with Consultant Neurophysiologists as to whether they are happy to report on P37 data when recorded from C1-C2 – Meeting to be arranged between Clinical Physiologists, Consultant Neurophysiologists and head of department
Audit of exam time to report availability	• Delay in 14 day reporting is due to Consultant Radiologist understaffing – Appointment of 10th and 11th consultant radiologist when available • Repeat audit
Audit of standards of communication of radiology reports and fail safe notifications	• All office staff to follow directorate policy – office manager to email staff • All radiology consultants to use same communication method to inform office staff of need for transmission of urgent results – To be discussed at Radiology consultants meeting
Service evaluation of dietetic services within neurorehabilitation	• Gaps in current service highlighted – to be fed back to relevant people
Standardising Electroencephalogram investigations for non-epileptic attack: a national service evaluation	• Standard 1 - Information sent to the patient prior to their appointment requests they are accompanied by a witness / Consider amendment of information leaflets and appointment letters • Standard 2 - Video recording is initiated from the time of entry into the clinical room and continues until the patient departs / Clinical Physiologists informed • Audit of new recommendations / will be planned when new guidelines are formally published
Neuromuscular patient satisfaction questionnaire	• No actions necessary
Audit of patient satisfaction in Radiology part 1 – Computerised Tomography	• Car parking availability at busy times – Patients to be guided to other areas to park around the Trust
Audit of patient satisfaction in Radiology part 2 – Magnetic Resonance	• No actions necessary
Audit of non-medical referrers in Radiology under Ionising Radiation Medical Exposure Regulations guidelines – part 2	• 6 non-medical referrers had referred out of the agreed protocols – Clinical Director of Radiology has contacted referrers to address these issues
Management of non-aneurysmal subarachnoid haemorrhage (NASAH) at WCFT	• No actions necessary

Audit of investigations and management of out of hours spinal emergencies	• Circulate results within the neurosurgical consultant body
Audit of presence radiology reports in medical notes	• Office staff to be reminded to hand every patient a results information slip • On-going audit - 12 months
Audit of Consent to treatment within neuroradiology	• Lack of documentation in pre-op booklet regarding information given to patient / Disseminate audit findings to vascular nurses emphasising importance of documenting all information provided to the patient at pre-op assessment in the appropriate place within the pre-op booklet (information leaflets). The new electronic pre-op form now includes a drop down tick box listing all information booklets for each speciality
Quality of clinical physiologist Microvascular Decompression, Deep Brain Stimulator and Brainstem Auditory Evoked Potential intraoperative monitoring clinical reports	• Clinical physiologists to proof read reports • Clinical physiologists to check clinical report against clinical data recorded prior submission to theatre monitoring lead for approval • Results discussed with Neurophysiology services manager and clinical lead
Audit of double reporting in line with Royal College of radiologists guidelines	• Results disseminated to all radiologists • Learning points to be noted when there was disagreement of the wording used in the report
Enteral feeding and Glycaemic control	• Present key findings and recommendations to Intensive Care Unit operational group • Disseminate to all dieticians at Walton Centre NHS Foundation Trust
Re-audit of volume of prescribed feed given in the rehab setting following pump training for therapists	• Feedback to HUB operational group 26/10/2017 • Arrange to deliver to HUB in service training in the new year (no slots available for 2017) • Feedback to therapy manager via email by 20/10/2017
Management of drooling of saliva using botulinum toxin	• Present findings to tracheostomy Multi-disciplinary team and to rehab clinicians
Evaluation of inpatient electroencephalogram referrals for non-convulsive status epilepticus	• Discussion with referrer and consultant Neurophysiologist for all suspected Non-convulsive status epilepticus Electroencephalogram • Consideration of mandatory field triggered by selecting Non-convulsive status epilepticus on future digital request forms
Audit of patient satisfaction in radiology – part 3	• Ongoing audit • Radiology manager has spoken to estates – unable to increase parking • Radiology manager has requested signs to be upgraded
Audit to assess technique compliance with National Patient Safety Agency patient safety alert 2011/PSA002 reducing harm caused by misplaced Nasogastric tubes	• No actions necessary
Audit of standards of communication of the	• Office manager informed of results and need for office staff to follow procedure

radiological reports and fail safe notifications – re-audit	• Radiologists were instructed to all follow the agreed protocol as the audit identified a number of pathways being undertaken
Audit of radiology multiple examinations – re-audit	• Agreement by radiology consultants to proof read reports to ensure all areas are reported and to check all images have been reviewed including additional requests by radiologists • Radiologist responsible to report the absent element and re issue the report to the referrer
Does the sleep deprived Electroencephalogram improve diagnostic yield compared with routine Electroencephalogram	• No actions required • Continue as normal departmental protocol
Re-audit of outpatient Intravenous immunoglobulin in use	• Ideal body weight to be calculated in all patients with BMI > 30
Assessing the recognition of physiotherapy needs in Parkinson's disease patients seen in movement disorder clinics	• Whether gait abnormalities are identified to be specifically documented on review of patient & if present, referral to Physiotherapy to be made
Survey of use of deprivation of liberty safeguard act on neuro-rehabilitation – re-audit	• Capacity assessment not documented – Printed capacity assessment in front of notes • Deprivation of liberty safeguards document not easily accessible – Printed Deprivation of liberty safeguards document in front of notes • Difficult to find Deprivation of liberty safeguards document on Ep2 – To liaise with IT team so that we can have a separate tab for safeguarding or the Deprivation of liberty safeguards form can be easily searchable
Audit of use of blood results for contrast radiology examinations	• No actions necessary
Audit of non-medical referrers in radiology under IRMER guidelines – re-audit	• 2 Non-medical referrers had referred out of the agreed protocols – Clinical governance lead had contacted to advise
Audit of peripheral neuropathy (re-audit)	• Temperature probes in each room – Temperature probes in each room. Healthcare assistants to record temperature on referral when patient bought into clinic room
Review current service provision against guideline – Acquired brain injury, a guide for occupational therapists	• No actions necessary
Audit of standard of communication of radiological reports and fail safe notifications part 3	• All radiologists to follow the same agreed procedure for instructing office staff of urgent reports • Office staff to follow the agreed procedure • 3 urgent reports were sent immediately to referring clinicians
Audit of compliance in Radiology of World Health Organisation surgical safety checklists	• Reminder to all consultant radiologists to complete the team brief and World Health Organisation safety checklist forms • Staff information / reminder in the staff monthly clinical

	governance brief
Diagnosis and initial management of myasthenia gravis: adherence to clinical guidelines	• Identify a mechanism to ensure patients are booked within the requested timeframe • Improve prescription of bone protection • Improve documentation of decision not to admit when admission was not deemed necessary
Audit of the recording of Computerised tomography radiation doses and unsaved Computerised Tomography images	• 2.5% of recorded doses on radiology information system (RIS) did not match with the summary sheet on the picture archiving communication system (PACS) • 5% of exams had partially unsaved images / Reminder from Computerised Tomography lead for this to always take place
Venous Thromboembolism prophylaxis	• Venous Thromboembolism risk assessment should be part of admission clerking document – This will become part of Ep2 electronic medical clerking pro-forma • JAC (prescribing system) cannot prompt for Venous Thromboembolism prophylaxis but an indirect prompt for a dummy drug has been implemented • Checking Venous Thromboembolism risk status and prescription should become part of neurology morning rounds as ward pharmacist is usually present – this has been discussed at the consultants meeting and is currently taking place • Thrombo-Embolic Deterrent Stockings contraindicated in stroke and can cause potential complications in other neurological conditions like neuropathies and so should not be used instead of low molecular weight heparin in cases where low molecular weight heparin is not contraindicated – DVT policy amended to reflect this
First fit clinic utilisation patterns	• No actions necessary

Neurosurgery Clinical Audits & Service Evaluations

Audit title	**Actions**
Review of ORION (Referral) documentation for ? Cauda Equina Syndrome referrals	• Cases found to be documented and assessed as per Bass Guideline • Registrars to be informed of audit results and reminded of the importance of improved documentation. Email sent out to all relevant staff • Audit findings discussed with staff at morning Handover meeting
Review of Management of poor grade Subarachnoid Haemorrhage patients	• Improve screening and admission criteria for poor grade Subarachnoid Haemorrhage • Szklener's scale can be used • Better instructions to referring hospitals on how to manage this patient group to ensure the patient can be assessed later if they improve • It was agreed at the Mortality & Morbidity meeting that it was not possible to have a protocol in place and patients should be assessed on a case by case basis.
Post anaesthesia patient	• A new patient friendly leaflet has been devised to give to

satisfaction survey	all patients at pre-op assessment. It explains the process of having an anaesthetic and covers some common questions asked by patients. It provides information about how you may receive anaesthesia and pain relief for your operation. The information in the leaflet is adapted from the information provided by the Royal College of Anaesthetists • The leaflet has been approved by the Patient Information Panel and is available on the Trust intranet
Trigeminal Ganglion Balloon Micro-compression	• The audit highlighted missing data on long-term follow up as this is not a routine pathway. This information is now being collected prospectively by the Clinical Outcomes Team
HTA 5: Traceability Audit of Blocks / Slides in file v's Material Logged into Lab Information Management System October – December 2015	• Staff reminded of the importance of recording everything in Technidata Histology / Cytology and to use tracers for traceability purposes
HTA 22: Traceability Audit of Blocks / Slides in file v's Material Logged into Lab Information Management System Jan – March 2016	• Overall there was correlation between what is in the file and the Technidata Histology / Cytology record • No actions required
HTA 23: Traceability Audit of Blocks / Slides in file v's Material Logged into LIMS April – June 2016	• Overall there is a correlation between what is in file and the Technidata Histology / Cytology record • No actions required
HIST 228: Surgical Vertical Audit 2016	• Document HSH68 The completion of neuropathology specimen request forms was updated and distributed to Theatre User Groups
HIST 155: Diagnostic Correlation between Intra-Operative report and final report Diagnoses 2015	• No actions required
Impact of junior doctor industrial action on neurosurgery on call referral workload	• There was no significant difference in the referral quality or frequency encountered during junior doctor industrial action. • No actions required
Dexamethasone audit	• Algorithm developed and placed on all wards • Teaching sessions for staff commenced 21 April 2017 – on-going • Findings highlighted on the risk bulletin • Findings discussed with Ward Managers, Practice Educator, staff nurses and healthcare assistant during the ward meeting
BIO91: Biochemistry Vertical Audit	• All reagents updated on the database; staff have been informed via email of the importance of recording reagents on the database as well as the bottles. • The pipettes service have been altered to 6 monthly checks when no issues are identified at the 3 month check – Pipettes are checked by an external company annually • PAT testing has been carried out on all relevant

	equipment.
Sinonasal outcome post endoscopic endonasal pituitary surgery	Audit:- • Further data collection needed to allow meaningful subgroup analysis of different types of adenoma and assess which aspects of sinonasal health were affected by surgery • Sinonasal Outcome Test (SNOT) questionnaires to be given to all patients undergoing pituitary surgery at pre-op assessment, 3 months follow-up and 6 months follow-up. • Extension of SNOT follow-up to 12 months post-op • Additional assessment - use of University of Pennsylvania Smell Identification Test pre-operatively, at 3 months and 6 months post-surgery to assess the smell/taste disturbance reported by some patients
Compliance with NICE guidance NG18-diagnosis and management of diabetes in children and young people.	• Ensure patients with a blood glucose level which is diagnostic of diabetes in a patient under eighteen years old, should be discussed and referred to Alder Hey and transferred there urgently if it is a new diagnosis of type 1 diabetes with ketoacidosis, as the management of diabetic ketoacidosis in children is somewhat different from adults • Assess on case by case basis • Actions to be discussed further amongst surgeons and Colleagues at Alder Hey
Consent to Treatment 2016	• Audit findings disseminate to the relevant staff groups via email highlighting the main issues • A further patient satisfaction survey was undertaken and as a result of the findings a new patient friendly leaflet on anaesthesia has been devised and is given to patients at pre-op, it is also available on the intranet • The new electronic pre-op form now includes a drop down tick box listing all information booklets for each speciality
Timing of post op high grade glioma Magnetic Resonance Imaging scanning	• Continue current practice • Re-audit
Alert for High Dose Fentanyl Prescription	• All patients who have been commenced on high dose (≥50mcg/hr) fentanyl patches should be reviewed by a pain specialist to ascertain whether this is an appropriate and effective treatment – • The implementation of an electronic alert system at The Walton Centre allowed patients who were on high doses of fentanyl to be recognised and reviewed in the pain clinic. As a result, these patients could be weaned off of these potentially harmful doses. A longer follow up period is required to fully evaluate the long term outcomes for these patients. • Information for General Practitioners has been included on the opioid section in the Pain Mersey Guidelines • Improve communication between tertiary and primary care
Anti-GAD Clinical audit -	• The Neuroscience Laboratories are investigating the

IMMU/57	development of an in-house ELISA (Enzyme Linked Immunosorbent Assay) with a lower functional sensitivity than the kit for use in neurological patients • Collaboration with other centres needs to be undertaken to pool together a large enough cohort of patients for statistical analysis. Consideration given to what treatments may be more effective than others
Complications and Cost Effectiveness of Post-Craniectomy, Cranioplasty Implants	• Carrying out a comprehensive cost effectiveness with support of health economics experts - Set up a cost analysis research project • Improving our cranioplasty outcomes: ➢ improving our post craniectomy complication rate ➢ considering early timing for cranioplasty ➢ in depth analysis of titanium cranioplasty infections • Re-audit cranioplasty outcomes in view of increasing use of hydroxy apatite (HA) and poly-ether-ether ketone (PEEK) implants over the last 2 years • Set up registry with prospective outcome data - National plans in place for cranioplasty registry
Biochemistry vertical audit 2017 - Xanthochromia	• Standard operating procedure amended to describe the practice of running two quality control levels on alternate days • Service carried out on the Spectrophotometer
Follow-Up of Pineal Cysts	• Continue current practice
Cytology Vertical Audit 2017 - HIST / 244	• CY9 updated and put on the intranet, turnaround times and more thorough instructions for specimen transport included • Service of the cytospin completed • Competency evidence completed on the members of staff involved in this procedure • Discuss specimen disposal and implement a record of disposal. The disposal of empty specimen pots is not required as it is in the policy they are disposed of 6 weeks after reporting. Standard operating procedure HSB3 and HSCY1 updated to reflect current practises • The supplier details are logged in the supplies module in QPulse • Add 'Time' to the report • Measures have been put in to place to ensure the records for acceptance testing are complete, this is still being monitored. To be reviewed in future audit
Ventilator Acquired Pneumonia Bundles (VAP): Adherence	• Use tidal volume ventilation of more than 6ml/kg if required • For the; less than 6mls per kg of ideal body weight, element of the ventilator care bundle – it was agreed at network level that patients with raised Intracranial pressure being marked N/A • A new Lung protective Ventilation Guideline (Standard operating procedure) for nursing staff to use has been developed and is available on the Intranet - this has been agreed at Intensive Care Unit Operational Group • Documentation of bed elevation on Intensive Care Unit daily charts

Is re-operation of recurrent Glioblastoma worthwhile?	• Re-operation is worthwhile but only for a limited number of patients • No actions required
Peripheral cannula care plans	• Continue to challenge medics when care plans are not fully completed • Staff reminded of the importance of completing the care plan
Theatres Perioperative documentation audit	• Good compliance • Staff will continue to be challenged regarding incomplete documentation
Human Tissue Authority 52: Coroners and Hospital Post Mortem Audit 2016	• The audit showed that the laboratories complied with Human Tissue Authority rules and regulations and no non-conformances have been raised for this audit • No actions required
HIST 245: Forensic Post Mortem Horizontal Audit 2016	• No non compliances were raised against Neuropathology as a result of this audit. The lab has adhered to all instructions and protocols • No actions required
Pre-operative fasting times in elective and emergency neurosurgery patients.	• Re-cascade fasting information and education to ward staff and pre-op service nurses to reinforce policy guidelines • Re-audit specifically focussing on education around safety and appropriateness of having patients drink plenty of clear fluids at 6am and taking their regular pain medication and water up till 2 hrs pre general anaesthetic • More emergency patients to be included in the next audit cycle
Compliance of standards and guidelines for nasogastric tube checks	• Overall findings were good, compliance fell down on the following areas:- Documentation of: ➢ Checking Nasogastric tube prior to administration ➢ pH aspirations check • Staff education to be arranged • Re-audit
Cheshire and Mersey Critical Care Network (CMCN) Pharmacy Intervention Audit	Two ward rounds take place simultaneously on the critical care unit and only one of these is attended each day by a pharmacist The results of the audit suggest that participation of a pharmacist on the ward round improves medication optimisation and reduces prescription errors • Action – Discuss with Medical Director the possibility of increasing pharmacy staff on the critical care unit to enable a pharmacist to attend both ward rounds each day
IMMU/52 Immunology vertical audit 2017 – Anti-MAG	• Standard operating procedure updated • Paper reports amended to include sample type • Staff reminded of the importance of recording kit information
Audit of anaesthetic Record Keeping	Staff reminded of the following: • Meticulous documentation • 2016v of the Anaesthetic chart only to be used, Medical

	records informed to order this version only. Printer has had the old versions deleted from their records • Documentation of the responsible consultant
Spinal MDT Audit at The Walton Centre	• Allot time within Multidisciplinary team to discuss if outcomes from previous meetings have been actioned appropriately • Quarterly audits to take place to monitor that all complex cases are discussed at Multidisciplinary team
Ventilator care bundles including deep vein thrombosis (DVT) prophylaxis	• Exclude high Intracranial Pressure patients from strict low tidal volume ventilation • Remind staff to document in patient notes and/or drug chart • Re-audit annually • Excellent compliance – No other actions required
Sedation Practice in Horsley ITU (2017)	Raise awareness among staff through dissemination and presentation of audit results:- • The patient's weight must be recorded in the notes. If actual body weight cannot be obtained an estimated weight should be established. Weight should be re-considered at least on a weekly basis • Continue the appropriate usage of propofol, alfentanil, atracurium and clonidine • Bolus doses given on top of the infusion should be clearly recorded • Highlight propofol use and monitoring for PRIS • Triglyceride (TG) and creatine kinase (CK) to be measured every day patient is on propofol • Ensure clear documentation of drug concentrations, particularly for intravenous midazolam as multiple preparations are currently in use on the unit • Document Richmond Agitated Sedation Scale (RASS) score and consultant reviews
Compliance with screening policy for level checking in theatre to avoid wrong level spinal surgery	• All patients complied with the minimum screening requirements and had either back marking or an intra-operative X-ray • No actions required • This audit will become an annual routine audit, and audited more frequently should policies be changed
HIST 261 Specimen Acceptance Policy Audit 2017	• The specimen pots have all been correctly labelled • When the new IT system Order Communications (COMMS) are initiated location will become a mandatory field
Surgical Vertical Audit 2017	• Standard operating procedure WRTBS2 has been reviewed and updated • Staff have been reminded to enter reagents onto database. This has been monitored for 3 months and no further issues have arisen
Quality of transfers into the Walton Centre ICU	• Document what advice has been given to the referring hospital • On-going review of all transfers in to ensure routine pick up of all substandard transfers • Ensure present guidance available to all trusts, when

	new version is published ensure all trusts are aware of it
Human Tissue Authority 53 Traceability Audit 2017	• Remind staff to use tracer slides in the slides file
Human Tissue Authority 51 Research Forms Horizontal Audit 2016	• Remind Specialist nurse and theatre staff of the consenting process and to use the white proforma
Timing Of IGF-1 Results Following Pituitary Function Tests	• Continue to maintain the excellent turnover times for this investigation • Continue to monitor the turnover times for this investigation, as this has suffered intermittent delays previously
Efficacy of the Epidural Blood Patch for the Treatment of Low Pressure Headache	• Develop a standardised recording template for: ➢ headache description ➢ diagnostic Lumbar Puncture with precisely documented level of injection, patient position, needle size and type and measured Cerebral Spinal Fluid pressure • Ensure more careful recording of targeted levels, given blood volume and immediate response on a patient discharge letter
Evaluation of discharge prescription process pre- and post- implementation of pharmacist independent prescribers	• Audit highlighted that there is an insufficient number of pharmacist independent prescribers to contribute and support all ward rounds. Audit findings have been disseminated to divisional leads for consideration of business case for additional staffing
Pilocytic Astrocytoma Recurrence	• Five year follow if a complete resection is performed • Maximal resection at presentation including 2nd look surgery is to be recommended

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	• Raise awareness of the need to establish, review and respect patient preferences regarding sharing information • Ensure nursing staff are aware of the requirement to document in Ep2, following the inclusion to the system to document discussion with the patient regarding their preferences for sharing information • Future audit following the sharing information section being added to Ep2
Inpatient Health Records Documentation Audit	• Disseminate results and highlight problem areas to focus improvements to be made • Include in risk bulletin • Clinical audit team continue quarterly audit
Outpatient Health Records Documentation Audit	• Feedback results to Health Records Group and Information Governance and Security Forum • 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 quarterly
Documentation of patient alerts within medical records	• Develop a robust process to ensure all patient alerts are recorded appropriately within the patient record and

	Clinical systems
Mental Capacity Act Audit 2017	• Review the current training via the Trust Safeguarding training needs analysis for Mental Capacity Act and make changes as appropriate • Provide more resources about Mental Capacity Act to the Trust Intranet Safeguarding pages and ensure staff are aware of available resources on Mental Capacity Act via Walton weekly and team brief • To develop and deliver a Mental Capacity Act Champions Study day which is available to multidisciplinary team • Share our audit results and recommendations at Regional Mental Capacity Act forum to share good practice • Re – audit in 12 months to evaluate changes in practice in relation to mental capacity and make changes to survey format

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 Risk & Governance 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 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 1039. The Trust continues to recruit patients and relatives to the Genome Medicine Centre in Liverpool; this is part of the Government's flagship 100,000 Genome project.

In total there are currently 85 clinical studies on-going at The Walton Centre and the Trust has confirmed its capability and capacity to deliver 27 new clinical research studies during 2017/18 in Neurology, Neurosurgery and Pain.

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.

In addition, the Trust was successful in its application to the Innovation Accelerator Adoption Programme to support the adoption of Trust led projects.

During 2017/18 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)
- Local Universities
- Other NHS trusts and NHS organisations
- Pharmaceutical companies (industry)

2.3.7 CQUIN Framework

Commissioning for Quality and Innovation (CQUIN) was introduced in 2009. A proportion of The Walton Centre's income in 2017/18 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 2017/18 and for the following 12 month period are available electronically at enquiries@thewaltoncentre.nhs.uk

A proportion of the Trust's income in 2017/18 was conditional upon achieving quality improvement and innovation goals. The total payment received against the CQUINS in 2017/18 equalled £1,606,647. The total payment received in 2016/17 was £1,285,443.

For the first time CQUIN schemes were for two years with the following goals agreed for both 2017/18 and 2018/19.

- Clinical Utilisation Review
- Critical Care Timely Discharge (4 hr Target)
- Spinal Networks
- Medicines Optimisation
- Digital Maturity
- Health and Wellbeing
- Advice and Guidance
- E-Referrals

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 has not taken enforcement action against The Walton Centre during 2017/18. The Walton Centre has not participated in any special reviews or investigations by the CQC during the reporting period. During the year 2017/18 the Trust has developed a process of self-assessments 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 escalation exceptions to the Quality Committee.

	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL-LED	OVERALL
Medical Care	GOOD	GOOD	OUTSTANDING	GOOD	GOOD	GOOD
Surgery	GOOD	GOOD	GOOD	GOOD	GOOD	GOOD
Critical Care	GOOD	OUTSTANDING	GOOD	GOOD	GOOD	GOOD
Outpatients	GOOD	Not Rated	OUTSTANDING	GOOD	GOOD	GOOD
Specialist Rehabilitation	GOOD	OUTSTANDING	GOOD	OUTSTANDING	GOOD	OUTSTANDING
OVERALL	GOOD	OUTSTANDING	OUTSTANDING	GOOD	GOOD	**OUTSTANDING**

2.3.9 Trust Data Quality

The Walton Centre submitted records during 2017/18 to the Secondary Uses Service (SUS) for inclusion in the Hospital Episode Statistics which are included in the latest published data.

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

99.7% for admitted patient care

99.9% for outpatient care

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

100% for outpatient care

100% for admitted patient care

Note: These results are in relation to the latest available information at the time of publication and relate to the period April 17 to January 18 (SUS data quality dashboard).

The Walton Centre's Information Governance Assessment report overall score for 2017/18 was 85% and was graded green in accordance with the Information Governance Toolkit Grading Scheme.

Once again the Trust has made significant progress for 2017/18, with the Trust achieving level 2 for 20 requirements and level 3 for the remaining 25 requirements.

The Trust has implemented additional action plans to make further improvements on this year's score and to further evidence the Trust's commitment to the Information Governance (IG) agenda. A review of the evidence and self-assessment scores undertaken by internal audit as part of the mandated 2017-18 IG audit requirements has provided the Trust with a level of significant assurance for the eighth year in succession.

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 Payment by Results clinical coding audit during the reporting period. The following table reflects the results of an audit carried out by an accredited internal coder and the error rates reported for this period for diagnoses and treatment coding (clinical coding) were as follows:

The Walton Centre Internal Clinical Coding Audit 2017/18

Coding Field	Percentage
Primary diagnosis	99%
Secondary diagnosis	98%
Primary procedure	100%
Secondary procedure	100%

The above results should not be extrapolated further than the actual sample audited. The sample covered 200 sets of clinical records which were randomly selected from across the whole range of activity and meet the level three standards as defined in the Information Governance Toolkit.

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.

2.3.11.1 During 2017/18 84 of The Walton Centre patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

25 in the first quarter

21 in the second quarter

20 in the third quarter

18 in the fourth quarter

By 31st March 2018 84 case record reviews and 3 investigations have been carried out in relation to 84 of the deaths included in item 2.3.11.1

In 1 case 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
- 1 in the third quarter
- 2 in the fourth quarter

2.3.11.2 1 representing 1.2% 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
- 1 representing 5.6% for the fourth quarter

These numbers have been estimated using the structured judgement review (SJR) 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 SJR methodology for the mortality review, but also in cases where there are potential issues highlighted a root cause analysis (RCA) is undertaken.

One case was identified where the death was judged to be more likely than not to have been due to problems in the care provided to the patient. This was a patient who died from subarachnoid haemorrhage due to an intracranial aneurysm. There were no issues with the in-hospital care but there had been a delay in treating the aneurysm. This had therefore not taken place when the patient presented with an acute haemorrhage. A full RCA has taken place, and the case has been heard at a Coroner's inquest.

The following lessons have been learnt from the review into this case:

1) There was a missed opportunity to treat the patient when they were admitted for an elective procedure to treat the aneurysm but the correct medication was not administered the night before and so the procedure was cancelled. It was then cancelled on subsequent days due to emergency cases.
2) There were then delays in reviewing the patient in clinic, and listing for a repeat procedure and so the fatal haemorrhage occurred before treatment could take place.

As a result of this case WCFT have taken immediate measures to ensure that no other vascular patients at high risk are awaiting appointments and that all appropriate clinical actions have taken place. There is an ongoing review of the vascular service to include a full capacity and demand review and redesign of patient pathways and processes. There has also been a standard operating procedure implemented for the medication required prior to elective interventional neuroradiology procedures.

A standard operating procedure for the medication required prior to elective interventional neuroradiology procedures has been implemented. This has been circulated to all wards and as a result the requirements for such procedures are much clearer. Prior to this there was no specific guidance available for these procedures and as a result there was the potential for confusion with the guidance for open neurosurgical procedures. There have been no further incidents of omitted medication for such cases.

Immediately following this case all Consultants involved in the service worked with the management team to identify any patients who were on the waiting list to be seen as a follow up or were awaiting a management decision. All patients identified during this process as being urgent, were seen promptly and appropriate clinical action taken.

A full review of the vascular service has now started but is not yet complete. This will include a full capacity and demand analysis, restructure of the clinics and redesign of the patient pathways. This is due to be complete within 3 months.

0 case record reviews and 1 investigation completed after 31.03.18 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.

1 representing 1.2% of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.3.11 Implementing Clinical Standards for Seven Day Hospital Services

The Walton Centre is committed to providing excellent care to our patients at all times. There are robust clinical systems in place to ensure that excellent care is provided out of hours and at weekends as well as weekdays.

The Trust has a high level of Consultant input out of hours and at weekends. The Trust has recently approved an enhanced neurosurgery Consultant on-call arrangement which recognises the need to have on-site Consultant presence at weekends. There are fundamental issues with the application of the 7 day services clinical standards to specialist Trusts, however WCFT agrees with the principle of Consultant input acutely and are making good progress with compliance with this. We demonstrated a considerable improvement in compliance with clinical standard 2 (% of patients assessed by a Consultant within 14 hours of admission) in the last survey in September 2017, with an overall rate of 79%.

Part 3 Trust Overview of Quality 2017/18

This section of the Quality Account presents an overview of performance in areas not selected as priorities for 2017/18.

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	2015/16	2016/17	2017/18
CDiff	9	9	7
MRSA Bacteraemia	1	1	1
Ecoli	14	12	11
Minor and Moderate Falls	30	36	35
Never Events	0	3	2

Clinical Effectiveness Indicators

Mortality – Procedure	2015/16	2016/17	2017/18
Tumour	13	8	8
Vascular	39	47	37
Cranial Trauma	26	21	21
Spinal	6	3	4

Patient Experience Indicators

Patient Experience Questions	2015/16	2016/17	2017/18
Were you involved as much as you wanted to be in decisions about your care and treatment?	93%	99%	91%
Overall did you feel you were you treated with respect and dignity while you were in the hospital?	98%	100%	98%
Were you given enough privacy when discussing your condition or treatment?	93%	97%	93%
Did you find someone on the hospital staff to talk to about your worries and fears?	94%	100%	84%

3.1 Complaints

3.1.1 Patient Experience and Complaints Handling

The Patient Experience Team provides help, advice and support 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 Experience Team are responsible for supporting the patients and their families in managing the complaint. We pride ourselves in working with patients, families and staff 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.

Our positive approach to managing and resolving complaints was recognised by Rob Behrens, Parliamentary and Health Service Ombudsman when he visited The Walton Centre in June 2017. We were the first NHS organisation Mr Behrens visited after coming into post. He commented *"The Walton Centre's strong commitment to patient experience was particularly evident; the senior leadership, the complaints teams and frontline staff I spoke to were committed to continuous improvement and saw responding to patient feedback and complaints as central to this. The Trust had also focused on staff health and wellbeing as they saw a link between mistakes and staff feeling stressed and unable to cope."*

3.1.2 Trend Analysis and Lessons Learnt

Every complaint is investigated and each complainant receives a detailed response from the Chief Executive. We ensure those responses are open and transparent and provide assurance that where mistakes have been made, those are rectified and lessons learned. Outcomes from complaints are reported monthly to various committees and meetings within the Trust and to the Executive Team. Any trends are reported to the Patient Experience Group, the Board and Council of Governors. Trends and actions taken are also discussed in detail in the Governance and Risk Quarterly report, the monthly divisional governance and risk group meetings and Quality Committee.

Examples of lessons learned from complaints during 2017/18 include revision to the rapid discharge pathway, improvements to the patient administration system, improvement to the radiology reporting process and personal reflection for teams and individual staff members.

3.1.3 Complaints Activity

We use feedback from people who have used the complaints process to help us improve our responsiveness and service. Following the restructure of the Patient Experience team in 2016/17, we reviewed our processes, so that we were more accessible to patients and families. We have developed a person centred approach so that complainants are kept involved and updated at each stage of the investigation, with regular contact from members of the Patient Experience Team.

Complaints received 01 April 2017 – 31 March 2018

	Quarter 1 April–June 17	**Quarter 2** July–Sept 17	**Quarter 3** Oct– Dec 17	**Quarter 4** Jan–Mar 18
Number of complaints received	27	34	41	29

The Trust received 131 complaints during 2017/18 which was slightly less than the 138 complaints received during 2016/17.

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 make contact with the patient or family member once a complaint is received to agree the best way of addressing their concerns. This individualised approach has led to many patients or family members wishing to resolve their concerns informally rather than pursuing the formal complaints procedure. In addition to resolving complaints, where improvements can be made that are irrelevant to the complaint but noted in the investigation, these too are taken forward.

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 daily 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 receives 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 2018/19.

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 and Patient Safety strategy which sets out key priorities and the principles that the Trust will continue to develop and apply to current and future planned services

The Quality and Patient Safety strategy is underpinned by the Trust's work internally to further improve patient safety and quality, and learning from national work such as the Francis Report and Berwick Review. The strategy is built on 5 foundations:

1: Leadership at all levels
2: Culture of continuous learning
3: Patient engagement
4: Build capacity and skills
5: Measurement to predict

The strategy is brought to life and kept a live document with interactive Quality Berwick sessions open to all staff. Different elements of its 5 foundations are discussed, building on our leadership at all levels and culture of continuous learning. Significant progress has been made, meeting several elements ahead of schedule including all the Sign up to Safety pledges and completion of the AQUA Advanced Board Quality and Safety action plan.

Following our Investors In People inspection in 2017 the Trust has been reaccredited with the Gold standard. It is a prestigious award that demonstrates the Trust's commitment to every member of the workforce and its drive to continually improve.

The assessor of the inspection stated how impressed he was with how committed Trust staff are to delivering high quality care to all of our patients and that he could see how our staff showcase the Walton Way values in everything they do. He said that he could see that our staff have a sense of pride in working at our hospital and 'a desire to be the best'. This fantastic achievement reflects the hard work of teams across the organisation and the supportive friendly culture that they have created together. Not only does this make The Walton Centre a great place to work but it also contributes to making a fantastic and caring environment for our patients to be treated in.

Berwick Sessions

The Berwick sessions have been popular with staff providing an opportunity to come together in an open and transparent forum with executives, non-executives and staff of all disciplines, both clinical and non-clinical to focus on quality, patient safety and staff experience together. The sessions look at what we do well, where we can improve, listening and learning from each other. Examples of feedback from the session include;

- '*Good to meet people and feel our opinions can be heard '*
- *'Lots of genuine discussion'*
- *'Enjoyed the inter activeness and sharing opinions/ideas '*
- *'Good to meet higher members of staff and not feel as daunting when approaching them with issues '*

3.4 Vanguard – The Neuro Network

The Neuro Network Vanguard is a partnership of organisations led by The Walton Centre to improve services for patients with long term neurology conditions and spinal problems. It has been operational for two years supported by national funding which came to an end in March 2018. The Vanguard work is a collaboration between The Walton Centre, NHS England, Commissioning groups, voluntary organisations and provider hospitals to deliver outstanding, effective, efficient and replicable neurology and spinal services.

All of the nine projects are established, with positive results demonstrated, relating to patient experience, overall efficiencies and clinical outcomes.

While the Neuro Network Vanguard has concentrated its work within the Trusts' existing catchment area, learning has been shared with services outside the catchment area as per the funding stipulations from the New Care Models Team.

As part of the evaluation process we are gathering feedback and stories from our patients, their families and carers. They have informed us about the great effect components of the Neuro Network Vanguard are having on their care and quality of life. One patient told us how it gave him a new life line as he no longer felt isolated and unable to access help when needed.

Under the Vanguard Programme the piloting of Telemedicine has been possible. Teleneurology enables clinical consultations to take place remotely using secure video technology.

This pilot service aims to enhance the support currently provided by the Walton Centre to our partner organisations by providing greater access and improved response time to specialist Neurological advice.

Remote consultations have been undertaken between The Walton Centre and The Countess of Chester Hospital and Southport District General Hospital. Positive feedback has been received from the patient and clinicians involved, although utilisation of the service has been lower than anticipated. Teleneurology is now being evaluated as part of the Vanguard Programme to inform its future development plan.

3.5 Social Media (Instagram)

On July 5th 2017 The Walton Centre created an Instagram account. Instagram is a social media platform that is photograph and video led, encouraging sharing and liking content. The aim was and is to engage with patients and visitors and potentially give them another channel in which they can interact with The Walton Centre. The account is progressing well with some posts being shared about staff achievements and championing the hospital's charity fundraisers. Staff and fundraisers have been interacting positively with the content and to date the account has 459 followers, which is increasing daily.

3.6 Sky View

The Sky View Ceiling System was installed in June 2017 as part of the Trusts initiative in preventing/ minimising delirium within the Intensive Care Unit.

Delirium in patients who are in intensive care is a well described phenomenon, the incidence of which varies from 50% in the low dependency patient to 80% in mechanically ventilated patients.

This system has been shown to improve sleep patterns thereby reducing delirium as well as stress and anxiety levels. As a result the patient experience and outcomes improve by restoring normal sleep patterns.

3.7 Patient Advice Line

Following engagement with patients and families the nurse advice line was reintroduced enabling improved access, advice and guidance on their medical condition. Feedback regarding the patient advice line has been positive. One patient who has recently been diagnosed with Motor Neurone's Disease said the advice was invaluable, providing peace of mind and reassurance at times when he needed support.

He said: *"Useful? It is out of this world. You speak to Karen (specialist nurse) and it's like I've always known her, she offers immediate support and encouragement. Just as soon as you ring her up and she speaks – the panic just goes out of you."*

He also spoke of the co-ordinating role the specialist nurses have between the GP, Consultant Neurologist and other health care professionals such as the occupational therapists.

3.8 Volunteers

Following the introduction of the Volunteer Coordinator role in 2016, the volunteer service has continued to grow at the Trust. There are currently 70 volunteers contributing to almost 750 hours per month on average. Volunteers have been providing a valuable service in roles relating to research, meet and greet, trolley service, befriending, infection prevention and control, administrative duties and assisting the Pain Management Programme.

There is extensive support for volunteers and close monitoring of volunteer activity. This was reflected in the Mersey Internal Audit Agency (MIAA) audit of the volunteer service conducted during 2017/18. MIAA audited the processes in line with national guidelines and established practice and rated the Trust's volunteer service as 'Significant Assurance'.

3.9 Theatre Scanner iMRI

The Walton Centre is the first hospital in the North West to use an in-theatre intra-operative MRI scanner (iMRI) for adult patients.

The iMRI system, which has been operational since May this year, allows surgeons to visualise more easily the extent and position of the tumour to ensure that as much of the tumour as possible is safely removed during the operation. This has made a difference to complicated cases by either making the surgery more in-depth, or allows patients to avoid a second anaesthetic and surgical procedure by allowing further surgery to be done immediately during the same operation.

3.10 Helipad

A new £1m helicopter landing pad was opened in July 2017 at Aintree University Hospital, part of the regional major trauma centre along with The Walton Centre. The regional trauma centre receives patients from across Cheshire and Merseyside who need urgent specialist care which isn't necessarily available in their local hospital. This will save vital minutes when transferring trauma and other time critical patients to hospital which ultimately improves chances of survival and reduces the risk of long-term injury. Until this new development, air ambulances had to land on the playing fields on Lower Lane, after which a road ambulance was sent to transfer patients to Aintree's Urgent Care and Trauma Centre. This could add up to half an hour to the journey but with the new helipad it will take just a few minutes.

3.11 Health and Work Champion

The Royal College of Occupational Therapists and Public Health England (PHE) supported by the Council for Work and Health are carrying out a project in which Occupational Therapists have been recruited and trained to become Health and Work Champions. They are using peer to peer education training sessions to encourage their NHS colleagues to routinely ask working age adults about their employment aspirations.

There is a strong evidence base showing that work is generally good for health and well-being. Being unable to work is linked with reduced health and well-being outcomes. Health care professionals are instrumental in giving patients the skills, belief, ability and confidence to make the adaptations needed to remain in work or return to work. This is reflected within the clinical experience of working with people whose ability to maintain their work role is compromised and the negative impact this has on social support and routine, self-esteem, identity and quality of life.

The Trust has appointed a Health and Work Champion Lead who is one of 40 across England who has delivered sessions to various staff Trust wide.

3.12 Launch Bio Bank

The Walton cerebro spinal fluid Research Biobank has been established to promote multidisciplinary basic and translational neurology research. The purpose of the Biobank is to collect and store samples and relevant clinical information for current and future neurological research projects. The Biobank received full approval of the Wales REC4 National Research Ethics Service.

Clinicians within the North West collaboration actively engage in neurology research to aid diagnosis and predict prognosis in neurological conditions and to gain an increased understanding of the basic biology of these diseases. We have also generated interest from local and national researchers and are expected to start new projects resulting in research collaborations with our clinicians and scientists.

3.13 National Guardian

The Trust welcomed the National Guardian for the NHS, Dr Henrietta Hughes, in September 2017. Dr Hughes met with the Trust's Freedom to Speak up Guardian to learn more about our 'speaking up' culture and procedures. Dr Hughes said: *"It was an absolute delight to meet Julie and staff who had spoken up to Julie, and to meet senior leaders and see how they maintain a transparent culture. I was struck by the passion and enthusiasm for the highest quality of compassionate patient care from everyone I spoke to. However, I think my abiding impression was that excellent practice was perceived as normal and that makes The Walton Centre truly special."*

3.14 Robotic Arm

In August 2017 The Walton Centre took delivery of a new Renishaw Neuromate Robotic Arm, which had been a full rebuild/ upgrade of an existing frame that was redundant within the Trust. The choice to utilise an existing piece of equipment rather than procure a brand new device resulted in a significantly improved purchase price, without any impact on quality. The purchase was supported by a private donor appeal and also a charitable donation from the Oakgrove Foundation Trust paid directly to the supplier, which further reduced the Trust purchase price. The robotic system allows for greater precision in minimally invasive surgery compared to more traditional methods and is complementary to the Trust's development of iMRI, which will be used in resections of tumour or in excision of an epilepsy lesion located using stereo electroencephalogram (EEG). At the time of purchase this was one of only 6 Renishaw Neuromate Robotic Arms in the country.

3.15 Overview of Performance in 2017/18 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	2016/17 Performance	2017/18 Target	2017/18 Performance
Incidence of MRSA	1	0	1
Screening all in-patients for MRSA	97%	95%	95.26%
Incidence of Clostridium difficile	9	10	7
All Cancers : Maximum wait time of 31 days for second or subsequent treatment: surgery	96.43%	94%	100%
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	100%	96%	100%
All Cancers : 2 week wait from referral date to date first seen	99.66%	93%	99.62%
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	96.44%	92%	95%
Maximum 6 week wait for diagnostic procedures	0.39%	<1%	0.06%
Certification against compliance with requirements regarding access to health are for people with a learning disability	Fully Compliant		Fully Compliant

3.16 Overview of Performance in 2017/18 against NHS Outcomes Framework Domain

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 2017/18, the Walton Centre provided and/or sub-contracted four relevant health services. These were neurology, neurosurgery, pain management and rehabilitation.

3.17 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):**
   Domain 1: Preventing people from dying prematurely and 2. Enhancing quality of life for people with long term conditions

   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**
   Domain 1: Preventing people from dying prematurely and 2. Enhancing quality of life for people with long term conditions

   NOT APPLICABLE

Rationale: The Trust does not provide mental health services

3. **Category A Ambulance response times:**
   Domain 1: Preventing people from dying prematurely

   NOT APPLICABLE

Rationale: The Trust is not an ambulance trust

4. **Ambulance Trust Clinical Outcomes:** that includes myocardial infarction and stroke
   Domain 1: Preventing people from dying prematurely & Domain 3: Helping people to recover from episodes of ill health or following injury

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**

   Domain 2: Enhancing quality of life for people with long term conditions

   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**

   Domain 3: Helping people to recover from episodes of ill health or following injury

   NOT APPLICABLE

Rationale: The Trust is a neurological trust and does not perform these procedures.

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

   Domain 3: Helping people to recover from episodes of ill health or following injury

   APPLICABLE

Response:

	No. of readmissions	% of Inpatient Discharges Readmitted
2016/17	233	4.3%
2017/18	251	4.6%
Change	18	0.3%

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.

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:

Domain 4: Ensuring that people have a positive experience of care

APPLICABLE

Response:

* The results of the 2017 National Inpatient Survey are expected to be released in May/June 2018.

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

* The results of the 2017 National Inpatient Survey are expected to be released in May/June 2018.

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

*At the time of publication, the results of the 2017 National Inpatient Survey were embargoed and are expected to be released in May/June 2018.

National Inpatient Survey Question	2013 Result	2014 Result	2015 Result	2016 Result	2017* Result
1. Were you involved as much as you wanted to be in decisions about your care?	7.9	8.3	8.3	8.0	TBC
2. Did you find a member of hospital staff to talk to about your worries or fears?	6.3	7.0	6.9	7.0	TBC
3. Were you given enough privacy when discussing your condition or treatment?	9.0	8.9	8.8	9.1	TBC
4. Did a member of staff tell you about the medication side effects to watch for? (following discharge)	5.1	5.8	5.6	5.6	TBC
5. Did hospital staff tell you who to contact if you were worried about your condition? (following discharge)	8.7	8.7	8.9	8.5	TBC

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

Friends and Family Test results for 2017/18 based on the question "How likely are you to recommend our service to friends and family if they needed similar care or treatment?"

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
99.0%	98.4%	99.0%	97.5%	95.9%	97.8%	98.0%	98.1%	97.4%	97.3%	97.7%	96.8%

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

Domain 4: Ensuring that people have a positive experience of care

APPLICABLE

Response:

The Trust had a response rate of 42% for the 2017 national staff survey, which is below average for acute specialist trusts in England (53%) and compares with a Trust response rate of 47% in the 2016 survey. Within the survey, the percentage of staff who would recommend the Trust as a place to work remained similar to 2016 at 78% and the percentage of staff who would recommend the Trust as a place to receive treatment" increased to 92% from 91% in 2016.

Out of the 32 key findings within the 2017 survey, the Trust had the best score for acute specialist trusts in England in 2 findings. In 25 of the findings the Trust was either better or the same as the national average and in 7 of the key findings the Trust's score was worse than the national average, though in 3 out of these 7, the Trust had improved their score from the 2016 survey.

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

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, the Friends and Family Test was issued to 400 staff using an online survey and 141 surveys were 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 82% 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, the Friends and Family Test was issued to a further 400 staff with 126 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 80% 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 results had 123 returned, 100% 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

The Trust also receives feedback about other areas in the survey and identified actions with regards to:

KF19 : Organisation and management interest in and action on health and wellbeing;

The Trust score for 2017 was 3.98 with the national average being 3.73; the Trust had the best score for an acute specialist trust.

KF27: Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse

The Trust score was 52% with the average score for acute specialist trusts being 47%. The trust had a score of 53% last year.

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 staff in the last 12 months: The lower the score the better.

The Trust score was 20% the average score for acute specialist trusts being 23%. This was the same score as 2016.

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 88% the same score as the national average for acute specialist trusts. This is a slight increase from last year’s score of 87%.

The Walton Centre has taken the following actions to improve this rate and so the quality of

its services, by:

- 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 following year.

- An action plan has been approved by Board and feedback will also take place to advise staff what action the Trust has taken in response to their comments.
- Although it is important to recognise that the majority of the findings were predominately positive in nature, the Trust action plan will also focus on any areas where the findings were slightly less positive.

10. Patient Experience of Community Mental Health Services

Domain 2: Enhancing the quality of life for people with long term conditions and

4. Ensuring people have a positive experience of care

NOT APPLICABLE

Rationale: The Trust does not provide mental health services

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

Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

APPLICABLE

Response: * To be updated once National data published anticipated 1st June 2018.

Year		Q1	Q2	Q3	Q4
2015/16	Walton Centre	97.6%	99.2%	98.5%	98.65%
	National Average	96.0%	95.9%	95.5%	95.5%
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%	TBC*

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.

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

(Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm)

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
20.4	15.6	21.0	21.6	15.7	14.5	7

The Cheshire & Merseyside figures (acute trusts) for 2017/18 are expected to be published on 6th July 2018.

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

In 2017/18 The Walton Centre had a total of 7 C. difficile infections against the trajectory by NHSE of 9. 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:

- Implementation of the Infection, Prevention and Control Work Plan
- Monthly environmental monitoring and infection control audits (hand hygiene and saving lives audits)
- Monitoring and reporting audits to the Quality Committee
- The Infection Prevention and Control Team/Ward Managers/Matrons will undertake environmental checklists on a weekly basis
- The cleanliness of isolation rooms which are used for the management of infected patients will be monitored by the nurse in charge on a shift by shift basis

- Cleaning schedules are regularly reviewed and frequency increased as required as our schedules meet the national standards
- Antibiotic usage will continue to be monitored via the antibiotic ward rounds
- The annual update for medical staff will include both antibiotic usage and promoting antibiotic stewardship

The Trust will continue to improve the quality of its service and aims to reduce C. difficile, which includes supporting our vision to work towards achieving zero tolerance in relation to avoidable infections and to ensure that all of our service users within the Trust are not harmed by a preventable infection.

To support this work a quality improvement C. difficile panel has been established with our key Commissioner where cases are discussed to identify any lapse in care.

12. Rate of patient safety incidents and percentage resulting in severe harm or death

(Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm)

APPLICABLE

Response:

In 2017/18, 1144 incidents occurred against 15245 admissions (excluding OPD as per NLRS figures) this equals 7.31 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.
- Share lessons learnt via the Governance safety bulletin.
- Improve the reporting of incidents through discussions at the Trust safety huddle.

Annex 1

The Walton Centre Quality Account Commentary

Healthwatch Liverpool welcomes the opportunity to comment on the 2017-18 Quality Account for The Walton Centre NHS Foundation Trust.

This commentary is informed by our ongoing engagement with the Trust and its patients, the feedback received through our information and signposting service and independent web-based resources (such as www.careopinion .org.uk), as well as the draft Quality Account that was made available to us prior its publication.

Healthwatch Liverpool held a listening event at The Walton Centre on 07/12/2017 where we spoke to 38 patients. Overall, the feedback was very positive with 2/3 giving the Trust a 5 star rating. In fact, almost all patients said they received enough information from the Trust regarding appointments or their condition which indicates on the whole they felt communication was good. The patients' main concerns were around staffing levels, yet patients seemed understanding of the situation and felt the staff were doing their best under the circumstances. It did not seem to affect their care, and most felt they were respected and treated with dignity. There were however some individual concerns such as letters going out late and lack of communication around appointments, as well as communication problems between a consultant and staff with regards to a patient's pain management.

It is encouraging to see that there has been a reduction of staff turnover which will hopefully be maintained through the welcomed priorities to invest in improving staff health and wellbeing and training to support staff dealing with patients with challenging behaviour, which will benefit both staff and patients.

It was especially heartening to see the great feedback from patients and volunteers regarding the Neuro Buddy scheme which evidences the Trust's dedication to the health and emotional wellbeing of their patients. Other examples of this are the Sky View ceiling system and the in-theatre intra-operative MRI scanner (iMRI) which Healthwatch Liverpool finds particularly impressive as it showcases the Trust's willingness to invest in innovative and modern facilities and equipment to enhance their patients' care, treatment and wellbeing. Healthwatch Liverpool would like to commend the Trust for the implementation of Mouth Care Matters as we feels this again shows their commitment to patient care in areas that may sometimes be overlooked.

Health watch Liverpool look forward to the further development of the Trust's Teleneurology, as although we do not have any patient feedback yet on how effective this is (although the Trust has had positive feedback from their own consultations), it is exciting to see that this is being piloted as it makes their services more accessible to those that may struggle to access the Walton Centre due to the nature of their conditions.

In the future, it would be beneficial to see some reflection in the quality account of the equality and diversity issues the Trust are trying to address through work they do with charities in the community. It would also be helpful to know whether they are monitoring their patient population and measuring whether their patients feel they are getting equal care.

Overall, the Trust is clearly striving to continually improve their high quality expert services which we hope they maintain as they have consistently done so in the past. This is reflected in their impressive Care Quality Commission rating of 'Outstanding'. Healthwatch Liverpool looks forward to further engagement activities with the Trust and its patients in the coming year.

The Walton Centre NHS Foundation Trust

Quality Account 2017 – 2018

Healthwatch Sefton welcomes the opportunity to comment on the Trust's draft Quality Account. Healthwatch Sefton was invited and attended the Presentation and Question & Answer session held on Friday 4th May 2018. The draft Quality Account was also circulated to Healthwatch Sefton in a timely manner with an opportunity for members to input into the priorities being set.

To note there are a number of areas were final figures are to be updated for the final Quality Account.

Healthwatch Sefton would like to note that the draft Quality Account is presented in a format that is easy to follow and clearly demonstrates the achievements for the Improvement Priorities for 2017 – 2018: 'How well we have done'. The draft account also clearly sets out what priorities have been set for 2018 – 2019.

Healthwatch Sefton would in particular like to comment on the below achievements:

- The improved discharge process is a welcomed achievement by Healthwatch Sefton as this is a theme picked up by Healthwatch Sefton across the Trust's that we work with and has also been identified as a National issue.

- The achievement of a fully trained cohort of Mental Capacity Act Champions who are now available to provide leadership and support to staff and patients.

- The development of a nursing bank and the benefits this has brought to both staff and patients along with the reduction of the use of agency staff is noted to be a good system to be implemented.
- The development of 'Neuro Buddy' volunteers who support patients and visitors across the Trust.

- The implementation of 'John's Campaign' championed by safeguarding matron who visits each ward when patients with dementia are admitted to the ward.

It is noted that the Trust has participated in an impressive number of national audits and service evaluations and collaborations with external agencies indicating their commitment to improve.

The Vanguard is drawing to a close but staff are looking to build on the experience and have been gathering feedback from patients who have informed them of the great effect which components of the Neuro Network Vanguard are having on their care and quality of life.

Healthwatch Sefton is impressed with the importance the Trust places on staff wellbeing and morale. During 2017-2018, the report highlights the Investors in People (Gold Standard) being reaccredited and also the award for Health@Work Workplace Wellbeing Charter.

The Trust continue to place emphasis on their staff wellbeing and safety as can be seen throughout the report with particular reference to **Priority 2** – Investing in staff training for patients with challenging behaviour and **Priority 3** – The introduction of Safety Huddles to provide staff with the opportunity to share experiences and to address potential safety issues.

The Trust has worked to improve patient experience internally including the setting up of patient panels to ensure that all patient groups have a chance to be heard. During the last 12 months, Healthwatch Sefton has held regular monthly stands to gather patient feedback. This resulted in the Trust achieving a Healthwatch Sefton rating of 5* out of 5. A system has been implemented by the Trust so that any concerns or complaints raised via Healthwatch Sefton are immediately reported to the Trust so that they can be dealt with efficiently and effectively.

Healthwatch Sefton has continued to work with the Trust to gather patient feedback independently and also attends the Trust's bi-monthly Patient Experience meetings.

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14th May 2018

Re: Healthwatch Warrington's Response to The Walton Centre NHS Foundation Trust's Draft Quality Account 2017 - 2018 (May 2018)

Healthwatch Warrington is pleased to have the opportunity to review The Walton Centre's 2017 – 2018 Quality Account (QA) and reflect on the current and future priorities in the document.

As a consumer champion for health and social care, we recognise the fundamental impact that patient voices and experiences have in shaping the quality and safety of services. Looking back at the Trust's performance in relation to its priorities in 2017 – 2018, we are pleased to see that different areas of improvement have been acknowledged within Safety, Clinical Effectiveness and Patient Experience, which have been identified in partnership with patients, families, governors, commissioners and other stakeholders including local Healthwatch.

The report format appears to be clear, well thought and detailed in most areas. Terms and acronyms are often well explained, but the QA could benefit from a Glossary, to offer further explanation and detail e.g. a definition of the Mental Capacity Act, shunt infections etc.

In regards to safety, the QA indicates that the Trust has a proactive approach to patient support e.g. screening, MCA training etc. These areas, however, would benefit from more in depth detail e.g. figures of screening rates, number of MCA champions. This is important not just to identify baseline data but to measure progress and any challenges/good practice.

The QA highlights that in 2017 – 2018 in Clinical Effectiveness (Priority 1 and 2) the Trust has moved towards same-day admissions, to shorten patient hospital stays and needs for other support, and that this has improved. However, there are no figures or data provided to evidence this success, which is needed. The next priority (Improved Discharge Process) states that at least 10% of patients are discharged from the Trust by noon, but again there is no data ascribed to this – year on year figures, breakdowns of departments or other discharge times is necessary here to measure progress and any effects of the work undertaken here.

Priority 3 (Surgical site infections) states a higher rate of infection than some other areas, but no examples are given/specified, nor are any reasons as to this increased risk. It would be beneficial to see comparable data re: the other areas of infection across the Trust, and evidence to show if the work on this priority is having a positive impact.

A key area of understanding and measuring safety and quality of service is through lessons learned from deaths and serious incidents (2.3.2). Unfortunately, much of this essential data re: investigations and reviews from 2017 – 2018 is not included in the QA, so we are unable to comment on this area. Emergency readmissions to hospital within 28 days of discharge (3.17 Indicators, 7) shows an increase of 1%, but actions to be taken and further steps to be taken are not yet updated, so we are unable to comment on the learning and responses of the Trust. Rates of patient safety incidents ((3.17 Indicators, 12) and percentages resulting in severe harm or death is reported at a rate of 7.31% per 100 admissions, but no further details have been provided to compare this data with other years to show if this has increased or decreased. This information could be further interrogated if this data was available.

As continuity of care and consistency of support continues to be an area of improvement for patient experience, development of the Nurse Bank is positive (Patient Experience, Priority 1). The volunteer initiative of Neuro Buddies (Priority 2) is also a good example of successful peer to peer support, with positive qualitative examples from staff, patients, and volunteers. More detail and figures would be useful within this priority, to measure success and progress of the initiative. It would also be beneficial to have further information about how volunteers are trained and co-ordinated by the Trust.

In Part 3, it is also positive to see that the Trust aims to provide comprehensive responses, as well as evidencing actions and ensuring this is done in a timely manner. The Trust states is has received a reduction in complaints (of 5%) since last year, which is positive. It would be positive to use more specific examples of impacts resulting from feedback here. Examples patient support e.g. Sky View Ceiling System (3.6) and the Patient Advice Line (3.7) could also use more detail e.g. figures showing successes of the Ceiling System, number of calls made to the PAL, forecasted benefits and further details about how these services will continue in future, would also be useful.

It is commendable to hear the Trust have achieved a Gold standard as Investors in People and have a strong values base with a focus on 'The Walton Way' (3.3) - hopefully this will continue to be built upon in future. The wider work of the Neuro Vanguard will also seek to improve services across a wider footprint, though the national funded has been concluded (3.4). There is no further information as to how this work will be continued without this funding, or what will be supported moving forwards.

Responsiveness to inpatients' personal needs based on five questions in the CQC via the National Inpatient Survey data (Indicators, 8) is also not provided within the QA, so we are unable to comment on this area within the document.

Responses to the Friends and Family Test could benefit from further explanation within the document (Indicators, 9), and there is a drop of 5% in returns relating to staff

responses in the survey from 2016 to 2017. It would be interesting to understand how the Trust will further seek to engage staff feedback, to move in line with the national average of 53%. The Trust also reports that the percentage of staff reporting experiences of bullying, harassment or abuse is 5% higher than the national average of Acute Trusts, an increase of 1% on last year. A year on year comparison of data and figures around this issue would be beneficial, as well as more detail and information about the types of challenges presented by this particular Trust as a neurological service, and patient needs as a result of neurological conditions, symptoms and incidents.

Moving forwards into 2018 – 2019, it's positive to see that the Trust continues to identify and support patients to reduce harm and falls, as we know that this continues to be an issue for many Trusts. Challenging behaviour is also a key behavioural issue for a neurological Trust, due to the type of patient injuries and conditions that present. Again, more explanation of why this is an area for priority would be beneficial (Priority 2). Missed medications/medication errors is a priority for many Trusts, and must be continually addressed. As certain conditions are reliant on time specific administration for management of symptoms e.g. Parkinson's, this must be effectively maintained and measured to ensure this is being addressed. Patient experience including listening and acting upon patient feedback, continues to be a key priority, and it is good to see that the Trust wants to enhance communication through social media (Patient Experience, Priority 1). Hopefully this will also include the Accessible Information standard, which will need to be considered and integrated in any approaches. Again, further detail and outcomes measuring would be helpful. The priority of oral hygiene is also an ongoing priority for Healthwatch Warrington, especially for those who lack capacity and those who have complex conditions. We look forward to hearing further about this initiative and its outcomes.

Overall the QA seems open to learning and adaptation, but there are some areas which need more in depth information and detail to quantify and understand how the Trust will measure progress and improvements. In the year ahead, we look forward to supporting The Walton Centre's engagement with the public by encouraging wider public participation in events and strengthening the voice of patients in other ways, including the Trust's inclusion at our Quality Accounts Involvement Day in May 2018.

We look forward to hearing from you and being involved in future developments.

Kind regards,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

NHS Liverpool Clinical Commissioning Group

NHS Knowsley Clinical Commissioning Group

NHS South Sefton Clinical Commissioning Group

25th May 2018

The Walton Centre Quality Account 2017/18

NHS England, NHS Liverpool CCG, South Sefton and Southport and Formby CCG wishes to thank The Walton Centre for the opportunity to comment on their Quality Account for 2017/18. NHS England is committed to working in partnership with The Walton Centre to provide safe, high quality care and services. The Quality Account accurately reflects the performance for the organisation.

The account clearly sets out the outcomes and achievements against priority areas and also demonstrates the additional quality achievements of the Trust, including a real focus on patient experience, engagement and innovation. Of particular note are the achievements in the surgical patient pathway that enhance the patient experience with same day surgery and improved patient discharge and the introduction of the Neuro buddy initiative which has received positive feedback from patients, staff and volunteers.

The priority areas for the coming year have been agreed by stakeholders and demonstrate a commitment to quality improvement. The account sets out how the priority areas will be monitored within the Trust and the focus on patients and staff is commendable. It would be good to see what additional measures are in place for the clinical effectiveness priorities to allow the Trust to demonstrate the benefits.

There is evidence of strong governance processes through the organisation and there is a continued emphasis on data quality to help inform the internal reporting of outcomes from ward to board. There is an open and honest culture of reporting within the Trust.
Participation in National and Local audit is clear, with visible actions leading to change in practice and improvements in care. Of note is the commitment to improving quality of care through the current clinical studies and the plans for new research studies in the coming year.

Infection prevention measures are robust and the trust is proactive in the management of infection prevention. There was one case of MRSA attributable to the trust during the year and the team have worked with commissioners and Public Health England to address prevention measures. It is encouraging to see the reduction in the number of Ecoli and C.Difficile cases over the last year.

The Vanguard programme has demonstrated how the Trust have collaborated across the health economy, although the programme has not yet concluded, improvements are evident including the use of telemedicine which has allowed patients to have greater access and offered improved response times to Specialist Neurosurgery advice.
Commissioners look forward to seeing the impact that the Vanguard has had on patients, staff and the wider health economy once the programme concludes.
The Trust has provided high levels of quality assurance throughout 2017/18 through regular quality and performance meetings with Specialised Commissioning and Clinical Commissioning Groups.

We look forward to continuing to work in partnership with The Walton Centre to further improve quality and experience for patients.

Sue McGorry
Head of Quality, Specialised Commissioning Team, Northwest Hub
May 2018
Yours sincerely

Chief Officer
Liverpool CCG

Chief Officer
South Sefton CCG
Southport & Formby CCG

Annex 2

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year.

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

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

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 2017/18 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2017 to April 2018
  - Papers relating to quality reported to the Board over the period April 2017 to April 2018
  - Feedback from the commissioners dated May 2018
  - Feedback from governors dated 14th December 2017 and 13th March 2018
  - Feedback from Healthwatch (Liverpool, Sefton, Warrington) dated May 2018
  - Feedback from the Overview and Scrutiny Committee (OSC) dated May 2018
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, will be dated June 2018
  - The National Staff Survey for 2017 presented to Trust Board on 29th March 2018
  - The Head of Internal Audit's annual opinion over the Trust's control environment was presented to Audit Committee April 2018
  - CQC inspection report dated April 2016
- the Quality Report presents a balanced picture of the NHS Foundation Trusts performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice

- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report

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

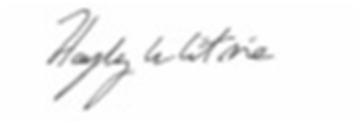
By order of the Board

Signature of Chair

Chair

Date 25/05/18

Signature of CEO



Chief Executive

Date 25/05/18

Glossary of Terms

CPE	Carbapenemase Producing Enterobacteriaceae
CQUIN	Commissioning for Quality and Innovation
DVT	Deep Vein Thrombosis
EEG	Electroencephalogram
ELISA	Enzyme Linked Immunosorbent Assay
EP2	Electronic Patient Record System
FFFAP	Falls and Fragility Fractures Audit Programme
GIRFT	Getting It Right First Time
HTA	Human Tissue Authority
ICNARC	Intensive Care National Audit & Research Centre
iMRI	Intra-Operative MRI Scanner
IRMER	Ionising Radiation Medical Exposure Regulations
LIMS	Laboratory Information Management System
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
MIAA	Mersey Internal Audit Agency
MRSA	Meticillin-Resistant Staphylococcus Aureus Bacteraemia
NASAH	Non-Aneurysmal Subarachnoid Haemorrhage
NCABT	National Comparative Audit of Blood Transfusion
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NELA	National Emergency Laparotomy Audit
NICE	National Institute for Clinical Excellence
NIHR	National Institute of Health Research
NNAP	National Neurosurgery Audit Programme
PCR	Polymerase Chain Reaction
PEEK	Poly-Ether-Ether Ketone
PACS	Picture Archiving Communication System
PRIS	Propofol Infusion Syndrome
RASS	Richmond Agitated Sedation Scale
RIS	Radiology Information System
SMART	Surgical and Medical Acute Response Team
SSNAP	Sentinel Stroke National Audit Programme
SUS	Secondary Uses Service
TACO	Transfusion Associated Circulatory Overload
TARN	Trauma Audit & Research Network
TG	Triglyceride
VTE	Venous Thromboembolism
WCFT	Walton Centre Foundation Trust

Independent auditor's report to the Council of Governors of The Walton Centre NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of The Walton Centre NHS Foundation Trust (the 'Trust') and its subsidiary (the 'group') for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and the NHS foundation trust annual reporting manual 2017/18.

In our opinion the financial statements:

give a true and fair view of the financial position of the group and of the Trust as at 31 March 2018 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended; and

have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/2018; and

have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the group and the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or

the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

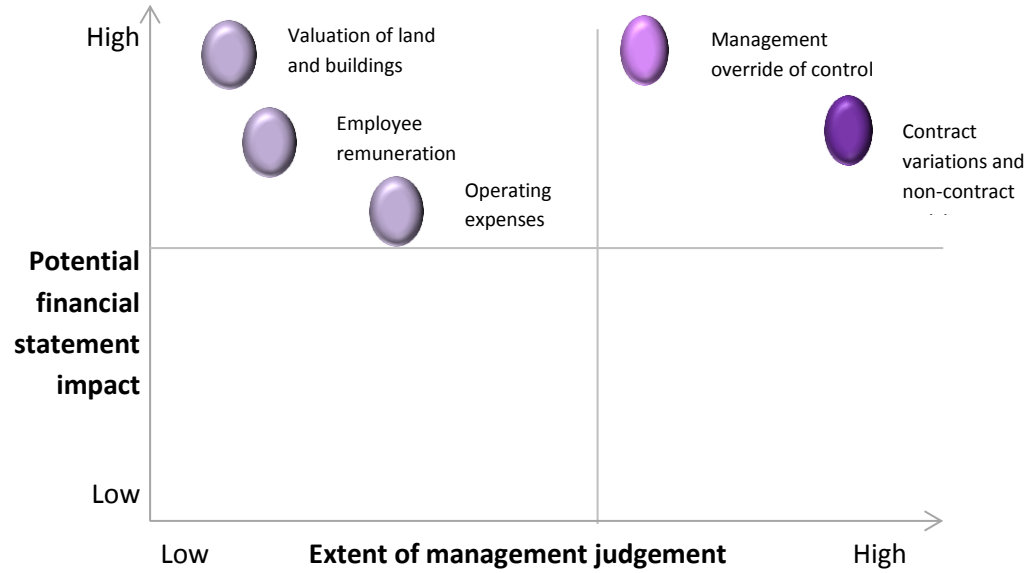
Overview of our audit approach

Overall materiality: £2,404,000, which represents 2% of the group's operating expenses;
The Group is formed of The Walton Centre NHS Foundation Trust and The Walton Centre Charity. We performed a full scope audit of the Trust and analytical procedures for the charity.

- The key audit matter identified was contract variations and non-contract activity
- We have tested, on a sample basis, all of the Trust's material income and expenditure streams, covering 97% of the Trust's income and operating expenses, 96 % of the Trust's expenditure and current and non-current assets, 99% of the Trust's total assets and current and non-current liabilities and 95% of the Trust's total liabilities.

Key audit matters

The graph below depicts the audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Trust and Group	How the matter was addressed in the audit – Trust and Group
Risk: Contract variations and non-contract activity Approximately 90% of the group's operating income is for income from patient care activities, which includes £6.4m from block contracts £105.4m from activity based contracts and £3.4m for non-contract activities. Block and activity based contract variations and non-contract activity income is subject to verification and agreement by the Trust's	Our audit work included, but was not restricted to: • evaluating the group's accounting policy for recognition of operating income for compliance with the Department of Health and Social Care Group Accounting Manual 2017/18; • gaining an understanding of the Trust's system for accounting for income from contract variations and non-contract activity and evaluating the design of the associated controls; • agreeing a sample of contract variations and non-contract activity income to supporting evidence and testing that it has been accounted for in accordance with the stated accounting policy The Trust's accounting policy on operating income is shown in note 1.4 to the financial statements and related disclosures are included in notes 2.1, 2.2 and 2.3.

Key Audit Matter – Trust and Group	How the matter was addressed in the audit – Trust and Group
commissioners. We therefore identified the occurrence and accuracy of income from contract variations and non-contract activity as a significant risk, which was one of the most significant assessed risks of material misstatement.	The Audit Committee identified recognition of income from patient care activities as a significant issue in its report on page 88, where the Audit Committee also described the action that it has taken to address this issue. **Key observations** We obtained sufficient audit evidence to conclude that: • the group's accounting policy for recognition of operating income complies with the DHSC Group Accounting Manual 2017/18 and has been properly applied; and • income from NHS contract variations and non-contract activity in relation to patient care activities is not materially misstated.

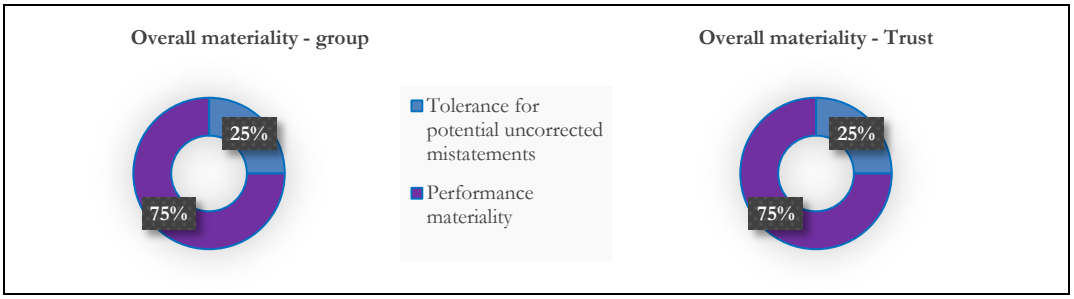
Our application of materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group	Trust
Financial statements as a whole	£2,404,000 which is 2% of the group's operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding.. Materiality for the current year is at the same percentage level of gross operating expenses as we determined for the year ended 31 March 2017 as we did not identify any significant changes in the group or the environment in which it operates.	£2,391,000 which is 2% of the Trust's operating expenses. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how it has expended its revenue and other funding. Materiality for the current year is at the same percentage level of gross operating expenses as we determined for the year ended 31 March 2017 as we did not identify any significant changes in the Trust or the environment in which it operates.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality	75% of financial statement materiality
Specific materiality		Disclosure of senior managers' remuneration in the Remuneration Report: £21,200, based on 2% of the total senior managers' remuneration. This is due to public interest in these disclosures and the statutory requirement for them to be made.
Communication of misstatements to the Audit Committee	£120,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£120,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile.

In particular our work included:

Evaluation by the group audit team of identified components to assess the significance of each component and to determine the planned audit response based on a measure of materiality and significance of the component as a percentage of the group's operating expenses. A full scope, targeted or analytical approach was applied for each component based on the relative materiality to the group and our assessment of audit risk;

Gaining an understanding of and evaluating the Trust's internal controls environment including its financial and IT systems and controls;

Full scope audit procedures on The Walton Centre NHS Foundation Trust which represents 99.8% of the group's income, 99.7% of the group's expenditure and 98.8% of its total assets;

Analytical procedures on the Walton Centre Charity;

Testing, on a sample basis of all of the Trust's material income and expenditure streams, covering 97% of the Trust's income and operating expenses, 96 % of the Trust's expenditure and current and non-current assets, 99% of the Trust's total assets and current and non-current liabilities and 95% of the Trust's total liabilities.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the Annual Report other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge of the group and Trust obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resources or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

Fair, balanced and understandable set out on page 9 in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the

Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

The Audit Committee reporting set out on page 86 in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit committee does not appropriately address matters communicated by us to the Audit committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2017/18. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2017/18 and the requirements of the National Health Service Act 2006; and

based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Accounting Officer's responsibilities, set out on pages 99 to 100 the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2017/18, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the group or the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the group or the Trust.

The Audit Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice we are required to report to you if, in our opinion we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

We have nothing to report in respect of the above matter**.**

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of The Walton Centre NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Robin Baker

Robin Baker
Director

for and on behalf of Grant Thornton UK LLP
Royal Liver Building
Liverpool
L3 1PS

26 May 2018

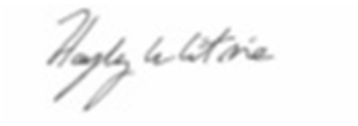
6. Foreword to the Accounts

The Walton Centre NHS Foundation Trust

Accounts for the period ending 31 March 2018

The following presents the accounts for the Walton Centre NHS Foundation Trust for the period ending 31 March 2018.

The accounts have been prepared in accordance with the requirements as set out in paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 (the 2006 Act) in the form which NHS Improvement, the Independent Regulator of NHS Foundation Trusts has, with the approval of the Treasury, directed.



Signed

Chief Executive 25 May 2018

7. Primary Financial Statements

Statement of Comprehensive Income

2016/17 Foundation Trust £000	2016/17 Group £000		Note	2017/18 Foundation Trust £000	2017/18 Group £000
106,094	106,094	Operating income from patient care activities	2	115,147	115,147
13,625	14,038	Other operating income	2	13,200	13,416
(113,268)	(113,619)	Operating expenses	3	(120,129)	(120,448)
6,451	**6,513**	**OPERATING SURPLUS/(DEFICIT) FROM CONTINUING OPERATIONS**		**8,218**	**8,115**
		Finance Costs			
21	51	Finance income	7	34	59
(646)	(646)	Finance expenses	7	(696)	(696)
(1,488)	(1,488)	PDC Dividends payable	25	(1,462)	(1,462)
(2,113)	**(2,083)**	**Net Finance Costs**		**(2,124)**	**(2,099)**
8	8	Gains/(losses) on disposal of non-current assets	8	28	28
4,346	**4,438**	**Surplus/(deficit) for the year from continuing operations**		**6,122**	**6,044**
4,346	**4,438**	**SURPLUS/(DEFICIT) FOR THE YEAR**		**6,122**	**6,044**
		Other comprehensive income			
		Will not be reclassified to income and expenditure:			
(3,740)	(3,740)	Impairments	9, 21	3,561	3,561
		May be reclassified to income and expenditure when certain conditions are met:			
0	111	Fair value gains/(losses) on available-for-sale financial investments	12	0	(15)
606	**809**	**TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE PERIOD**		**9,683**	**9,590**
		Surplus/(deficit) for the period attributable to:			
4,346	4,438	Owners of the parent		6,122	6,044
4,346	**4,438**	**TOTAL**		**6,122**	**6,044**
		Total comprehensive income/(expense) for the period attributable to:			
606	809	Owners of the parent		9,683	9,590
606	**809**	**TOTAL**		**9,683**	**9,590**

Reconciliation from the Statement of Comprehensive Income to the Trust trading position:

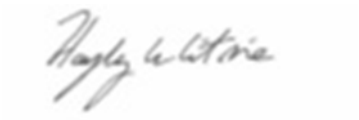
Foundation Trust £000		Foundation Trust £000
4,346	Surplus/(deficit) from continuing operations	6,122
	Normalising adjustments:	
(2,044)	Capital donation from the Charitable Fund	(164)
(694)	Impairment/(reversal of impairment) of land and buildings	(650)
1,608	**Trading (deficit)/surplus for the period**	**5,308**

The Notes on pages 213 to 244 form part of these accounts:

Statement of Financial Position

31-Mar-17 Foundation Trust £000	31-Mar-17 Group £000		Note	31-Mar-18 Foundation Trust £000	31-Mar-18 Group £000
98	98	Intangible assets	10	65	65
80,700	80,700	Property, plant and equipment	11	83,348	83,348
0	836	Other investments/financial assets	12	0	812
80,798	**81,634**	**Total non-current assets**		**83,413**	**84,225**
		Current assets			
1,986	1,986	Inventories	13	1,210	1,210
6,779	6,417	Trade and other receivables	14	8,651	8,633
11,728	12,678	Cash and cash equivalents	15	17,169	17,694
20,493	**21,081**	**Total current assets**		**27,030**	**27,537**
101,291	**102,715**	**Total Assets**		**110,443**	**111,762**
		Current liabilities			
(15,020)	(15,059)	Trade and other payables	16	(15,570)	(15,596)
(1,165)	(1,165)	Borrowings	17	(1,293)	(1,293)
(292)	(292)	Provisions	18	(297)	(297)
(550)	(550)	Other liabilities	19	(512)	(512)
(17,027)	**(17,066)**	**Total current liabilities**		**(17,672)**	**(17,698)**
84,264	**85,649**	**Total assets less current liabilities**		**92,771**	**94,064**
		Non-current liabilities			
(29,098)	(29,098)	Borrowings	17	(27,887)	(27,887)
(276)	(276)	Provisions	18	(267)	(267)
(29,374)	**(29,374)**	**Total non-current liabilities**		**(28,154)**	**(28,154)**
54,890	**56,275**	**Total assets employed**		**64,617**	**65,910**
		Financed by			
		Taxpayers' equity			
26,619	26,619	Public Dividend Capital	25	26,663	26,663
732	732	Revaluation reserve	21	4,293	4,293
27,539	27,538	Income and expenditure reserve		33,661	33,661
		Others' equity			
0	1,386	Charitable fund reserves	27	0	1,293
54,890	**56,275**	**Total taxpayers' and others' equity**		**64,617**	**65,910**

The financial statements and notes on pages 207 to 244 were approved by the Board on 25 May 2018 and signed on its behalf by:



Chief Executive **25 May 2018**

Statement of Changes in Taxpayers Equity

	Group					Foundation Trust			
Statement of Changes in Taxpayers Equity	**Total Group equity £000**	**Charitable funds reserves £000**	**Public Dividend Capital £000**	**Revaluation Reserve £000**	**Income and Expenditure Reserve £000**	**Total Taxpayers equity £000**	**Public Dividend Capital £000**	**Revaluation Reserve £000**	**Income and Expenditure Reserve £000**
Taxpayers' and Others' Equity at 1 April 2017	**56,275**	**1,386**	**26,619**	**732**	**27,538**	**54,890**	**26,619**	**732**	**27,539**
Surplus/(deficit) for the year	6,044	147	0	0	5,897	6,122	0	0	6,122
Impairments	2,058	0	0	2,058	0	2,058	0	2,058	0
Revaluations	1,503	0	0	1,503	0	1,503	0	1,503	0
Fair value gains and losses on available for sale investments	(15)	(15)	0	0	0	0	0	0	0
Public Dividend Capital received	44	0	44	0	0	44	44	0	0
Other reserve movements	0	(225)	0	0	225	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2018	**65,910**	**1,293**	**26,663**	**4,293**	**33,661**	**64,617**	**26,663**	**4,293**	**33,661**
Taxpayers' and Others' Equity at 1 April 2016	**55,466**	**1,182**	**26,619**	**4,472**	**23,193**	**54,284**	**26,619**	**4,472**	**23,193**
Surplus/(deficit) for the year	4,438	2,240	0	0	2,198	4,346	0	0	4,346
Impairments	(3,740)	0	0	(3,740)	0	(3,740)	0	(3,740)	0
Fair value gains and losses on available for sale investments	111	111	0	0	0	0	0	0	0
Other reserve movements	0	(2,147)	0	0	2,147	0	0	0	0
Taxpayers' and Others' Equity at 31 March 2017	**56,275**	**1,386**	**26,619**	**732**	**27,538**	**54,890**	**26,619**	**732**	**27,539**

Statement of Cash Flows

2016/17 Foundation Trust £000	2016/17 Group £000		2017/18 Foundation Trust £000	2017/18 Group £000
		Cash flows from operating activities		
6,451	**6,513**	**Operating surplus/(deficit)**	**8,218**	**8,115**
		Non-cash income and expense:		
4,352	4,352	Depreciation and amortisation	4,860	4,860
(694)	(694)	Net impairments	(650)	(650)
(2,044)	0	Income recognised in respect of capital donations	(164)	0
(1,268)	(984)	(Increase)/decrease in trade and other receivables	(1,966)	(2,295)
(1,050)	(1,050)	(Increase)/decrease in inventories	776	776
209	209	Increase/(decrease) in trade and other payables	1,668	1,668
11	11	Increase/(decrease) in other liabilities	(38)	(38)
(260)	(260)	Increase/(decrease) in provisions	(5)	(5)
0	54	Movements in charitable fund working capital	0	(18)
5,707	**8,151**	**NET CASH GENERATED FROM/(USED IN) OPERATING ACTIVITIES**	**12,699**	**12,413**
		Cash flows from investing activities:		
21	21	Interest received	34	34
(8,269)	(8,269)	Purchase of property, plant and equipment	(4,334)	(4,334)
33	33	Sales of property, plant and equipment	32	32
2,044	0	Receipt of cash donations to purchase capital assets	164	0
0	30	NHS charitable funds: net cash flows from investing activities	0	25
(6,171)	**(8,185)**	**Net cash generated from/(used in) investing activities**	**(4,104)**	**(4,243)**
		Cash flows from financing activities:		
0	0	Public dividend capital received/(repaid)	44	44
4,969	4,969	Movement in loans from the Department of Health	(1,131)	(1,131)
(31)	(31)	Capital element of finance lease rental payments	(34)	(34)
(631)	(632)	Interest paid	(684)	(684)
(5)	(5)	Interest paid on finance lease liabilities	(2)	(2)
(1,597)	(1,597)	PDC Dividend paid	(1,347)	(1,347)
2,705	**2,704**	**Net cash generated from/(used in) financing activities**	**(3,154)**	**(3,154)**
2,241	**2,670**	**Increase/(decrease) in cash and cash equivalents**	**5,441**	**5,016**
9,487	10,008	Cash and Cash equivalents at 1 April	11,728	12,678
11,728	**12,678**	**Cash and Cash equivalents at 31 March**	**17,169**	**17,694**

8. Notes to the Accounts

Accounting Policies

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

1.1 Accounting Convention

These accounts have been prepared under the historical cost convention, modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Going Concern

Following extensive enquiries, the directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. They have identified no material uncertainties that cast significant doubt on the Trust's ability to continue as a going concern. For this reason, they continue to adopt the going concern basis in preparing the accounts.

The main factors in reaching this conclusion were:

- The Trust's latest two-year plan (2017/18 – 2018/19) forecasts a surplus position across the period. A refresh of the 2018/19 plan is being undertaken to update financial assumptions made in the two-year plan as well as rebasing activity, income and expenditure positions;
- Projected cash balances are sufficient to sustain the investment programme and meet short term operating costs. The Trust has sufficient cash headroom to support its plans;
- There is no expectation for short-term loans or overdraft facilities;
- Internal auditor's opinions have provided assurance as to the accuracy and reliability of the Trust's financial systems and the robustness of the internal controls.

1.3 Consolidation

The Walton Centre Charity

The Trust is the corporate trustee to The Walton Centre Charity (the Charity). The Trust has assessed its relationship to the Charity and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the Charity and has the ability to affect those returns and other benefits through its power over the Charity.

The Charity's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the Charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Trust's accounting policies; and
- Eliminate intra-group transactions, balances, gains and losses.

Associates
Associate entities are those over which the Trust has the power to exercise a significant influence so as to obtain economic or other benefits. Associate entities are recognised in the Trust's financial statements using the equity method. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust's share of the entity's profit or loss or other gains and losses following acquisition. It is also reduced when any distributions are received by the Trust from the associate.

Associates which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

1.4 Income
The main source of revenue for the Trust is from NHS England (via the North West Specialised Commissioning Hub) for specialist treatment, Liverpool Clinical Commissioning Group for non-specialist services (as contract lead for the majority of non-specialist CCG activity), Welsh Assembly for patients from Wales and from the Isle of Man, which are government funded commissioners of NHS health and patient care.

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. At the year end, the Trust accrues income relating to activity delivered in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued and agreed with the commissioner.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met and is measured as the sums due under the sale contract.

Interest revenue is accrued on a time basis, by reference to the principal outstanding and interest rate applicable.

1.5 Expenditure on Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that the employees are permitted to carry forward leave into the following period where it is deemed to be material.

Pension costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme (the Scheme). The Scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as a defined contribution scheme. The cost to the Trust of participating in the Scheme is equal to the contributions payable to the Scheme for the accounting period.

Employer's pension cost contributions are charged to the Statement of Comprehensive Income as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the Scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on Other Goods and Services
Expenditure on goods and services is recognised when, and to the extent that, they have been received and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Capitalisation
Property, plant and equipment is capitalised where:
- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- It is expected to be used for more than one financial year; and
- The cost of the item can be measured reliably.

The asset must:
- Individually have a cost of at least £5,000; or
- Collectively have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control; or
- Form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the Trust's services or for administrative purposes are measured subsequently at fair value. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the Statement of Financial Position date. Fair values are based on modern equivalent assets basis for existing use on an alternative site valuation.

The freehold properties of The Walton Centre NHS Foundation Trust were valued as at 31 March 2018 by an external valuer, Gerald Eve LLP, a regulated firm of Chartered Surveyors. The valuation was prepared in accordance with the requirements of the RICS Valuation – Global Standard 2017 and the notional standards and guidance set out in RICS Valuation – Professional Standards UK January 2014 (revised 2015), the International Valuation Standards, and IFRS as adapted and interpreted by the Financial Reporting Manual (FReM). The valuations of specialised properties were derived using the Depreciated Replacement Cost (DRC) method, with other in-use properties reported on an Existing Use Value basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be measured reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated. Assets in the course of construction are not depreciated until the assets are brought into use. The estimated useful lives and residual values are reviewed each year-end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives or, where shorter, the lease term. Property, plant and equipment which has been reclassified as ‘held for sale’ ceases to be depreciated upon the reclassification.

Revaluation gains and losses
Revaluation gains are taken to the revaluation reserve except where, and to the extent that, they reverse a revaluation decrease for the same asset previously recognised in the Statement of Comprehensive Income, in which case it is credited to the Statement of Comprehensive Income. A revaluation loss is charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, is charged to the Statement of Comprehensive Income.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income.’

Impairments
At each Statement of Financial Position date, the Trust reviews its tangible and intangible non-current assets to determine whether there is an indication that any have suffered impairment due to a loss of economic benefits or service potential. If there is an indication of

an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefits or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenses to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Donated, government grant and other grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to the Statement of Comprehensive Income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.8 Intangible Assets
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Expenditure on research activities is recognised as an expense in the period in which it is incurred and is not capitalised. Intangible assets are capitalised when they have a cost of at least £5,000.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Trust intends to complete the intangible asset and sell or use it;
- The Trust has the ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- Adequate technical, financial and other resources are available to the Trust to complete the development and sell or use the asset;
- The Trust can measure reliably the expenditure attributable to the intangible asset during its development.

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of amortised replacement cost (modern equivalent asset basis) and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5. Internally-developed software is held at historic cost to reflect the opposite effects of development costs and technological advances.

Intangible assets not yet available for use are tested for impairment annually.

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.9 Revenue Government and Other Grants

Government grants are grants from government bodies other than income from commissioners or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in, first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.11 Financial Instruments and Financial Liabilities

Recognition and de-recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs (i.e. when receipt or delivery of the goods or services is made).

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation has been discharged, cancelled or expires.

Classification and measurement
Financial assets are categorised as:

- ‘At fair value through income and expenditure’;
- ‘Available for sale financial assets;
- ‘Loans and receivables’; or
- ‘Held to maturity’ investments.

'Loans and receivables' is the only category relevant to the Trust. The Charity investments are ‘available for sale.’

Financial liabilities are classified as:

- ‘Fair value through income and expenditure’; or
- ‘Other financial liabilities.’

All of the Trust's financial liabilities are categorised as ‘other financial liabilities.’

The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust’s loans and receivables comprise:

- Current investments;
- Cash and cash equivalents;
- NHS receivables;
- Accrued income; and
- Other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
Other financial liabilities are recognised in the Statement of Financial Position when the Trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received.

Financial liabilities are initially recognised at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

1.12 Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.13 Provisions
The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. The contribution is charged to the Statement of Comprehensive Income. Although NHS

Resolution is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed in Note 18 but is not recognised in the Trust's accounts. The excess on these claims payable by the Trust is included in the accounts and disclosed in Note 18 as 'other legal claims.'

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to the Statement of Comprehensive Income when the liability arises.

1.14 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 20, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.15 Public Dividend Capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of the establishment of the predecessor NHS Trust. HM Treasury has determined that, being issued under statutory authority rather than under contract, PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:

- Donated assets (including lottery funded assets);
- Average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility;
- Any PDC dividend balance receivable or payable; and
- Any STF incentive and STF bonus fund receivable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.16 Value Added Tax
Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.17 Corporation Tax
HM Treasury has decided to defer the planned implementation of legislation requiring NHS Foundation Trusts to pay corporation tax on profits generated on their commercial activities. As a result, NHS Foundation Trusts will not become taxable on their profits. This may change with future Government legislation.

1.18 Foreign Currencies
The Trust operates and accounts for its transactions in sterling. Transactions denominated in a foreign currency are translated into sterling at the spot exchange rate on the date of the transaction. Resulting exchange gains and losses are taken to the Statement of Comprehensive Income. At the Statement of Financial Position date, monetary items denominated in foreign currencies are retranslated at the rates prevailing at the Statement of Financial Position date.

1.19 Third Party Assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. Details of third party assets are given in Note 26 to the accounts.

1.20 Losses and Special Payments
Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Note 28 on Losses and Special Payments is compiled directly from the losses and compensations register which is prepared on a cash basis.

1.21 Critical Accounting Judgements and Key Sources of Estimation
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates. The estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

Critical judgements in applying accounting policies
In the process of applying the Trust's accounting policies, management has not been required to make any judgements, apart from those involving estimations, which has had a significant effect on the amounts recognised in the financial statements.

Key sources of estimation uncertainty
The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Valuation and impairment of non-financial assets – the Trust assesses whether there are any indicators of impairment for all non-financial assets at each reporting date. The key area of uncertainty relates to the Trust's valuation of its land and buildings. Further details are provided in Note 11. The land and buildings were valued by Gerald Eve LLP as at 31 March 2018.

1.22 Operating Segments
The Trust is the UK's only specialist neurological centre and sees patients with neurological associated conditions referred from all over the country. Contracts for services are negotiated with commissioners and monitored on the basis of point of delivery, inpatients, outpatients etc. The services provided by the Trust are interdependent and therefore the Board considers that the Trust operates as a single segment.

1.23 Accounting standards that have been issued but have not yet been adopted
The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018/19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9 Financial Instruments – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 15 Revenue from Contracts with Customers – application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 16 Leases – application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts – application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – application required for accounting periods beginning on or after 1 January 2018.
- IFRIC 23 Uncertainty over Income Tax Treatments – application required for accounting periods beginning on or after 1 January 2019.

Note 2.1 Operating Income by Source

2016/17 Foundation Trust £000	2016/17 Group £000		2017/18 Foundation Trust £000	2017/18 Group £000
		Income from patient care activities		
289	289	NHS Foundation Trusts	254	254
273	273	NHS Trusts	81	81
76,571	76,571	NHS England	79,370	79,370
11,161	11,161	Clinical commissioning groups	15,593	15,593
15,254	15,254	NHS other	17,371	17,371
182	182	Non-NHS: private patients	139	139
19	19	Non-NHS: overseas patients (non-reciprocal)	0	0
267	267	Injury cost recovery scheme (was RTA)	341	341
2,078	2,078	Non-NHS: other	1,998	1,998
106,094	**106,094**	**Total income from patient care activities**	**115,147**	**115,147**
		Other operating income		
1,986	1,986	Research and development	1,696	1,696
3,488	3,488	Education and training	3,384	3,384
2,111	0	Charitable and other contributions to expenditure	225	0
413	413	Non-patient care services to other bodies	14	14
1,879	1,879	Sustainability and Transformation Fund income	3,322	3,322
2,792	2,755	Other income	3,517	3,517
749	749	Rental revenue from operating leases	755	755
207	207	Income in respect of staff costs where accounted on gross basis	287	287
0	2,561	Charitable incoming resources (excluding investment income)	0	441
13,625	**14,038**	**Total other operating income**	**13,200**	**13,416**
119,719	**120,132**	**TOTAL OPERATING INCOME**	**128,347**	**128,563**
		Of which:		
119,719	120,132	Related to continuing operations	128,347	128,563

All income from activities and the income in respect of education and training arise from the provision of mandatory services set out in the NHS Improvement terms of authorisation.

NHS other includes income for patients from Wales, Scotland and Northern Ireland. Non-NHS other includes income for patients from the Isle of Man and Overseas.

Note 2.2 Operating income from patient care activities (by nature)

2016/17 £000	Foundation Trust and Group	2017/18 £000
	Acute services	
27,251	Elective income	27,998
12,829	Non-elective income	15,535
10,588	First outpatient income	10,742
14,347	Follow-up outpatient income	16,467
40,052	Other NHS clinical income	43,347
	Community services	
578	Income from CCGs and NHS England	578
	All trusts	
182	Private patient income	139
267	Other clinical income	341
106,094	**Total income from activities**	**115,147**
	Of which:	
106,094	Related to continuing operations	115,147

The Trust has met the requirement of Section 43 (2a) of the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012) that income in respect of NHS services in England exceeds all other sources of income.

Note 2.3 Analysis of Other Operating Income

2016/17 Foundation Trust £000	2016/17 Group £000		2017/18 Foundation Trust £000	2017/18 Group £000
124	124	Car parking	104	104
272	272	Clinical excellence awards	196	196
30	30	Catering	0	0
0	0	IT recharges (external)	10	10
174	174	Workforce funding	0	0
1,882	1,882	Vanguard funding from NHS England	1,860	1,860
73	73	NHS Blood & Transport	90	90
0	0	Non-recurrent residual funding	893	893
237	200	Other	364	364
2,792	**2,755**	**Total**	**3,517**	**3,517**

Note 2.4 Operating Lease Income

2016/17 £000	Foundation Trust and Group	2017/18 £000
	Operating Lease Income	
749	Lease receipts recognised as income in the period	755
749	**TOTAL**	**755**
	Future minimum lease receipts due	
382	- not later than one year;	364
1,390	- later than one year and not later than five years;	1,296
17,546	- later than five years.	17,231
19,318	**TOTAL**	**18,891**

The operating lease income relates to the lease of land to The Clatterbridge Cancer Centre NHS FT to build a radiotherapy and stereotactic surgery centre, the lease of the coffee shops to ISS, the lease of the shop to RVS and the lease of part of the Sid Watkins building to Mersey Care NHS FT for their brain injury rehabilitation unit.

Note 3.1 Operating Expenses (by type)

2016/17 Foundation Trust £000	2016/17 Group £000		2017/18 Foundation Trust £000	2017/18 Group £000
61,678	61,815	Employee Expenses - staff and executive directors	64,814	64,961
130	130	Employee Expenses - non-executive directors	121	121
1,309	1,309	Employee Expenses - research and development	1,231	1,231
340	340	Employee Expenses - education and training	359	359
13,006	13,006	Drugs costs	14,761	14,761
19,830	19,830	Supplies and services - clinical (excluding drug costs)	19,398	19,398
3,863	3,863	Supplies and services - general	3,497	3,497
1,096	1,096	Establishment	1,185	1,185
345	345	Research and development - non-staff	618	618
510	510	Premises - business rates payable to local authorities	703	703
3,000	3,000	Premises - other	3,614	3,614
105	105	Operating lease expenditure (net)	103	103
119	119	Increase/(decrease) in impairment of receivables	923	923
35	35	Change in provisions discount rate	19	19
6	6	Inventories written down (net including drugs)	27	27
4,307	4,307	Depreciation on property, plant and equipment	4,826	4,826
45	45	Amortisation on intangible assets	34	34
(694)	(694)	Net Impairments	(650)	(650)
48	48	Audit fees payable to the external auditor: - audit services - statutory audit	47	47
6	6	- other auditor remuneration (external audit only)	8	8
0	4	- charitable fund audit	0	1
65	65	Internal audit - non-staff	61	61
1,571	1,571	Clinical negligence - amounts payable to NHS Resolution (premium)	2,164	2,164
120	120	Legal fees	33	33
467	467	Consultancy costs	198	198
453	453	Education and training - non-staff	580	580
213	213	Transport (business travel only)	226	226
192	192	Transport - other (including patient travel)	183	183
358	358	Car parking and security	370	370
14	14	Hospitality	12	12
32	32	Insurance	24	24
426	426	Other services (e.g. external payroll)	255	255
11	11	Other losses and special payments - non-staff	32	32
0	210	Other NHS charitable fund resources expended	0	171
262	262	Other	353	353
113,268	**113,619**	**TOTAL OPERATING EXPENSES**	**120,129**	**120,448**
		Of which:		
113,268	113,619	Related to continuing operations	120,129	120,448

The external auditors' liability is limited to £2,000,000. Audit fees are shown inclusive of VAT.

Note 3.2 Employee benefits

2016/17 Foundation Trust £000	2016/17 Group £000		2017/18 Foundation Trust £000	2017/18 Group £000
51,222	51,222	Salaries and wages	54,547	54,547
4,728	4,728	Social security costs	4,889	4,889
0	0	Apprenticeship levy	244	244
5,571	5,571	Employer's contributions to NHS pensions	5,856	5,856
288	288	Termination benefits	54	54
2,622	2,622	Temporary staff (including agency)	2,077	2,077
0	137	NHS charitable funds staff	0	147
64,431	**64,568**	**Total gross staff costs**	**67,667**	**67,814**
(740)	(740)	Recoveries in respect of seconded staff	(711)	(711)
(364)	(364)	Costs capitalised as part of assets	(552)	(552)
63,327	**63,464**	**Total staff costs**	**66,404**	**66,551**

Note 4 Retirement Benefits

Foundation Trust and Group

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 5 Retirements due to ill-health

Foundation Trust and Group

During the period 1 April 2017 to 31 March 2018 there was one early retirement from the Trust agreed on the grounds of ill-health valued at £53,502 (2016/17: two, £105,131).

Note 6.1 Operating leases

2016/17 £000	Foundation Trust and Group	2017/18 £000
105	Minimum lease payments	103
105	**TOTAL**	**103**

Note 6.2 Arrangements containing an operating lease

2016/17 £000	Foundation Trust and Group	2017/18 £000
	Future minimum lease payments due:	
105	- not later than one year;	103
205	- later than one year and not later than five years;	103
310	**TOTAL**	**206**

Note 7.1 Finance income

Foundation Trust 2016/17 £000	Group 2016/17 £000		Foundation Trust 2017/18 £000	Group 2017/18 £000
0	30	NHS charitable fund investment income	0	25
21	21	Bank interest	34	34
21	**51**	**TOTAL**	**34**	**59**

Note 7.2 Finance expenditure

Foundation Trust 2016/17 £000	Group 2016/17 £000		Foundation Trust 2017/18 £000	Group 2017/18 £000
		Interest expense		
637	637	Interest on capital loans from the Department of Health	693	693
5	5	Interest on finance lease obligations	2	2
642	**642**	**Total interest expense**	**695**	**695**
4	4	Unwinding of discount on provisions	1	1
646	**646**	**TOTAL**	**696**	**696**

Note 8 Gains/(losses) on disposal

2016/17 £000	Foundation Trust and Group	2017/18 £000
8	Gain on disposal of property, plant and equipment	28
8	**Net profit/(loss) on disposal of non-current assets**	**28**

Note 9 Revaluation/impairment of assets

2016/17 £000	Foundation Trust and Group	2017/18 £000
	Net impairments charged to operating surplus / deficit resulting from:	
(694)	Changes in market price	(650)
(694)	**Total net impairments charged to operating surplus / deficit**	**(650)**
3,740	Impairments charged to the revaluation reserve	(2,058)
0	Revaluations	(1,503)
3,046	**Total revaluation/net impairments**	**(4,211)**

During 2017/18 following a review of the Trust's assets, including a revaluation of land and buildings by the Trust's valuers, £4,210,528 impairment reversals and revaluations were identified.

- £650,209: related to a net reversal of a previous impairment of the Sid Watkins land and building charged against operating surplus;
- £2,057,528: related to a net impairment reversal of land and buildings charged against the revaluation reserve; and

- £1,502,791: related to a revaluation to buildings.

In 2016/17 £3,046,473 net impairments were identified: £693,745 related to a net reversal of a previous impairment of the Sid Watkins land and building charged against operating surplus, while £3,740,218 related to a net impairment of land and buildings charged against the revaluation reserve. Further details of the valuation are included in Note 1. There have been no impairments identified on other assets in the Trust (2016/17: none).

Note 10 Intangible assets

	Software licences (purchased)	
Foundation Trust and Group	**2016/17**	**2017/18**
	£000	**£000**
Valuation/Gross cost at 1 April	**582**	**582**
Additions - purchased	0	0
Gross cost at 31 March	**582**	**582**
Amortisation at 1 April	**439**	**484**
Provided during the year	45	34
Accumulated amortisation at 31 March	**484**	**518**
Net Book Value at 31 March	**98**	**65**

Software assets are carried at historic cost and amortised on a straight line basis over a period of five years. Software assets in use at the Trust have economic lives of between three and five years.

Note 11.1 Property, plant and equipment – 2017/18

Foundation Trust and Group	Total £000	Land £000	Buildings Excluding Dwellings £000	Assets Under Construction £000	Plant & Machinery £000	Information Technology £000	Furniture & Fittings £000
Valuation/gross cost at 1 April 2017	**96,552**	**2,020**	**62,538**	**270**	**26,575**	**4,410**	**739**
Additions - purchased	3,022	0	206	0	1,903	912	0
Additions - leased	82	0	0	0	82	0	0
Additions - assets purchased from cash donations/grants	164	0	0	0	164	0	0
Impairments	(140)	(140)	0	0	0	0	0
Reversals of impairments	1,230	0	1,230	0	0	0	0
Reclassifications	0	0	94	(94)	0	0	0
Revaluations	1,503	0	1,503	0	0	0	0
Disposals/derecognition	(1,075)	0	0	0	(1,075)	0	0
Valuation/Gross cost at 31 March 2018	**101,338**	**1,880**	**65,571**	**176**	**27,649**	**5,322**	**739**
Accumulated depreciation at 1 April 2017	**15,852**	**0**	**0**	**0**	**13,333**	**2,236**	**283**
Provided during the year	4,827	0	1,618	0	2,397	769	43
Reversals of impairments	(1,618)	0	(1,618)	0	0	0	0
Revaluations	0	0	0	0	0	0	0
Disposals/derecognition	(1,071)	0	0	0	(1,071)	0	0
Accumulated depreciation at 31 March 2018	**17,990**	**0**	**0**	**0**	**14,659**	**3,005**	**326**

Note 11.2 Property, plant and equipment – 2016/17

Foundation Trust and Group	Total £000	Land £000	Buildings excluding dwellings £000	Assets Under Construction £000	Plant & Equipment £000	Information Technology £000	Furniture & fittings £000
Valuation/Gross cost at 1 April 2016	**91,190**	**2,820**	**59,992**	**766**	**23,038**	**3,835**	**739**
Additions - purchased	9,992	0	5,696	92	3,629	575	0
Impairments	(4,950)	(800)	(4,150)	0	0	0	0
Reversals of impairments	412	0	412	0	0	0	0
Reclassifications	0	0	588	(588)	0	0	0
Disposals	(92)	0	0	0	(92)	0	0
Valuation/Gross cost at 31 March 2017	**96,552**	**2,020**	**62,538**	**270**	**26,575**	**4,410**	**739**
Accumulated depreciation at 1 April 2016	**13,105**	**0**	**0**	**0**	**11,332**	**1,536**	**237**
Provided during the year	4,307	0	1,492	0	2,069	700	46
Reversals of impairments	(1,492)	0	(1,492)	0	0	0	0
Disposals	(68)	0	0	0	(68)	0	0
Accumulated depreciation at 31 March 2017	**15,852**	**0**	**0**	**0**	**13,333**	**2,236**	**283**

Note 11.3 Property, plant and equipment financing

Foundation Trust and Group Net book value 31 March 2018	Total £000	Land £000	Buildings excluding dwellings £000	Assets Under Construction £000	Plant & Equipment £000	Information Technology £000	Furniture & Fittings £000
Owned	**81,231**	**1,880**	**65,571**	**176**	**10,901**	**2,318**	**385**
Finance lease	**82**	0	0	0	82	0	0
Owned - donated	**2,035**	0	0	0	2,007	0	28
Total net book value at 31 March 2018	**83,348**	**1,880**	**65,571**	**176**	**12,990**	**2,318**	**413**
Net book value 31 March 2017	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Owned	**78,593**	**2,020**	**62,538**	**270**	**11,195**	**2,144**	**426**
Finance lease	30	0	0	0	0	30	0
Owned - donated	2,077	0	0	0	2,047	0	30
Total net book value at 31 March 2017	**80,700**	**2,020**	**62,538**	**270**	**13,242**	**2,174**	**456**

The Trust's land and buildings comprise the hospital site on Lower Lane, Fazakerley, Liverpool. The main hospital building was built in 1998 and the Sid Watkins Building was completed in December 2014. The site was revalued as at 31 March 2018 by Gerald Eve LLP as disclosed in Note 1.

Note 11.4 Economic life of property, plant and equipment

Foundation Trust and Group	Min Life Years	Max Life Years
Buildings excluding dwellings	41	55
Assets under construction & POA	0	0
Plant & machinery	5	15
Information technology	3	10
Furniture & fittings	5	25

Note 12 Other investments

31-Mar-17 £000	Foundation Trust and Group	31-Mar-18 £000
733	**Carrying value of investments at 1 April**	**836**
113	Acquisitions in the year	136
111	Fair value movements taken to other comprehensive income for available for sale financial assets	(15)
(121)	Disposals	(145)
836	**Carrying value of investments at 31 March**	**812**

Note 13.1 Inventories

31-Mar-17 £000	Foundation Trust and Group	31-Mar-18 £000
1,986	Consumables	1,210
1,986	**TOTAL Inventories**	**1,210**

Note 13.2 Inventories recognised in expenses

31-Mar-17 £000	Foundation Trust and Group	31-Mar-18 £000
9,905	Inventories recognised in expenses	10,922
6	Write-down of inventories recognised as an expense	27
9,911	**TOTAL Inventories recognised in expenses**	**10,949**

Note 14.1 Trade receivables and other receivables

31-Mar-17			31-Mar-18	
Foundation Trust £000	Group £000	Current	Foundation Trust £000	Group £000
1,277	1,277	Trade Receivables	2,819	2,819
(374)	(374)	Provision for impaired receivables	(1,260)	(1,260)
995	995	Prepayments (revenue)	554	554
2,990	2,990	Accrued income	4,930	4,930
94	94	PDC dividend receivable	0	0
39	39	VAT receivable	162	162
1,758	1,396	Other receivables	1,446	1,413
0	0	NHS charitable funds: trade and other receivables	0	15
6,779	**6,417**	**TOTAL CURRENT TRADE AND OTHER RECEIVABLES**	**8,651**	**8,633**
3,058	3,058	Of which receivables from NHS and DHSC group bodies	4,921	4,921

Note 14.2 Provision for impairment of receivables

31-Mar-17 £000	Foundation Trust and Group	31-Mar-18 £000
262	**At 1 April**	**374**
277	Increase in provision	1,105
(7)	Amounts utilised	(37)
(158)	Unused amounts reversed	(182)
374	**At 31 March**	**1,260**

Note 14.3 Analysis of impaired receivables

Foundation Trust and Group	31-Mar-18 £000 Trade and other receivables	31-Mar-17 £000 Trade and other receivables
Ageing of impaired financial assets		
0-30 days	893	0
30-60 days	0	0
60-90 days	0	0
90-180 days	0	0
Over 180 days	367	374
Total	**1,260**	**374**
Ageing of non-impaired financial assets past their due date		
0-30 days	2,082	1,017
30-60 days	59	279
60-90 days	182	19
90-180 days	187	383
Over 180 days	0	85
Total	**2,510**	**1,783**

Note 15 Cash and cash equivalents

31-Mar-17 Foundation Trust £000	31-Mar-17 Group £000		31-Mar-18 Foundation Trust £000	31-Mar-18 Group £000
9,487	**10,008**	**At 1 April**	**11,728**	**12,678**
2,241	2,670	Net change in year	5,441	5,016
11,728	**12,678**	**At 31 March**	**17,169**	**17,694**
		Comprising:		
56	56	Cash at commercial banks and in hand	20	545
11,672	12,622	Cash with the Government Banking Service	17,149	17,149
11,728	**12,678**	**Cash and cash equivalents as in SoFP**	**17,169**	**17,694**
11,728	**12,678**	**Cash and cash equivalents as in SoCF**	**17,169**	**17,694**

Note 16 Trade and other payables

31-Mar-17 Foundation Trust £000	31-Mar-17 Group £000		31-Mar-18 Foundation Trust £000	31-Mar-18 Group £000
		Current		
4,725	4,725	Trade payables	4,895	4,895
2,438	2,438	Capital payables (including capital accruals)	1,290	1,290
689	689	Social security costs	701	701
637	637	Other taxes payable	661	661
1,381	1,381	Other payables	2,529	2,529
4,958	4,958	Accruals (revenue costs only)	5,273	5,273
0	0	PDC dividend payable	21	21
192	192	Accrued interest on DH loans	200	200
0	39	NHS charitable funds: trade and other payables	0	26
15,020	**15,059**	**TOTAL CURRENT TRADE AND OTHER PAYABLES**	**15,570**	**15,596**
1,571	1,571	Of which payable to NHS and DHSC group bodies	2,652	2,652

Note 17 Borrowings

31-Mar-17 £000	Foundation Trust and Group	31-Mar-18 £000
	Current	
1,131	Capital loans from the Department of Health	1,263
34	Obligations under finance leases	30
1,165	**TOTAL CURRENT BORROWINGS**	**1,293**
	Non-current	
29,086	Capital loans from the Department of Health	27,823
12	Obligations under finance leases	64
29,098	**TOTAL OTHER NON CURRENT LIABILITIES**	**27,887**

Note 18.1 Provisions for liabilities and charges

	Current		Non-current	
Foundation Trust and Group	**31-Mar-18**	**31-Mar-17**	**31-Mar-18**	**31-Mar-17**
	£000	**£000**	**£000**	**£000**
Pensions - early departure costs	28	27	267	276
Other legal claims	28	24	0	0
Other	241	241	0	0
Total	**297**	**292**	**267**	**276**

Note 18.2 Analysis of provisions for liabilities and charges

Foundation Trust and Group	Total	Pensions - early departure costs	Legal claims	Other
	£000	£000	£000	£000
At 1 April 2017	**568**	**303**	**24**	**241**
Change in the discount rate	19	19	0	0
Arising during the year	34	0	34	0
Utilised during the year - cash	(54)	(28)	(26)	0
Reversed unused	(4)	0	(4)	0
Unwinding of discount rate	1	1	0	0
At 31 March 2018	**564**	**295**	**28**	**241**
Expected timing of cash flows:				
- not later than one year	297	28	28	241
- later than one year and not later than five years	110	110	0	0
- later than five years	157	157	0	0
TOTAL	**564**	**295**	**28**	**241**

The pension provision relates to the anticipated costs for the enhanced element of ill-health pensions for former employees. These entitlements are explained in Note 4.

The provision for legal charges is in respect of legal claims accounted for as described in the accounting policies in Note 1. The figures are provided by NHS Resolution.

£39,416,618 (2016/17: £20,610,626) is included in the provisions of NHS Resolution at 31 March 2018 in respect of clinical negligence liabilities of the Trust.

The other provision relates to claims for potential underpayments in respect of salaries to doctors on call where the incorrect rate may have been paid in the past. The provision has been reduced following confirmation that only Deanery trainees would have the right to claim.

Note 19 Other liabilities

31-Mar-17 £000	Foundation Trust and Group	31-Mar-18 £000
550	Deferred income	512
550	**TOTAL OTHER CURRENT LIABILITIES**	**512**

Note 20 Contingencies

The Trust has £21,663 contingent liabilities relating to NHS Resolution cases as at 31 March 2018 (2016/17: £11,405). There have been no contingent assets or other contingent liabilities recognised at 31 March 2018 (2016/17: nil).

Note 21 Revaluation reserve

Foundation Trust and Group	Total revaluation reserve £000	Property, plant and equipment £000
Revaluation Reserve at 1 April 2017	**732**	**732**
Net impairments	2,058	2,058
Revaluations	1,503	1,503
Revaluation reserve at 31 March 2018	**4,293**	**4,293**

Foundation Trust and Group	Total revaluation reserve £000	Property, plant and equipment £000
Revaluation Reserve at 1 April 2016	**4,472**	**4,472**
Impairments	(3,740)	(3,740)
Revaluation reserve at 31 March 2017	**732**	**732**

The impairments, reversals and revaluations relate to the impact of the land and building valuation on The Walton Centre carried out by Gerald Eve LLP as at 31 March 2018.

Note 22 Capital Commitments

At 31 March 2018 the Trust had capital commitments of £280,572 (31 March 2017: £1,228,784) in relation to orders for capital items.

Note 23.1 Financial instruments

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with its commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Trust has considered its exposure to the following financial risks:

- **Currency Risk** – the Trust has no overseas operations and the majority of transactions are sterling based. Foreign currency transactions arise from purchases of equipment and supplies from overseas providers and a small proportion of charitable investments. However, these are not significant in value or number of transactions and the Trust therefore has low exposure to currency rate fluctuations;

- **Interest Rate Risk** – the Trust has loans for its capital expansion programme. However, these are at fixed rates with the Independent Trust Financing Facility. The Trust therefore has low exposure to interest rate fluctuations;

- **Credit Risk** – the majority of the Trust's revenue is from contracts with other public sector bodies. The Trust holds significant cash balances but these are also held through the Government Banking Service. Therefore the Trust has low exposure to credit risk. The Charity uses a commercial bank but its cash balances are not material to the Group. The Charity's investments are managed through external investment managers. Investments are held in UK fixed interest bonds and a wide portfolio of UK investments. The maximum exposure on receivables at 31 March 2018 is disclosed in Note 14 Trade Receivables and Other Receivables; and

- **Liquidity Risk** – the Trust's operating costs are incurred principally under contracts with commissioners. Capital expenditure is funded principally for the provision of public sector services. The Trust is not exposed to significant liquidity risk.

Note 23.2 Fair value of non-current financial assets

The Charity held investments at 31 March 2018 with a fair value of £812,365 (31 March 2017: £836,015). The book value of these assets is £682,204 (31 March 2017: £685,421).

Note 23.3 Financial assets by category

	Foundation Trust		Group		
	Total carrying value	Loans and receivables	Total	Loans and receivables	Available for sale
	£000	£000	£000	£000	£000
Assets per Statement of Financial Position at 31 March 2018					
Trade and other receivables (excluding non-financial assets) - with NHS and DH bodies	**5,511**	5,511	**5,511**	5,511	0
Trade and other receivables (excluding non-financial assets) - with other bodies	**2,006**	2,006	**1,988**	1,988	0
Cash and cash equivalents at bank and in hand	**17,169**	17,169	**17,169**	17,169	0
Consolidated NHS charitable fund financial assets	**0**	0	**1,337**	525	812
Total as at 31 March 2018	**24,686**	**24,686**	**26,005**	**25,193**	**812**
Assets per Statement of Financial Position at 31 March 2017					
Trade and other receivables (excluding non-financial assets) - with NHS and DH bodies	**3,026**	3,026	**3,026**	3,026	0
Trade and other receivables (excluding non-financial assets) - with other bodies	**2,274**	2,274	**1,914**	1,914	0
Cash and cash equivalents at bank and in hand	**11,728**	11,728	**11,728**	11,728	0
Consolidated NHS charitable fund financial assets	**0**	0	**1,786**	950	836
Total as at 31 March 2017	**17,028**	**17,028**	**18,454**	**17,618**	**836**

Note 23.4 Financial liabilities by category

	Foundation Trust		Group	
	Total	Other financial liabilities	Total	Other financial liabilities
	£000	£000	£000	£000
Liabilities per Statement of Financial Position at 31 March 2018				
Borrowings excluding Finance lease and PFI liabilities	**29,086**	29,086	**29,086**	29,086
Obligations under finance leases	**94**	94	**94**	94
Trade and other payables (excluding non-financial liabilities) - with NHS and DH bodies	**4,066**	4,066	**4,066**	4,066
Trade and other payables (excluding non-financial liabilities) - with other bodies	**7,889**	7,889	**7,915**	7,915
Total at 31 March 2018	**41,135**	**41,135**	**41,161**	**41,161**
Liabilities per Statement of Financial Position at 31 March 2017				
Borrowings excluding Finance lease and PFI liabilities	**30,217**	30,217	**30,217**	30,217
Obligations under finance leases	**45**	45	**45**	45
Trade and other payables (excluding non-financial liabilities) - with NHS and DH bodies	**2,566**	2,566	**2,566**	2,566
Trade and other payables (excluding non-financial liabilities) - with other bodies	**9,840**	9,840	**9,879**	9,879
Total at 31 March 2017	**42,668**	**42,668**	**42,707**	**42,707**

Note 24 Events after the statement of financial position date

The Directors are not aware of any event after the Statement of Financial Position date and up to the date that the financial statements were approved which will affect the accounts.

Note 25 Public dividend capital

NHS Trusts are required to pay a dividend of 3.5% of their average net relevant assets to the Department of Health. This is calculated on a full financial year. The dividend is payable in two instalments in September and March.

Note 26 Third party balances

At 31 March 2018 the Trust held £916 on behalf of patients (31 March 2017: £516).

Note 27 Related party transactions

The Walton Centre NHS Foundation Trust is a public interest body authorised by NHS Improvement, the Independent Regulator for NHS Foundation Trusts. During the period none of the Board members or members of the key management staff, or parties related to them, has undertaken any material transactions with The Walton Centre NHS Foundation Trust.

The Department of Health and Social Care is a related party as the parent department of the Trust. During the period The Walton Centre NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

- NHS England;
- Health Education England;

- NHS Liverpool CCG;
- NHS South Sefton CCG;
- NHS Warrington CCG;
- NHS Wirral CCG;
- Aintree University Hospital NHS Foundation Trust;
- Royal Liverpool and Broadgreen University Hospitals NHS Foundation Trust; and
- NHS Resolution.

In addition the Trust has had material transactions with the following central government body:

- Welsh Assembly Government including all Welsh Health bodies.

In 2012/13, Liverpool Health Partners Ltd, a company limited by guarantee, was set up between the University of Liverpool, Aintree University Hospital NHS FT, Alder Hey Children's NHS FT, The Clatterbridge Cancer Centre NHS FT, Royal Liverpool and Broadgreen University Hospitals NHS Trust, Liverpool Women's NHS FT, The Walton Centre NHS FT, Liverpool Heart and Chest NHS FT and Liverpool School of Tropical Medicine. The objects of the company are to advance education, health, learning and research by facilitating world class research among the partners. Each organisation has a single share in the company and the Chief Executives are ex-officio directors of the company. A contribution of £80,000 (2016/17: £80,000) was made to the company to enable it to carry out its objectives.

The Trust's Council of Governors comprise 17 elected Governors, 4 staff Governors and 12 appointed Partnership Governors. Governors are drawn from a range of stakeholders including patient groups, neurological charities, research and academic groups, CCGs, Local Authorities, NHS England and Wales. Therefore, many, by the nature of their appointment, have interests in organisations with whom the Trust contracts. A register of interests is maintained and declarations of interests are given at each Governor meeting.

Since 2013/14 the Trust has included The Walton Centre Charity as a subsidiary because the Trust has the power to govern the financial and operating policies of the Fund so as to obtain benefits from its activities for itself, its patients or its staff. Transactions between the Trust and the Charity are not material and are eliminated on consolidation. Assets held by the Charity are to be used for charitable purposes only.

The financial activity of the Charity during 2017/18 and its balance sheet at 31 March 2018 are summarised as:

Summary statement of financial activities	**2017/18 £'000**	**2016/17 £'000**
Operating income (incoming resources including investment income)	466	2,591
Operating expenditure	(544)	(2,499)
Net (outgoing)/incoming resources before other recognised gains and losses	**(78)**	**92**
Fair value gains/(losses) on investments (available for sale financial assets only)	(15)	111
Net movement in funds	**(93)**	**203**

Summary balance sheet	**31-Mar-18 £'000**	**31-Mar-17 £'000**
Non-current assets		
Other investments/financial assets	812	836
Total non-current assets	**812**	**836**
Current assets		
Trade and other receivables	15	0
Cash and cash equivalents	525	950
Total current assets	**540**	**950**
Current liabilities		
Trade and other payables	(59)	(400)
Total current liabilities	**(59)**	**(400)**
Total net assets	**1,293**	**1,386**
Restricted funds	0	0
Unrestricted funds	1,293	1,386
Total funds	**1,293**	**1,386**

Note 28 Losses and special payments

During the period the Trust made 17 (2016/17: 18) special payments with a total value of £27,916 (2016/17: £7,463). Of these £23,057 (2016/17: £3,375) related to payments in respect of 5 (2016/17: 4) claims by third parties which are handled by NHS Resolution. The Trust also wrote off 5 (2016/17: 21) debts with a total value of £37,292 (2016/17: £7,182) and £26,677 (2016/17: £6,168) of stock items due to loss, damage or expiry.

Independent Practitioner's Limited Assurance Report to the Council of Governors of The Walton Centre NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Walton Centre NHS Foundation Trust to perform an independent limited assurance engagement in respect of The Walton Centre NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and additional supporting guidance in the 'Detailed requirements for quality reports 2017/18' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

We refer to these national priority indicators collectively as the 'Indicators'.

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2017/18'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2017/18'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance, and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period 1 April 2017 to April 2018;
- papers relating to quality reported to the Board over the period 1 April 2017 to April 2018;
- feedback from commissioners dated May 2018;

- feedback from governors dated 14 December 2017 to 13 March 2018;
- feedback from local Healthwatch organisations dated May 2018;
- feedback from the Overview and Scrutiny Committee dated May 2018;
- the Trust's complaints report published under regulation 18 of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009, due to be published in June 2018;
- the national staff survey dated March 2018;
- the Care Quality Commission inspection report dated April 2016; and
- the Head of Internal Audit's annual opinion over the Trust's control environment dated April 2016.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of The Walton Centre NHS Foundation Trust as a body, to assist the Council of Governors in reporting The Walton Centre NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body, and The Walton Centre NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed
We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- making enquiries of management
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations
Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques that can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by The Walton Centre NHS Foundation Trust.

Our audit work on the financial statements of The Walton Centre NHS Foundation Trust is carried out in accordance with our statutory obligations. This engagement will not be treated as having any effect on our separate duties and responsibilities as The Walton Centre NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to The Walton Centre NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to The Walton Centre NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of The Walton Centre NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than The Walton Centre NHS Foundation Trust and The Walton Centre NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion
Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the ‘NHS foundation trust annual reporting manual 2017/18’ and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement’s 'Detailed requirements for external assurance for quality reports 2017/18’; and
- the indicators in the Quality Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2017/18' and supporting guidance.

Grant Thornton UK LLP

Grant Thornton UK LLP
Chartered Accountants
Liverpool

29 May 2018