NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Annual Report and Accounts 2016/2017






Quality first and foremost

Bridgewater Community Healthcare NHS Foundation Trust

Annual Report and Accounts 2016/17

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Contents

1. Statement from Chairman and Chief Executive

We are delighted to present the Annual Report and Accounts for Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) for the period 1 April 2016 to 31 March 2017.

This year has seen a number of changes to the services that we provide. On 1 April, we welcomed the staff working in Children's services across Oldham. During the year, we were informed that we had been successful in the tender to provide healthcare services in HMPs Garth and Wymott, testament to our strong track record in other secure establishments and our ongoing partnership with Greater Manchester Mental Health NHS Foundation Trust who provide the mental health care element of the service. We also found out that we had not been successful in retaining adult community nursing services in St Helens and very sadly have had to say goodbye to colleagues transferring to the new provider. We wish them well for the future as a vital part of the local Clinical Commissioning Group (CCG)'s preferred model of care integrated vertically between hospitals and the community.

In early June 2016, we were visited by colleagues from the Care Quality Commission (CQC) for our first full inspection since becoming a Foundation Trust. Our report was published in February 2017 with an overall rating of 'requires improvement'. The CQC measured 40 domains in total, across eight service groupings, with one rated as outstanding, 27 as good and 12 as requires improvement. It has been heartening to see the dedication of our staff in making a number of changes to our services in response to the CQC's comments. We continually strive to improve the quality of care and experience for patients. Details of the progress we have made this year in this regard are available in the 2016/17 Quality Report, contained within this document.

In November 2016, in partnership with Liverpool GP Provider Federation and Liverpool City Council we were delighted to be named as the preferred provider for Liverpool's community health services following a very involved and demanding transaction process led by NHS Improvement (NHSI). However, following this decision, NHSI recognised that there are significant issues that continue to exist around Liverpool's community health services that would benefit from locally based leadership and management. They therefore decided not to proceed with the transaction. NHSI has fundamentally confirmed that it has no quality concerns regarding our organisation and the services that we provide.

Like other public sector bodies, this year has been challenging for us as we continue to face tough financial conditions alongside an increasing demand for services. We are delighted to report that the Trust met its financial obligations and finished the year in surplus, a tremendous achievement in the current NHS climate. We remain committed to providing leading healthcare services that offer the best value for money for taxpayers, whilst reforming what we do, in partnership with others.

We are incredibly proud of our staff here at Bridgewater, and the progress that they have achieved this year. We look forward to continuing the work towards developing our services to ensure that they reflect the needs of our communities and deliver the best possible care for our patients.

Colin Scales

Chief Executive Officer

Harry Holden

Chair

2. Performance Report

2.1 Overview of Performance

The purpose of the overview is to give a short summary to provide sufficient information to understand our organisation, its purpose and the key risks to the achievement of its objectives and how it has performed during the year.

Chief Executive's statement

2016-17 has been an exciting year in the development of the Trust. Over the course of the year, I have been privileged to work with staff who wholeheartedly share the Trust's aim to improve the health and wellbeing of the people we serve. This is reflected in the consistently good reports we receive about the quality of our services from our stakeholders, with patient feedback overwhelmingly positive about the services we offer.

In terms of performance, this year has seen the Trust maintain its achievement of performance against its statutory waiting times targets for referral to treatment, cancer waiting times and A&E targets. However, like other providers nationally, Bridgewater has found the increasing demand of patients attending our A&E-type provisions has presented a challenge for us to achieve our access and treatment targets. In quarter four the trust has overcome some of the challenges it experienced in the earlier part of the year in relation to access standards which in quarter four have been fully achieved against the Single Oversight Framework objectives.

In common with the wider NHS, this year has been challenging in financial terms, and we have seen our Use of Resources rating, used by the regulator NHS Improvement (NHSI), improve over the year. I am proud to report that the Trust hit its year-end financial target despite the challenges it faced, and has declared a surplus, a tremendous achievement in the the context of also meeting our performance challenges and maintaining quality. Whilst the situation remains challenging, the Trust finds itself in a more robust position at the start of 2017-18

I am proud of the achievements Bridgewater has made this year. This stands the Trust in excellent stead to continue to deliver its aims throughout the coming year.

Profile of the Trust

Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) is a leading provider of community health services in the North West of England. We are focused on delivering healthcare in the heart of the community, in settings including patients' homes, clinics, health centres, GP practices, community centres and schools.

We are an expert provider of out of hospital care and one of the largest UK employers of healthcare staff in community settings. Our mission is to improve local health and wellbeing in the

communities we serve and we are working with our commissioners and partners to bring more care closer to home to ensure a sustainable NHS for current and future generations.

The services we provide by borough:

Bolton: Children's services and community dental

Halton: Adults' services, children's services and community dental

Oldham: Children's services

Salford: Health for justice services

Southport: Children's audiology[1]

St Helens: Adults' services[2], children's services[3], community dental and health for justice services

Tameside, Glossop, Stockport and Eastern Cheshire: Community dental

[1] Bridgewater will cease to provide Children's audiology services in Southport on 28 April 2017
[2] Adults' services will transfer to St Helens and Knowsley NHS Trust on 1 April 2017
[3] Children's services transferred to 5 Boroughs Partnership NHS Foundation Trust on 1 September 2016

Trafford: Community dental and sexual health[4]

Warrington: Adults' services, children's services, community dental, sexual health and offender health services

Western Cheshire: Community dental and Willaston GP practice

Wigan: Adults' services, children's services, community dental, and offender health services

We operate in a complex health and social care environment. We have a number of different commissioners including Clinical Commissioning Groups and Local Authorities plus some services commissioned by NHS England. Bridgewater was awarded NHS Foundation Trust status by Monitor on 1 November 2014. Through an active Council of Governors we support engagement with over 9600 public members from our local communities. The average Full Time Equivalent (FTE) and Headcount of our staff for the period 01 April 2016 – 31 March 2017 was 2486.65 FTE and Headcount 3259 – the majority of whom are staff members of our Foundation Trust.

Our income for the year 1 April 2016 to 31 March 2017 totalled £164.1m including £114.8m from Clinical Commissioning Groups and NHS England, £36.6m from local authorities, £2.1m from Health Education England and £2.2m from other NHS Foundation Trusts. The income from the provision of goods and services for the purposes of the health service in England is greater than our income from the provision of goods and services for any other purposes. (As per section 43(2a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012)).

Our Strategy for Health and Wellbeing 2015/16 to 2020/21

In 2015 we published "Our Strategy for Health and Wellbeing 2015/16 to 2020/21". The strategy focuses on four main themes:

- Connecting people - through supporting shared decision making and self-care and working with the wider community to enable more people to remain independent for longer
- Connecting places - we have established multi-disciplinary/multi agency teams in each of our boroughs to deliver joined up health and social care
- Connected technology - we have continued to roll out mobile electronic records across the boroughs we serve and are working with our partners to create electronic integrated health and care records
- Connected support - we are working with our partners in each borough to design a better way for how the NHS, social care and the voluntary sector work together – this will mean less duplication, more personalised care and a greater emphasis for patients on keeping well and to take more control of their lives

[4] Trafford sexual health service transferred to Central Manchester University Hospitals Foundation Trust on 16 September 2016

Over the last twelve months the NHS and social care have seen unprecedented demand for services and we must work together better in order to be able to continue to provide the care and support people need. Across Greater Manchester we have seen the ten local authorities and CCGs develop integrated plans and Bridgewater has been a major player in the Wigan locality plan. In 2016/17 Wigan received £15m in transformation funding from Greater Manchester, £4.4m of which was used to support our Integrated Community Services in the borough.

In Cheshire and Merseyside (and the rest of England), Sustainability and Transformation plans (STPs) have been produced which describe the financial challenges in the years ahead and what must be done to meet them whilst continuing to deliver the best possible health and care. Bridgewater has led on the design of an "out of hospital" model (this includes more community based care to keep people independent) across the boroughs of Halton, St Helens, Knowsley and Warrington. The model includes the four main themes listed above. During 2017/18, we will lead on the development of investment proposals in each of our towns that will help us to continue to deliver our strategy.

Key issues/risks

There is a growing demand for care as the population we serve is living longer, with an increasing prevalence of long term conditions such as diabetes, cancer, heart disease, lung disease and dementia.

The geography of Bridgewater includes some of the most deprived communities in England, with the associated health and lifestyle challenges.

Current spending forecasts suggest that the significant financial pressures we currently face are likely to remain for the foreseeable future.

The NHS Five Year Forward View, published by NHS England in 2014, describes a view on why change is needed and recommends that more attention should be given to prevention and public health; patients should be given far greater control of their own care and breaking down barriers to the provision of more joined-up health and social care services.

Going Concern

The financial statements have been prepared on a going concern basis. Commissioner intentions for 2017/18 are documented and contracts have been signed for the Trust's planned income stream for 2017/18 and in the case of NHS contracts for 2018/19 as well. A detailed paper was reviewed by the Finance and Investment Committee on 19 May 2017 and subsequently by the Audit Committee on 24 May 2017. This paper set out the key financial indicators drawn from the Trust's Annual Finance Plan for 2017/18. These indicators show:

- An improving Statement of Comprehensive Income deficit position from an indicative outturn of £0.6m, excluding additional amounts for STF incentive and bonus payments

which were not confirmed until 24 April 2017, for 2016/17, improving to a planned deficit of £0.5m in 2017/18.

- A positive cash balance throughout the year rising to £2.1m by 31 March 2018.
- A Use of Resources Risk Rating (UOR) score of 2 by the end of 2017/18, which confirms the Trust's financial position as of minor concern from a regulatory perspective.

The Committee and Board considered any material uncertainties which might impact the 'going concern' basis and concluded that there were none to report.

2.2 Performance Analysis

Effective performance management is critical to Bridgewater's ambition to become a high performing Foundation Trust which is financially viable, well governed and consistently compliant with the terms of its authorisation.

As part of the governance requirements of being a Foundation Trust and to provide clarity throughout the organisation on accountabilities and responsibilities, a strategy has been developed. This ensures that an integrated approach to managing performance is taken and there is clear visibility and lines of accountability from the Board down through to service level with the aim of providing internal and external assurance.

A set of balanced scorecards have been adopted that set out how metrics contribute to both the delivery of the strategic objectives and the Darzi domains of high quality care. Further development work will need to be undertaken during 2017/18 to review all service level metrics particularly in relation to quality and outcome measures reporting at service level.

In addition, a set of supporting metrics and outcomes measures provide focused intelligence at a service line, team and individual level in order to create a clear and consistent picture of quality, financial and operational performance and to support any service level intervention.

On a quarterly basis the Executive Management Team focuses on a full review of the current performance position reviewing exceptions, risk and variation. Assurance is gained via the Senior Operations Team management of 'standardised improvement and recovery plans' and a formal 'escalation log'. There is also the option to bring the Area Management Team into the meeting to account for their current position. The over-arching management of all recovery plans will be reported via the relevant lead Director to the formal committees of the Trust Board.

A standardised remedial action planning process will be used for all metrics that are off track and formulated into a clear improvement and recovery plan.

A monthly Integrated Performance Report (IPR) is presented at the Board meeting to provide a high level summary of the organisational performance against exceptions and discuss the mitigating actions in place. This also supports the organisational reassurance process. A copy of the IPR is made available to the general public via the internet.

The Corporate Information Performance Management Strategy is set within the overall strategic planning and contracting cycle and these plans drive the priorities and objectives for delivery with clearly articulated monitoring arrangements.

Organisation and Director Team Objectives 2016-17

Strategic Objectives

Quality – to deliver high quality, safe and effective care which meets both individual and community needs
Innovation and collaboration- to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living
Sustainability – to deliver value for money, be financially viable and be commercially successful
People – to be a highly effective organisation with empowered, highly skilled and competent staff

Corporate Objectives

Quality (Leads: Chief Nurse and Medical Director)
- We will deliver safe and effective patient care
- We will deliver a positive experience of our services for patients
- We will play our part in reducing health inequalities by making it integral to all service developments and delivery
- We will ensure we continue to develop our clinical teams and support them through revalidation

Innovation & Collaboration (Lead: Director of Strategic Development)
- We will effectively manage and develop our relationships with our commissioners and stakeholders
- We will defend and grow our core business
- We will lead the delivery of out of hospital integrated care
- We will deliver transformation supported by innovation and robust business intelligence

Sustainability (Lead: Director of Finance)
- We will optimise the use of our resources including our estate and facilities
- We will effectively manage our finances effectively and ensure they are well governed
- We will deliver our efficiency programme fully
- We will deliver to the expectations of our commissioners and demonstrate value and quality

People (Lead: Director of People and Organisational Development)
- We will further develop and maintain a competent, caring and flexible workforce
- We will continuously develop the organisation capability including leadership at every level of the organisation
- We will effectively engage with our staff to deliver our strategic objectives
- We will engage effectively with the patients and the communities we serve

Cross-cutting Objectives (Leads: All Executives)
- We will be a well-led organisation with fit for purpose structures and business processes in line with the expectations of our regulator
- We will ensure we effectively prepare for our next CQC inspection and learn any lessons from that process as part of our continual learning process
- We will ensure that the delivery of sustainable clinical services is supported by effective corporate services

Operations Specific Objectives (Leads: Area Directors)
- We will meet our obligations to deliver those statutory and mandatory targets and the planning guidance 'must dos' set out nationally.

Director Team Objectives

- Grow our reputation for delivering high quality services
- Build and develop the team
- Formulate and deliver the Trust's strategy
- Develop and improve organisational capability and culture
- Contribute to the delivery of clinical and financial sustainability in/of the systems in which we operate
- Promote measurement as a basis of decision making

Director Team Operating Principles

As a team we will hold each other to account so that we always :
- Work as a team
- Work in the best interests of patients
- Trust and support you and each other to do our best
- Build plans that affect you, with you
- Listen to you and each other
- Recognise everybody's contribution and support you and each other to do even better

Progress against our Strategic Objectives

During 2016/17, we had four strategic objectives, which we have continued to work towards during the course of the year. Some examples of how we have done this are described below:

Strategic Objective: To deliver high quality, safe and effective care which meets both individual and community needs.

- On 1 April 2016, Bridgewater started to deliver school nursing, health visiting and family nurse partnership services in Oldham as part of an innovative new service called Right Start, following the award of a contact by Oldham Council. The Trust also delivers oral health services in the town.
- Bridgewater's Willaston Surgery was been rated as good by the healthcare regulator the CQC. The CQC visited the GP practice, which is located in the village of Willaston on The Wirral, as part of their routine inspection programme in August 2016. They reported that patients were positive about their care with their needs assessed and treatment planned in line with best practice. Staff were well supported and systems were in place to reduce risk and ensure safety.
- Our urgent care services continued to support our local health economies by providing high quality care alternatives to accident and emergency. During 2016/17 our Urgent Care Centre in Widnes and NHS Walk-in Centres in Leigh and St Helens helped alleviate some of the strain on local hospitals by assessing and treating a total of 167,000 patients.
- In February 2017 the Trust welcomed the publication of the Care Quality Commission report, following an inspection of our services during May and June 2016. The overall rating was requires improvement but at the time of publication the Trust could demonstrate a range of actions to strengthen services since the inspection eight months ago. The CQC measured 40 domains in total, across eight service groupings, with one rated as outstanding, 27 as good and 12 as requires improvement.

Strategic Objective: To deliver innovative and integrated care close to home which supports and improves health, wellbeing and independent living.

- In Wigan Community nurses and other health professionals are working with social workers as part of a new single team to improve care and support for local patients. Wigan Integrated Community Services launched in October 2016 to make it easier to coordinate care and services for patients. This programme involves Bridgewater working with Wigan Borough Clinical Commissioning Group, Wrightington, Wigan and Leigh NHS Foundation Trust, Wigan Council and 5 Boroughs Partnership NHS Foundation Trust to deliver the new-look service.
- Bridgewater launched a new integrated 0-19 children and young people's service in Warrington. Launched in partnership with Warrington Borough Council, this involves staff from health visiting, school nursing, oral health improvement, the family nurse partnership and immunisation and national child measurement programme working more closely together to deliver an improved service for patients and families.

Strategic Objective: To deliver value for money, be financially sustainable and be commercially competitive.

- We launched operational and strategic plans for our boroughs covering the key challenges we are facing and our immediate operational priorities for the present year.
- We were successful in winning the tenders for prison health services for HMP Garth and HMP Wymott as part of a partnership with Greater Manchester Mental Health NHS Foundation Trust. This contract is due to commence on 1 April 2017.
- Our IT team rolled out the mobile electronic patient record to more services during the year, helping our staff keep patient records up-to-date whilst out and about in the community and saving time on administration tasks.
- Bridgewater engaged staff in an It All Counts campaign to generate momentum for the Trust's financial recovery plan. The main focus being to reduce non-pay expenditure by cutting down on non-essential travel and reviewing procurement of equipment and medical supplies to reduce waste. A Bridgewater Equipment Swap Shop was set up allowing teams advertise spare equipment and supplies.

Strategic Objective: To be a highly effective organisation with empowered, highly skilled and competent staff

The Improvement and Organisational Development Team offer various Leadership Development programmes to support staff in Bridgewater in their leadership capacity.

A number of staff also access NHS Academy leadership programmes such as Elizabeth Garrett Anderson, Nye Bevan, Mary Seacole and Board level developments.

Internally, leadership development is currently provided as follows:

- Leadership Development programme for Band 7 Team Leaders (ILM accredited)
- Leadership development support for Band 6 staff awaiting SPQ
- Trust wide programme "Leading at the Speed of Trust"
- Team Journey – developing cohesive high performing teams through team leadership
- Compassion IN leadership approach
- System leadership for Wigan Borough
- System Leadership for Warrington Borough
- Talent plan in development

Financial Performance for 2016/17

The Trust's accounts have been prepared under a direction issued by Monitor under the National Health Service Act 2006.

For the financial reporting year ended 31 March 2017, Bridgewater has reported a headline surplus of £2.1m, though the underlying operating deficit was £2.0m and this is the same figure as in the summarisation schedules that underpin the accounts.

Accounting Policies

The accounts have been prepared to comply with International Financial Reporting Standards (IFRS) as modified by the Foundation Trust Annual Reporting Manual, published by NHS Improvement.

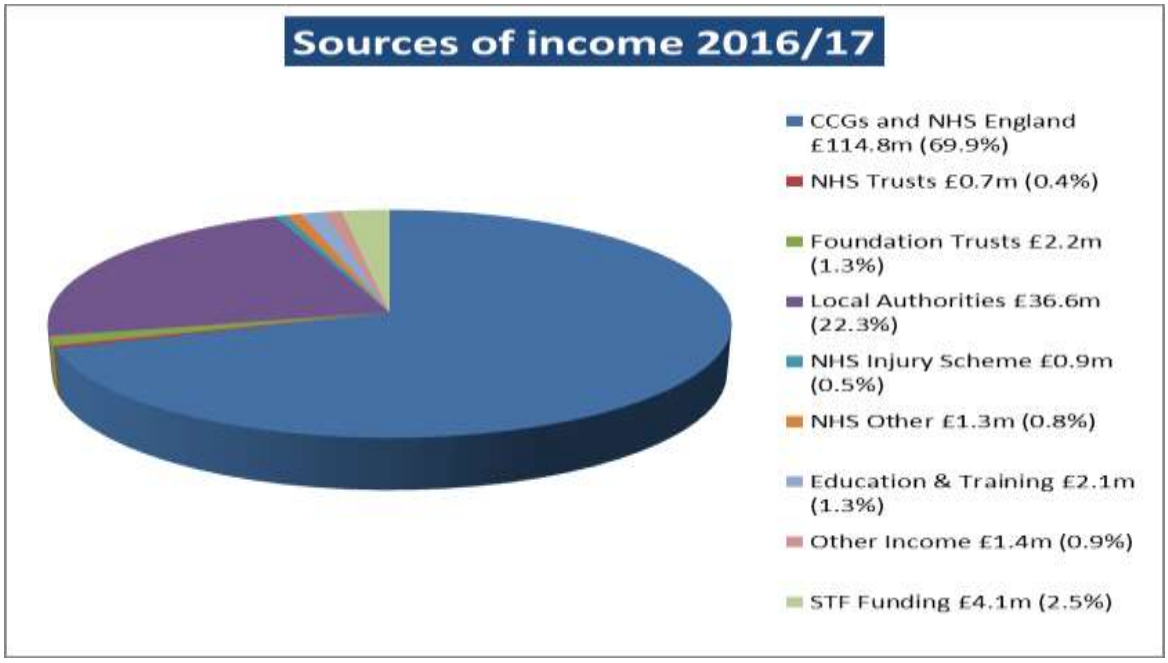
Capital Expenditure

The Trust incurred capital expenditure in 2016/17 of £2.5m, split between community home loan equipment £1.5m, IT investment and other equipment £1.0m.

Income

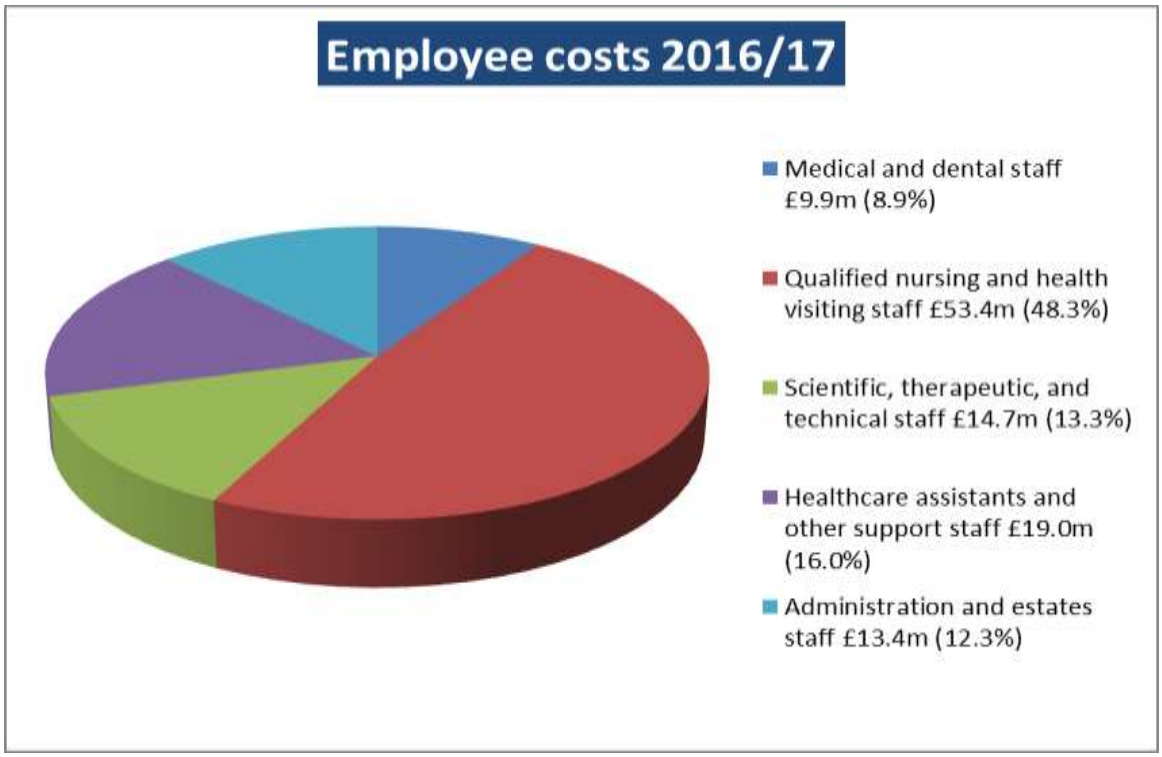
The Trust generated income in the accounting period of £164.1m. Income derived from Clinical Commissioning Groups (CCGs) and NHS England was £114.8m. The vast majority of the Trust's healthcare income is through 'block service level agreements'.

The Trust's income was generated as shown in the chart below, which highlights the categorisation of all the Trust's income taken from the accounts.

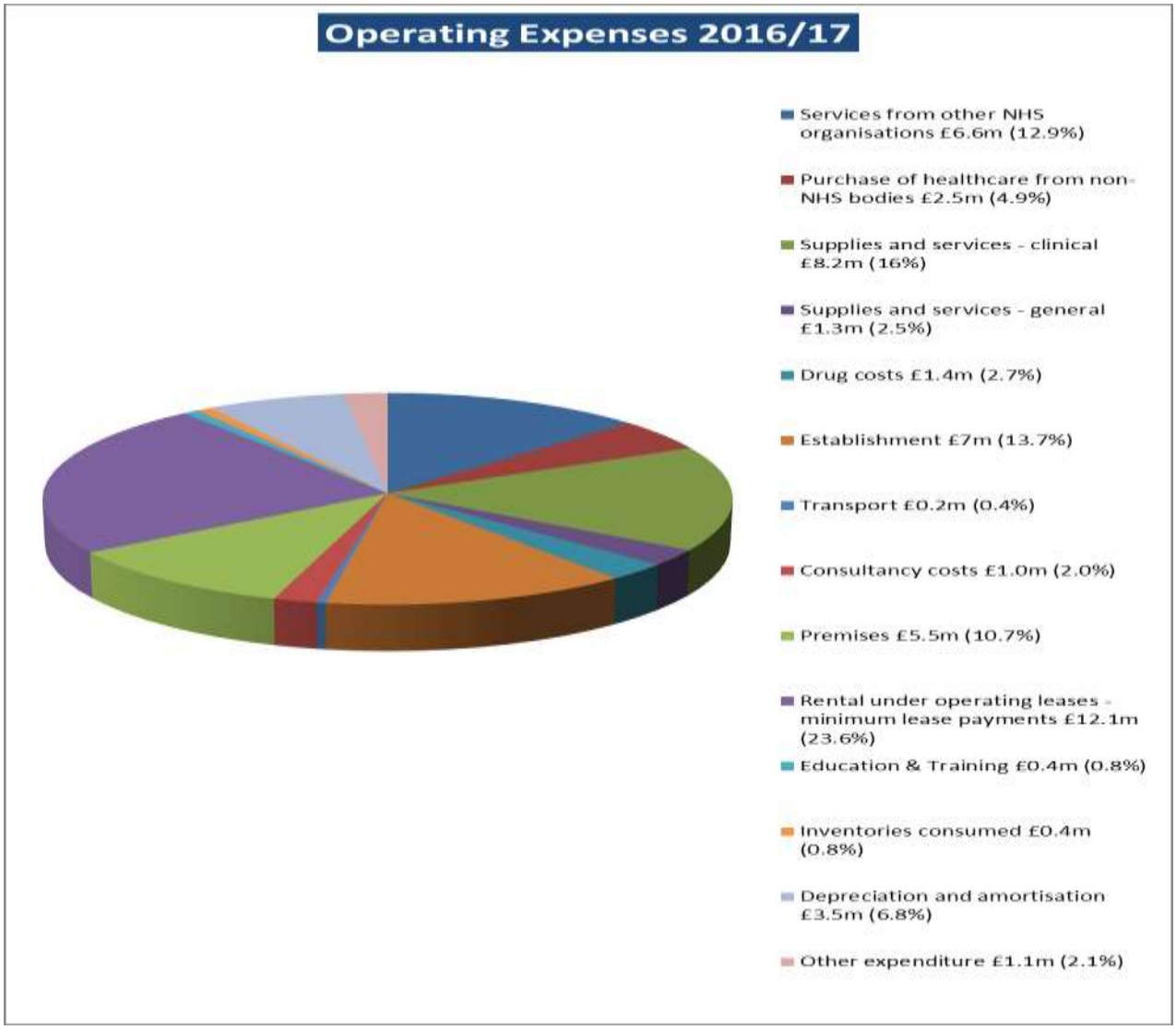


Expenditure

The Trust's main source of expenditure is Employee Costs (staff) totalling £110.4m representing 68% of total expenditure. The chart below highlights the breakdown of these costs.



Expenditure on Operating Expenses, excluding employee costs, amounted to £51.2m. The chart below provides an analysis of this expenditure by category.



Events After the Reporting Period

There were no events after the reporting period.

Going Concern

The financial statements have been prepared on a going concern basis. Commissioner intentions for 2017/18 are documented and contracts have been signed for the Trust's planned income stream for 2017/18 and in the case of NHS contracts for 2018/19 as well. A detailed paper was reviewed by the Finance and Investment Committee on 19 May 2017 and subsequently by the Audit Committee on behalf of the Board on 24 May 2017. This paper set out the key financial indicators drawn from the Trust's Annual Finance Plan for 2017/18. These indicators show:

- An improving Statement of Comprehensive Income deficit position from an indicative outturn of £0.6m, excluding additional amounts for STF incentive and

bonus payments which were not confirmed until 24 April 2017, for 2016/17, improving to a planned deficit of £0.5m in 2017/18.

- A positive cash balance throughout the year rising to £2.1m by 31 March 2018
- A Use of Resources Risk Rating (UOR) score of 2 by the end of 2017/18, which confirms the Trust's financial position as of minor concern from a regulatory perspective.

The Committee and Board considered any material uncertainties which might impact the 'going concern' basis and concluded that there were none to report.

Future Financial Performance

The Trust faces a number of challenges over the next few years:

Ensure expenditure levels are controlled in line with contractual income assumptions.

The Trust has significant Cost Improvement Programme (CIP) targets for 2017/18 and beyond. This will require the Trust to continue to review all services to ensure that each service is performing efficiently whilst ensuring that the quality of service is not affected.

Environmental management and sustainability

The core sustainability focus of the Trust's work since its inception has been the maintenance of our accreditation to international Environmental Management System (EMS) ISO 14001: 2004 Standard. Bridgewater is one of only a handful of community healthcare Trusts in England to have achieved this status and it takes the Trust well beyond the best practice requirements set out for the NHS. The EMS focuses on three key themes which form the basis of the EMS action plan: Energy Use in Buildings, Travel and Transport, Procurement and Waste. The EMS provides a strategic framework which supports the Trust in quantifying, monitoring and reviewing its performance in all of these key areas.

During the previous business year however, the Trust has undergone significant changes in terms of both the number of clinics which are included within the scope of the EMS and the reduction in staff numbers across the whole Trust. These changes have inevitably had an impact on availability of internal staff to gather and collate key environmental data. However, we have been able to continue our EMS support via external environmental consultants who manage the ISO 14001: 2004 system on our behalf. It is the intention that our external consultant will extend that remit to include more proactive environmental performance management and also oversee our on-going ISO 14001 certification status.

The EMS Standard itself has been updated (ISO 14001: 2015), which requires a more rigorous, high-level approach and involvement, and includes many new clauses and sub-clauses. There is a three year transition period (from September 2015) for companies

already certified to conform to the requirements of the 2015 version. The Trust was delighted to be awarded the new certificate in the spring of 2017. The EMS goals are as follows:

Goal 1: A healthier environment

Goal 2: Communities and services which are ready and resilient for changing times and climates.

Goal 3: Every opportunity contributes to healthy lives, healthy communities and healthy environments.

Social, community and human rights issues

As a Trust it is important that we understand the health inequalities and other challenges that face people in the communities we serve, and that we design and deliver services that address these. Supporting access and inclusion and ensuring that principles such as equality, independence and respect are important in all we do as a Trust, for both patients and for our employees. The Trust complies with and upholds the requirements and duties of legislation such as the Human Rights Act 1998 and the Equality Act 2010.

Using information from a wide range of sources we map health inequalities in our boroughs, looking at the effects of protected characteristic status, socio-economic status, and deprivation on health and life expectancy. This information can then be used, for example, when designing or redesigning services, when carrying out engagement work, and when delivering other projects. In recognition of the challenges our communities face, in addition to the nine protected characteristic groups, the Trust has chosen to also recognise and commit to identifying and removing barriers to access and reducing health inequalities for other vulnerable health groups including carers, sex workers, those with chaotic lifestyles such drug or alcohol abuse, our prison communities and asylum seekers/refugees.

The five principles of universal human rights (fairness, respect, equality, dignity and autonomy – FREDA) are important in all areas of Trust business, both service delivery and employment. This is recognised in such diverse areas as:

- Policies and procedures
- The continuing work being carried out on the Accessible Information Standard
- The submission of data and action planning for the NHS Workforce Race Equality Standard
- The analysis and reporting annually of staff and patient data in the Public Sector Equality Duty Annual Report

- The assessment and grading of equality performance in the NHS Equality Delivery System (EDS2) annual process.
- The service equality analysis process

More information on the work taking place within the Trust to understand and address inequality can be seen in the Equality, Diversity and Inclusion section.

There are no overseas operations to declare.

There have not been any important events since the end of the financial year which have affected the foundation trust.

The Performance Report for Bridgewater Community Healthcare NHS Foundation Trust was approved on behalf of the Board on 24 May 2017.

Accounting Officer Colin Scales (Chief Executive)

26 May 2017

3. Accountability Report

3.1 Directors' Report

Directors' statement

As directors, we take responsibility for the preparation of the annual report and accounts. We consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

The Board of Directors

Bridgewater Community Healthcare NHS Foundation Trust was authorised and awarded its Foundation Trust Licence by the independent regulator Monitor on 1 November 2014.

The Trust Board has overall responsibility for leading and setting the strategic direction for the organisation. It is also takes a lead in holding the Trust to account for the delivery of the strategy, through monitoring performance and seeking assurance that systems of control are robust and reliable. This includes ensuring the delivery of effective financial control, high standards of clinical and corporate governance and promoting partnership working in the communities we serve. The Board is also responsible for shaping the culture of the organisation.

The Board consists of both Executive and Non-executive Directors. We consider each Non-executive Director to be independent. The length of each Non-executive Director appointment is detailed in the biographies below.

The directors of the Bridgewater Community Healthcare NHS Foundation Trust for the period 1 April 2016 to 31 March 2017 were as follows:

Harry Holden – Chairman

Harry was confirmed in the post of Chairman of the Trust in November 2010 when the Trust was established as a statutory body and was re-appointed as Chair on 1 April 2013. Prior to this he chaired the Board of Ashton, Leigh and Wigan Community Healthcare – the provider arm of NHS Ashton, Leigh and Wigan Primary Care Trust (PCT) and previously held roles on the board of the PCT, including the position of Vice-Chair.

During his career Harry served as a Chief Officer and member of the Cabinet at Wigan Council, holding the post of Director of Land and Property and Community Safety for 15 years. This role led him to becoming Chairman of the Community Safety Partnership Joint Commissioning Group. In these roles Harry provided strong leadership and worked with partners at all levels to develop a range of successful projects and organisations. Harry's current term of office is until 31 October 2018.

Harry also chairs the Nominations and Remuneration Committee.

The Chairman has had no other significant commitments or any that have changed during the reporting year.

Qualifications

Member Association of Building Engineers (M.B.Eng)

Fellow Chartered Association of Building (F.C.I.O.B)

Colin Scales – Chief Executive Officer

Colin joined the NHS in 1994 after leaving university and has undertaken a range of roles within commissioning, operational management and the Department of Health during his career. As an Executive Director he has been responsible for developing strong relationships between organisations, developing leadership capacity and introducing systems to support managers to improve the performance of services.

He has experience of working in a number of different NHS Trusts and was a member of a Trust Board that successfully achieved Foundation Trust status.

Colin joined the Trust on 9 November 2011 as Chief Operating Officer and was appointed to the position of Chief Executive Officer on 1 April 2015.

Qualifications

BA (Hons) Degree in Geography, University of Salford

Cranfield University, School of Management, Strategic Leadership Executive Programme, May 2014

NHS Top Leaders Programme 2014/15

Mike Barker – Director of Strategic Development

Mike joined the NHS in 2002 as an associate director at the ambulance service and was part of the leadership team for the merger of the four ambulance trusts into NWAS before taking up a director post at the Royal Liverpool Hospital.

In 2008 he moved to Trafford PCT where he spent five years on the development of the place-based transformation agenda focused on what were then new concepts called 'integrated care'. He went on to lead the design and establishment of Trafford CCG before moving to Lancashire to expedite the development of two further CCGs in Preston and Chorley. Immediately prior to joining us, he was responsible for leading the strategy, planning, partnerships and communications function at Warrington hospital.

In terms of his early career, after graduating in Leeds, Mike started out in local government on Merseyside. He then went on to work in the private sector, advising household brands on their marketing and communications strategies.

Mike joined the Bridgewater Board on 24 October 2015.

<u>Qualifications</u>

BA Dual Hons, Sociology & Media Studies, University of Leeds (1995)

Postgraduate Diploma in Public Relations, CIPR (2004)

King's Fund Top Manager Programme Graduate (2011)

NHS Top Leaders Programme Graduate (2012)

MSc Healthcare Leadership (2016)

Karen Bliss – Non-executive Director

Karen qualified as a Chartered Accountant in 1991 after joining PricewaterhouseCoopers as a graduate trainee. She has held a variety of roles within the company at senior management level and has worked in audit, business assurance and due diligence.

She was originally appointed to the Board of Ashton, Leigh and Wigan Community Healthcare in 2008 and appointed to the Board of Bridgewater in 2010. Her term of office was recently renewed by the Council of Governors until 31 March 2020.

Karen held the position of Chair of Audit Committee until 31 March 2017, and is Chair of the Finance and Investment Committee within the Trust.

Qualifications

BA (Hons) Engineering, Cambridge University

Fellow of The Institute of Chartered Accountants (FCA)

Marian Carroll – Non-executive Director

Marian Carroll is a retired Executive Director of Nursing and has held roles at a number of North-West hospital trusts. As an experienced nurse and senior NHS manager, she has a strong clinical focus but is also committed to representing the views of patients and service users, having recently been a volunteer at Healthwatch Wigan. Marian's first term of office with the Trust is from 1 September 2015 to 31 August 2018.

Qualifications

MSc: Quality in Healthcare Management (Birmingham University) 1997

RGN: Wolverhampton School of Nursing - 1975

Steve Cash – Non-executive Director

Steve has held a number of senior roles in commercial management, strategic partnership and financial management spanning 30 years and most recently held a senior leadership position within the FTSE 100 company BT. He has broad leadership and business skills including strategy, finance, marketing, partnering and operational management.

He was originally appointed to the Board of Ashton, Leigh and Wigan Community Healthcare in 2008 and appointed to the Board of Bridgewater in 2010. His term of office was recently renewed by the Council of Governors until 31 March 2018.

Qualifications

Global Partner Vision programme – Harvard and Beijing University

Diploma in Marketing – Manchester University

BA Business Studies – University of Central Lancashire

Gareth Davies – Director of Finance

Gareth is a chartered accountant and started his career as a NHS graduate finance trainee in the North West. He has a broad range of experience in both public and private sector finance and initially qualified with the Chartered Institute of Public Finance and Accountancy but now holds the Institute of Chartered Accountancy in England and Wales qualification.

Immediately prior to joining Bridgewater Gareth has been acting Director of Finance at University Hospital of South Manchester NHS Foundation Trust (UHSM). Prior to this he worked for United Utilities in Warrington and Arthur Andersen in London and Manchester. Gareth is passionate about supporting the role community services has to play in providing more patient care closer to home and ensuring the long term sustainability of the Trust and our local health economies.

Gareth joined the Board of Bridgewater on 1 February 2016.

Qualifications

Institute of Chartered Accountancy in England and Wales (ICAEW), 2010.

BA (Hons) Public Administration – University of Glamorgan

Esther Kirby – Chief Nurse/Director of Quality

Esther started her career as a registered nurse, midwife and district nurse in 1980's and has worked in community services for the major part of her career. As a senior nurse she has undertaken a range of roles within commissioning and provider organisations in various parts of the North West. As a senior nurse leader and Executive Director she has been responsible for developing strong relationships between organisations, developing leadership capacity and leading nationally on nurse staffing levels in district nurse services.

Esther joined the Trust on 1 April 2015.

Qualifications

Registered General Nurse, Midwife and District Nurse – NMC Registration 79J0616E

Post-graduate Diploma in professional counselling from University of Central Lancashire

Diploma in Palliative Care from University of Central Lancashire

MSc in Healthcare Improvement Leadership, Middlesex University,

Leadership Development

Kings Fund Top Managers Programme -2015

Maggie Pearson – Non-executive Director

Professor Maggie Pearson has most recently been Pro Vice Chancellor and Dean of the College of Health and Social Care at Salford University. She trained as a nurse, and has a wide range of experience as a Non-executive and has held senior positions at universities and a range of national organisations including the Department of Health. She is the founding Director of the Salford Institute for Dementia. She is committed to citizens having a voice, and to equality and diversity. Maggie's first term of office is from 1 September 2015 until 31 August 2018.

Maggie holds the position of Chair of Audit Committee from 1 April 2017.

<u>Qualifications</u>

BA (Hons) Geography Cambridge University 1975

(converted to MA 1977)

State Registered Nurse 1978

PhD University of Liverpool 1985 – Leprosy Control in West Nepal; Social and Spatial Perspectives

Christine Samosa – Director of People and Organisational Development/Deputy CEO

Christine has more than 30 years' experience in human resources, training and organisational development. She has spent the majority of her career in NHS organisations including primary care trusts, community trusts, mental health trusts and a specialist tertiary centre and held a director level position for more than 20 years. She has extensive experience of working with local and regional officers of the main trade unions within the NHS.

Christine joined Bridgewater on 9 November 2011 and became a voting director on the Board on 1 November 2014. She was appointed as Deputy Chief Executive in January 2016

Qualifications

Fellow of the Chartered Institute of Personnel and Development

Masters Degree in Strategic HR Management with research into the impact of mergers and acquisitions on staff

HR Director Development Programme at the NHS North West Leadership Academy

Bob Saunders – Non-executive Director

Bob started his career in environmental health in London and having worked in a number of local authorities was appointed to the post of Corporate Director at Wigan Council in 1989. In addition to responsibility for environmental health, housing, urban renewal, trading standards, licensing and community safety his portfolio also included corporate strategy, business planning and performance management.

Bob was originally appointed to the Board of Ashton, Leigh and Wigan Community Healthcare in 2009 and most recently re-appointed to the Bridgewater Board in April 2013 until 31 March 2017.

Bob also holds the position of Chair of the Quality and Safety Committee

Qualifications

BSc Zoology (London)

BSc Environmental Health (Aston)

Royal Society of Health, Chartered Institute of Housing and Institute of Acoustics

Post Graduate Diploma in Management Studies

PRINCE 2 Project Manager

Dr Karen Slade – Medical Director

Karen's background is in Public Health, she was a Consultant in Public Health in North Lancashire for 8 years and will draw on her experience to help the Trust realise the vision set out in Bridgewater's Health and Wellbeing Strategy. For the last year Karen has worked for the National Institute of Health and Care

Excellence, advising on the development of quality standards and indicators. Karen's medical career has always been driven by her motivation to improve the quality and safety of patient care.

Karen joined the Bridgewater Board on 17 March 2016.

Qualifications

Bachelor of Medicine – University of Southampton 1997

Masters in Public Health – University of Birmingham 2001

Completion of Higher Specialist Training in Public Health (MFPHM) – 2004

GMC Registration 4423821

Dorothy Whitaker – Non-executive Director

Dorothy originally trained as a nurse and worked in London before returning to the North West. She has 20 years' experience in the third sector and has undertaken a range of roles involving the development of innovative solutions to health and social care issues. Her final post was as Chief Officer for Blackburn with Darwen Council for Voluntary Service.

Dorothy was appointed to the Board of NHS Ashton, Leigh and Wigan Primary Care Trust in 2006 and later joined the predecessor organisation to Bridgewater (Ashton, Leigh and Wigan) Community Healthcare in March 2008. Her term of office was recently renewed by the Council of Governors until 31 March 2020.

Dorothy also holds the position of Vice Chair.

Qualifications

State Registered Nurse Certificate

OU Post Experience Certificate – Handicapped Person in the Community.

Sally Yeoman – Non-executive Director

Sally started her career working in services for adults with learning disabilities and has since had more than 10 years' experience leading charitable organisations which support community, voluntary, not for profit and faith groups. She is an Institute of Directors certified Company Director and is currently Chief Executive Officer at Halton and St Helens Voluntary & Community Action.

Sally was re-appointed to the Board of Bridgewater on 1 January 2016 for a term until 31 December 2018. From 1 January 2015 Sally held the position of Senior Independent Director. It is a requirement for foundation trusts to appoint a Senior Independent Director (SID) who is available to members and governors if they have concerns that cannot be resolved through normal channels.

Qualifications

BSc (Hons) in Sociology

Institute of Directors Certificate in Company Directorship

Balance, Completeness and Appropriateness of Board Membership

Our board is satisfied that it has the appropriate balance of knowledge, skills and experience to enable it to carry out its duties effectively. This is supported by the Council of Governors which takes into consideration the collective performance of the board via the Nomination Committee.

Performance Evaluation of the Board

During the year, the Board undertook a review of its effectiveness, with the output of the exercise used to inform the board development programme in place throughout the year. The Trust has used a combination of internal subject matter experts and external development support. All Board members have an appraisal with the Chair or Chief Executive, and the Council of Governors oversee the performance review of the Chair and the Non-executive directors of the trust to help inform their decisions on the re-appointment or termination of Non-executives as necessary.

The Board meets on a bimonthly basis, allowing the intervening month to be spent on a full day of development as a team. This has proved invaluable in enabling the board to spend time debating in depth the issues facing the Trust. It has also allowed time for personal and team development.

Non-executive Directors' appointments may be terminated on performance grounds or for contravention of the qualification criteria set out in the Constitution with the approval of

three quarters of the Council of Governors or by mutual consent for other reasons. There is no provision for compensation for early termination or liability on the Trust's part in the event of termination.

During 2016/17, the terms of reference of all Board Committees have been reviewed. Each meeting of the Board or Committee undertakes a review at the end of its meeting, with feedback provided to improve the performance in the coming months. This process is supplemented by pre-meets between the Trust Secretary, committee chair and the lead executive director for the Committee to set the agenda and to improve the function of the meeting. Formal evaluation is undertaken annually by means of a questionnaire to all attendees.

Register of Interests

A Register of Directors' Interests is maintained by the Trust and can be accessed on request to the Trust Secretary.

Board Committees

A schedule of director attendance for all committees can be found at appendix 1.

Audit Committee

The aim of the Audit Committee is to provide the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.

In addition, the Audit Committee:

- Provides assurance of independence for external and internal audit.
- Ensures that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the Audit Committee Monitors corporate governance (e.g. compliance with codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).
- Ensures the provision of an effective system of internal control and risk management including the Trust's financial controls.

During the financial reporting period for 2016/17, from April 2016 to March 2017 the Committee consisted of six Non-executive Directors, one of whom is the Chair.

The Committee has met on five occasions throughout the reporting period. The Chair, Karen Bliss, is a qualified Chartered Accountant, and the Director of Finance, and the Internal Audit Manager attend routine meetings of the Audit Committee.

External audit representatives and a representative of the local counter fraud service also regularly attend Audit Committee meetings as do Trust Directors and/or their staff in respect of issues which the Audit Committee consider to be of risk or special interest.

A schedule of attendance at the meetings is provided in appendix 1 which demonstrates the compliance with the quorate requirements and regular attendance by those invited by the Committee.

The Trust's internal audit function is carried out through Mersey Internal Audit Agency (MIAA). The Trust's external auditors are PwC.

Self-Assessment:

During the financial reporting period for 2016/17 the Committee have complied with 'good practice' recommended through:

- Agreement of Internal and External Audit and Counter Fraud plans.
- Regular review of progress and outcomes, i.e. risks identified and action plans agreed.
- Private meetings with External and Internal Audit.
- Regular review of the Audit Committee work plan.
- Review of the Committee's Terms of Reference.

Audit Committee Business

Counter Fraud

During the year, the Committee has reviewed the progress of the Local Counter Fraud Specialist's programme of work. The Counter Fraud Plan has been delivered in accordance with the schedule of days agreed with the Committee at the start of the financial year.

Internal Audit

Throughout the year the Committee has worked effectively with the internal auditors to strengthen the Trust's internal control processes. The Internal Audit Plan has been delivered in accordance with the schedule of days agreed with the Committee at the start of the financial year. During the year, some agreed amendments to the plan had been approved by the Audit Committee. The Committee Chair reported these amendments to the Board.

During the year MIAA has completed 15 internal audit reviews, covering both clinical and non-clinical systems and processes

No reports were issued with High Assurance during the year.

The following reports were issued with Significant Assurance during the year:

- Nurse Revalidation
- General Ledger
- Accounts Receivable
- Accounts Payable
- Capital Asset Management
- Information Governance Toolkit
- Cost Improvement Programme & Quality Impact Assessments
- IT Virtual Desktop infrastructure
- Feedback of Learning to staff

The following reports were issued with Limited Assurance during the year:

- Mobile Computing
- Payroll
- IT Asset Management

There were no reports issued with No Assurance during the year.

Three reports were issued which did not contain an assurance opinion; these were Assurance Framework, Cyber Security and a briefing note issued on Wound Management.

The Committee has ensured that, where gaps in assurance are identified, appropriate action plans are agreed with management, and progress against these plans is regularly reviewed by management, internal audit and the Committee.

The Trust has a Finance and Investment Committee which looks at the challenges and issues associated with financial planning and forecasting, and the Audit Committee will seek assurances in respect of the processes and work undertaken.

As previously agreed with the Trust's Council of Governors, a procurement process was undertaken in 2016/17 to appoint a new external audit provider. The outcome of the process was to appoint PwC as the Trust's new external auditors replacing Grant Thornton

with effect from November 2016, in time to undertake sufficient pre-work for the 2016/17 audit.

Disclosure to Auditors

So far as the directors are aware, there is no relevant audit information of which the NHS Foundation Trust's auditors are unaware.

The directors have taken all steps that they ought to have taken as directors to make themselves aware of any relevant audit information. Furthermore, the Trust has made all relevant audit information available to the external auditor, PricewaterhouseCoopers (PwC), and the cost of work performed by them in the accounting period is as follows:

Category	**Amount (£000)**
Audit services	67.9
Further assurance services	-
Other services	-
Total	67.9

PwC does not provide any non-audit services. ('Other services' is in relation to the Limited Assurance review of the Quality Report)

Finance and Investment Committee

The Committee is responsible for monitoring the overall financial performance of the organisation including the delivery of the cash-releasing efficiency savings and within this to be satisfied that any risks to quality have been mitigated to an acceptable level.

Its duties are to:

- Oversee the financial performance of the organisation, reporting to the Board the likely future financial position of the Trust.
- Ensure delivery of the Trust's cost improvement programmes (CIP).
- Oversee the design and delivery of future CIP schemes.
- Make recommendations as to the content of financial and investment policies.
- Keep under review the content and application of the Trust's financial, investment and borrowing strategies and policies.

Nominations and Remuneration Committee

The overarching role and purpose of the Nominations and Remuneration Committee is to be responsible for identifying and appointing candidates to fill all the Executive Director positions on the Board and for determining their remuneration and other conditions of service.

Before an appointment is made, the Committee is responsible for evaluating the balance of skills, knowledge and experience on the Board and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. The process for identifying suitable candidates includes using open advertising or the services of external advisers to facilitate the search; considering candidates from a wide range of backgrounds; on merit and against objective criteria. The Council of Governors Nominations Committee follows this process for Non-executive appointments and the Trust Board Nominations and Remuneration Committee is responsible for the appointment of Executive Directors.

The Chairman of the Trust chairs this Committee and in accordance with the NHS Foundation Trust Code of Governance it is comprised exclusively of Non-executive Directors.

During the year, three Executive Directors attended the Committee to advise it in its work. These were the Chief Executive Officer, the Director of People and Organisational Development and the Medical Director. No other advisors were used by the Committee this year.

Quality and Safety Committee

The Quality and Safety Committee enables the Board to obtain assurance that high standards of care are provided by the Trust and, in particular, that adequate and appropriate governance structures, processes and controls are in place throughout the Trust.

The Committee's duties include the review and approval of the Trust's Quality Strategy, underpinning frameworks and supporting plans/strategies and the agreement of quality governance priorities to inform strategy and to give direction to quality governance activities across service areas.

The Committee reviews compliance with policy in relation to Infection Prevention and Control, Health and Safety, Complaints, Claims, Incident reporting, Safeguarding and Equality and Diversity.

Council of Governors

The Trust has a Council of Governors which consists of both elected and appointed governors. The Council of Governors contributes to the development of the Trust strategy and works with the Trust Board to forward plan. It will be involved in service development through member engagement. Governors have responsibility for the following decisions:

- Appointing the Chairman;
- Appointing the Non-executive Directors;
- Approving the appointment of the Chief Executive;
- Removing the Chairman and Non-executive Directors;
- Agreeing Non-executive Directors' terms and conditions, and
- Approving changes to the Constitution.

Governors' responsibilities include:

- Holding the Non-executive Directors individually and collectively to account for the performance of the Board;
- Appointing and removing external auditors;
- Receiving the Annual Report and Accounts;
- Being consulted on proposed changes and providing feedback on the future direction of the NHS Foundation Trust, and
- Representing the interests of members and public.

The 2016/17 Council of Governors' membership is shown below:

Constituency	Governor	Date of election
Public: Ashton, Leigh and Wigan (1)	Susan Francis	1/11/16 to 31/10/19
Public: Ashton, Leigh and Wigan (2)	John Prince	1/11/16 to 31/10/19 (second term)
Public: Ashton, Leigh and Wigan (3)	Rebecca Reece	1/11/16 to 31/10/19
Public: Ashton, Leigh and Wigan	Dr Gary Young	28/10/15 to 27/10/18 (second term)

Public: Ashton, Leigh and Wigan	Ken Griffiths	28/10/15 to 27/10/18
Public: Halton	Diane McCormick	1/11/16 to 31/10/19 (second term)
Public: Halton	Vacancy	
Public: Halton	Vacancy	
Public: St Helens (4)	Rita Chapman	1/11/16 to 31/10/19 (second term)
Public: St Helens (5)	Bill Harrison	1/11/16 to 31/10/19
Public: St Helens	Canon Geoff Almond	28/10/15 to 27/10/18
Public St Helens	Derek Maylor	28/10/15 to 27/10/18 (second term)
Public: Warrington	Paul Mendeika	28/10/15 to 27/10/18
Public: Warrington	Alan Guthrie	28/10/15 to 27/10/18
Public: Warrington (6)	Vacancy	
Public: Warrington (7)	Vacancy	
Community Dental (8)	Vacancy	
Rest of England	Vacancy	
Staff: Registered Nurses and Midwives	Fiona Bremner	1/11/16 to 31/10/19
Staff: Registered Nurses and Midwives (9)	Corina Casey Hardman	1/11/16 to 31/10/19 (second term)
Staff: Registered Nurses and Midwives (10)	Janet Rawlings	1/11/16 to 31/10/19
Staff: Allied health professionals/other registered healthcare professionals (11)	Steven Lowe	1/11/16 to 31/10/19 (second term)
Staff: Allied health professionals/other registered healthcare professionals (12)	Heulwen Sheldrick	1/11/16 to 31/10/19
Staff: Clinical Support Staff including Assistant Practitioners/ Healthcare	Vacancy	

assistants and trainee clinical staff		
Staff: registered Medical practitioners	Dr Deb Mandal	28/10/15 to 27/10/18
Staff: Registered dentists (13)	Vacancy	
Staff: Non-clinical support staff including managerial and administrative staff (14)	Dave Smith	1/11/16 to 31/10/19
Partner: Wigan	Cllr Nigel Ash	27/05/14 to 13/10/19
Partner: St Helens (15)	Marlene Quinn	14/10/13 to 13/10/19
Partner: Halton (16)	Cllr Geoff Zygadlo	19/05/16 to 13/10/19
Partner : Warrington	Cllr Judith Guthrie	23/06/14 to 13/10/19
Partner: Higher Education	Janette Gray	14/10/13 to 13/10/19
Partner: voluntary sector	Alison Cullen	10/06/15 to 13/10/19

Council of Governors Tenures – narrative

1) Wigan governor post formerly vacant until conclusion of governor elections on 1 November 2016.

2) John Prince, Lead Governor re-elected from 1 November 2016 to existing position.

3) Wigan governor post previously held by Mick Taylor. Following his resignation on 10 May 2016 the post remained vacant until conclusion of governor elections on 1 November 2016.

4) Rita Chapman re-elected from 1 November 2016.

5) St Helens governor position held by Peter Appleby until 1 November 2016 following governor elections.

6) Warrington governor vacancy – previously held by Jean Bullock who resigned in summer 2016

7) Warrington governor vacancy from 1 November 2016 previously held by G. Scott Baron.

8) Community Dental – governor position vacant following governor elections on 1 November 2016. Post previously held by Irene Deakin.

9) Corina Casey-Hardman re-elected from 1 November 2016 to existing position.

10) Nursing and Midwifery governor position held by Helen Case until her resignation in September 2016. The post remained vacant until governor elections were concluded on 1 November 2016.

11) Steven Lowe re-elected from 1 November 2016.

12) AHP post vacant prior to the conclusion of governor elections on 1 November 2016.

13) Staff dental governor position vacant 1 November 2016 following governor elections. Position previously held by Angela Akers.

14) Non-Clinical Support governor position held by Vikki Morris until 1 November 2016 following governor elections.

15) Position previously held by Councillor J Pearson until May 2016

16) Position previously held by Councillor Peter Lloyd Jones until May 2016.

Governors can be contacted via a dedicated email address:

bridgewater.governors@bridgewater.nhs.uk or via the Trust Secretary.

All members of the Board have a standing invitation to attend Council of Governors meetings and similarly all Governors are routinely invited to attend to observe those meetings of the Board of Directors which are held in public. All members of the Board attend the Council of Governor meetings on a regular basis in order to develop an understanding of the views of the Governors and members on the Trust. The agendas for these meetings are structured to enable Governors to ask questions of the Board of Directors.

The Governors have not exercised their power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the Directors to attend a Governor's meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties. They have not proposed a vote on the Trust's or Directors' performance during the reporting year.

Membership

The aim of our membership is to provide an opportunity for people to share feedback and opinions on how our services are meeting their needs and how we might improve. It also provides us with an opportunity to be more integrated with the communities we serve and engage them in the decision making process when and where appropriate.

Our membership is drawn from two constituencies:

- Public Constituency – people aged over 14 based in the boroughs we serve – this includes patients, service users and carers. We have a total of 9,600 public members.
- Staff Constituency – all permanent members of staff – staff are given the option to opt out – we have a total of 3,109 staff members.

The public constituency consists of six distinct areas:

- Wigan
- Warrington
- St Helens
- Halton
- Rest of England – incorporating Bolton and Oldham
- Community Dental.

Our staff constituency is drawn from the main staff groupings in the organisation:

- Nursing and midwifery
- Allied health professionals
- Medical
- Dental
- Non-clinical support staff
- Clinical support staff.

Up until November 2015, our membership target was 10,000 public members – since the achievement of this we have shifted our emphasis from recruitment of members to engagement.

The Trust's Membership Strategy and Action Plan are reviewed annually by a number of public governors. Our action plan determines our activity for the forthcoming year, highlighting priority areas for the forthcoming 12 months.

In the past year the focus has been on recruiting members in more 'hard to reach' groups. Contact has been made with the Healthwatch in each of the boroughs we serve so we might join any engagement activities in the boroughs they serve and our staff have spoken at events highlighting the work they do to support some of the most vulnerable in our communities.

We have also attended events aimed at specific groups in our community including the Disability Awareness Day in Warrington. We have also attended events aimed at students in local colleges of further education.

Our members regularly receive a newsletter outlining the main developments and achievements of the Trust and are invited to a number of public events including our annual staff awards, annual members meeting and annual general meeting. Many have also attended one of several workshops and focus groups organised by our staff and partners looking at the work they do and how it might be improved to better meet the needs of the communities we serve. In Wigan, work to progress the development of integrated models of care actively engaged the public and communities.

In September 2016, our members voted in the election for our Council of Governors and in October this year we welcomed an additional three public governors and our lead governor John Prince was re-elected. An additional four staff governors were also elected. There are eight vacancies on our Council of Governors and work is currently underway to review and revise the Bridgewater constitution to reflect the changing landscape of our footprint.

The governors representing our members meet quarterly and are given information about the members living in their areas. Together we identify where we need to be focusing future activity and have already taken the opportunity of addressing community groups, recruitment fairs and events aimed at carers, patients suffering with multiple sclerosis and diabetes.

Our staff have engaged with our members at a range of events including clinicians from the wheelchair services team who attended the disability awareness day and staff from the dental health promotion service, the community midwifery service and the walk in centres who attended the steam fair in Halton.

In Bolton, staff from the Parallel Centre which focuses on the emotional and physical well-being of young people were on hand at ‘Sport on the Square’ in Bolton town centre alongside colleagues from school nursing and the drugs and alcohol misuse teams.

Bridgewater also supported colleagues from Wigan Council, Wigan Clinical Commissioning Group and Wrightington, Wigan and Leigh NHS Foundation Trust to promote its work and engage the public at Well-fest and Wigan Pride aimed at the lesbian, gay, bisexual and transgender communities.

Our membership engagement is supported by a robust database and our member information is protected by the Data Protection Act. These systems were scrutinised during the year by auditors from Mersey Internal Audit and were found to be robust.

Monthly membership reports are shared with our governor and Non-Executive colleagues and opportunities for engagement are regularly highlighted. During the year our data is

subject to a data cleanse that removes members who have moved out of the area, opted out of our membership scheme or have passed away. This ensures our membership database is accurate.

As an organisation we greatly respect and value the views of those individuals who have signed up to become members of our Trust and we were delighted by their nominations for our Patient Choice award. This award recognises those attributes that make a very real difference to the experience of our patients. Their nominations this year, as in past years, have been extremely gratifying and heart-warming. The winners of the Patient Choice Award for 2016 were the Heart Failure/ Cardiac Rehabilitation team based at Fingerpost Health Centre in St Helens – pictured with our lead Governor, John Prince:

We are extremely grateful to those of our members who have given up their time in support of our organisation. Their continued diligence in reading leaflets and information sheets and participating in the PLACE assessment at Newton Community Hospital has been extremely valuable and allows us to incorporate the views of those we serve in the information we produce.

During the next year we shall further build on our engagement activities in the boroughs we serve and ensure the patient/user voice and opinion is heard as we focus on the integration of health and social care services in the boroughs where we deliver care. This increasingly important area of work has been the mainstay of significant activity during the past 12 months and in many of our communities, patients are benefitting from this joined up approach to care.

Systems of Internal Control

As outlined in the previous section, the Board and its subcommittees are responsible for monitoring the Trust's governance structure and systems of internal control to ensure that

risk is managed to a reasonable level and that governance arrangements exist to enable the Trust to adhere to its policies and achieve its objectives.

The Board assessed its own performance with regard to risk management and systems of internal control through the Quality Governance Assessment Framework (QGAF) and Board Governance Assessment Framework (BGAF). It is preparing for a Well-led review during 2017/18 and self-assessment is underway. Ongoing assurance that the Board is sighted on its key strategic risks is provided in the Board Assurance Framework (BAF)

During the year we received an internal audit assessment of our systems of internal control and received a rating of "significant assurance".

More detail is contained in the Annual Governance Statement.

In line with the requirements of the Financial Reporting Manual (FReM) paragraph 5.3.9, the Directors make the following statements on behalf of the Trust:

Bridgewater has complied with the cost allocation and charging guidance issued by HM Treasury.

It has not made any political donations

Better payment practice code (BPPC)

The better payment practice code gives NHS organisations a target of paying 95% of invoices within agreed payment terms or in 30 days where there are no terms agreed.

	2016/17 Number	2016/17 £'000	2015/16 Number	2015/16 £'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	28,017	30,353	36,008	41,887
Total Non-NHS Trade Invoices Paid Within Target	19,734	20,392	29,969	27,107
Percentage of Non-NHS Trade Invoices Paid Within Target	70.4	67.2	83.2	64.7
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,470	20,882	1,085	11,944
Total NHS Trade Invoices Paid Within Target	637	8,131	608	4,357
Percentage of NHS Trade Invoices Paid Within Target	43.3	38.9	56.0	36.5

Quality Governance

The Trust has in place a governance structure to ensure that quality governance arrangements are fit for purpose throughout the organisation. These are described in detail in the Annual Governance Statement and in the annual Quality Report. The Trust uses these structures to ensure that patient feedback is heard and can be triangulated with other information about the performance of the Trust, including activity performance, workforce metrics, quality measures and financial performance. The principle committee for maintaining the oversight on quality governance is the Quality and Safety Committee. During 2016/17, the Trust has reviewed its structures and has strengthened the role of the governance reporting groups which provides assurance to the Quality and Safety Committee that risks are managed and mitigated and that appropriate controls are in place.

In May and June 2016, the trust received its first full Care Quality Commission (CQC) inspection. This involved a comprehensive review of the services we provide which included inspectors visiting clinical services, speaking to staff, patients and other stakeholders and reviewing key organisational documents, policies and procedures. The outcome, which was published in February 2017, was that the trust 'requires improvement'. Please see the matrix below:

	Safe	Effective	Caring	Responsive	Well-led
Adult community	Good	Good	Good	Good	Good
Children	Good	Good	Good	Requires Improvement	Requires Improvement
Inpatients	Good	Good	Outstanding	Good	Good
End of Life	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Dental	Requires Improvement	Good	Good	Good	Requires Improvement
Midwifery	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Sexual Health	Good	Good	Good	Good	Good
Urgent Care	Requires Improvement	Requires Improvement	Good	Good	Good

Out of the 40 key lines of enquiry, 27 were rated 'good', 12 were rated 'requires improvement' and one was rated 'outstanding'. For the areas that were rated 'requires

improvement', a full trust action plan has been submitted to the CQC and is being monitored on a regular basis as part of our drive to support quality improvement.

The CQC has confirmed that they will re-inspect the services that were rated as 'requires improvement' during 2017.

There are no material inconsistencies between:

the annual governance statement, annual and quarterly board statements required by the Risk Assessment Framework, the corporate governance statement submitted with the annual plan, the quality report, and annual report and reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.

Income disclosures

The directors can confirm that 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.

Directors' statement

As directors, we take responsibility for the preparation of the Annual Report and Accounts. We consider the annual report and accounts, taken as a whole, to be fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

3.2 Remuneration Report

The remuneration report includes:

- Annual Statement on Remuneration
- Senior Remuneration Policy
- Non-executive Director Remuneration
- Salaries and Allowances – Table x 2
- Pay Multiples
- Exit Packages
- Appointments & Remuneration Committee
- Pension Benefits - Table
- Cash Equivalent Transfer Values (CETV)
- Real Increase in CETV

Annual Statement on Remuneration

As Chair of the Remuneration Committee of the Trust I confirm that the remuneration committee has met on 4 occasions between 1st April 2016 and the 31st March 2017.

During the period, the remuneration committee reviewed the salary levels of all directors against national comparators. Following this review, the salaries of the Chief Nurse and the Director of People and Organisational Development were revised to bring them into line with colleagues and to reflect the changes in responsibility during the year.

There have been no changes otherwise to the remuneration of any other Director during the above period as the trust had agreed that VSM/Director salaries would not be increased during 2016/17 and no cost of living increases have been awarded to Directors.

Harry Holden

Chair

Senior Managers Remuneration Policy

With the exception of Directors and the CEO, all senior managers within the Trust are employed on Agenda for Change terms and conditions and associated salary scales. Bridgewater Community Healthcare NHS Foundation Trust has adopted the NHS VSM pay framework (PCT Band 4) as the salary scale for all Directors. This provides a spot salary for each post, based on a percentage of the CEO salary.

It should be noted that the salaries of all directors have not been increased since the increase in the CEO salary on 1 April 2015, except where additional responsibilities have been assumed as declared in the Annual Statement on Remuneration. The Trust is required to explain the steps taken to ensure remuneration is reasonable where one or more senior managers are paid more than £142,500. The CEO's salary is the only one greater than £142,500.

The Trust satisfied itself that this was reasonable at the time of appointment following a market assessment using benchmarked information and also information presented by the specialist recruitment consultants who advised on the salaries of recent CEO appointments that they had been involved in and the salaries of those candidates for the post that held current positions of CEO in NHS organisations.

The Trust is required to report what constitutes the senior manager's remuneration policy in tabular format set out below:

Components of Remuneration Package of Executive and Non-Executive Directors	Basic pay in accordance with their contract of employment (executive) and letters of appointment (non-executive)
Components of Remuneration Report that is relevant to the short and long term Strategic Objectives of the Trust	The directors do not receive any remuneration tailored towards the achievement of Strategic Objectives
Explanations of how the components of remuneration operate	With the exception of Directors and the CEO, all senior managers within the Trust are employed on Agenda for Change terms and conditions and associated salary scales. Bridgewater Community Healthcare NHS Foundation Trust has adopted the NHS VSM pay framework (PCT Band 4) as the salary scale for all Directors. This provides a spot salary for each post, based on a % of the CEO salary.

Maximum amount that could be paid in respect of the component	Maximum payable is the director's annual salaries as determined by the NHS VSM pay framework (PCT Band 4).
Explanations of any provisions for recovery	If an individual is overpaid in error, there is a contracted right to recover the overpayment.

There is no facility for performance related pay within the Trusts pay structure. As a Community Trust, with the requirement to travel across a wide geographical footprint, all directors are entitled to receive a lease car or take a car allowance equivalent to £5,700 pa.

All Directors are set annual objectives, in line with the organisational strategy and objectives and are assessed against these on an annual basis. There is input into the assessment from the Chairman and CEO (for directors). Should any director performance be determined to be at an unacceptable level, the Trust would use its agreed performance management policies and procedures. The assessment period runs from 1 April to 31 March each year.

All Directors have been issued with NHS contracts of employment, with notice periods not exceeding 6 months. There is no provision for any additional payments to be made to Directors over and above their agreed salary level and car allowance. There is no payment for loss of office, other than those terms contained in section 16 of the Agenda for Change terms and conditions relating to redundancy situations.

Non-Executive Director Remuneration

The Remuneration levels for the Chairman and Non-Executive directors are as follows:

- Chairman: £42,544 p.a.
- NED: £12,359 p.a.
- Allowances for Chairs of committees/SID: £1,500 p.a.

There are no additional payments that are considered to be remuneration in nature.

The above remuneration levels were considered and agreed by the Council of governors in line with NHS Improvement guidance.

The tables shown on the following pages provide information on the remuneration and pension benefits for Senior Managers for the period 1 April 2016 to 31 March 2017. These tables plus their associated narrative (including pay multiples) on pages 50-53 and 55-56 are subject to External Audit review.

Governor and Director Expenses

During the reporting period, a total of 6 governors claimed a total of £963 in expenses. A total of 7 directors claimed a total of £26,283 in expenses.

Salaries and Allowances

Period from 1 April 2016 to 31 March 2017

Directors

Name and title	Salary at 31.3.2017 Bands of £5,000 £'000s	Taxable benefits at 31.3.2017 Total to nearest £100	Performance pay and bonuses at 31.3.2017 Bands of £5,000 £'000s	Long term performance pay and bonuses at 31.3.2017 Bands of £5,000 £'000s	All pension-related benefits at 31.3.2017 (1) Bands of £2,500 £'000s	TOTAL at 31.3.2017 Bands of £5,000 £'000s
Harry Holden Chairman	40-45	0	0	0	N/a	40-45
Colin Scales Chief Executive	145-150	64	0	0	30-32.5	185-190
Christine Samosa Deputy Chief Executive Executive Director of People, and Organisational Development	100-105	0	0	0	102.5-105	205-210
Esther Kirby Chief Nurse and Director of Quality	95-100	64	0	0	97.5-100	200-205
Caroline Williams Associate Director of Operations - Children	90-95	0	0	0	55-57.5	145-150
Carole Hugall Associate Director of Operations - Adult	80-85	0	0	0	47.5-50	130-135
Michael Barker Executive Director of Strategic Development	95-100	64	0	0	50-52.5	155-160
Gareth Davies Executive Director of Finance	105-110	64	0	0	30-32.5	140-145
Karen Slade Medical Director	105-110	64	0	0	285-287.5	400-405
Bob Saunders	10-15	0	0	0	N/a	10-15

Non-Executive Director						
Karen Bliss Non-Executive Director	10-15	0	0	0	N/a	10-15
Steve Cash Non-Executive Director	10-15	0	0	0	N/a	10-15
Dorothy Whitaker Non-Executive Director	10-15	0	0	0	N/a	10-15
Sally Yeoman Non-Executive Director	10-15	0	0	0	N/a	10-15
Margaret Pearson Non-Executive Director	10-15	0	0	0	N/a	10-15
Marian Carroll Non-Executive Director	10-15	0	0	0	N/a	10-15
Band of Highest Paid Directors Remuneration (£'000s)		150-155				
Median Total Remuneration (£)		22,161				
Ratio		6.9				

All of the above Directors were in post for the year ended 31 March 2017 except where indicated.

(1) Calculated in line with the prescribed guidance in Chapter 7 of the NHS Annual Reporting Manual for Foundation Trusts

Salaries and Allowances

Period from 1 April 2015 to 31 March 2016

Directors

	Salary at 31.3.2016	Taxable benefits at 31.3.2016	Performance pay and bonuses at 31.3.2016	Long term performance pay and bonuses at 31.3.2016	All pension-related benefits at 31.3.2016 (1)	TOTAL at 31.3.2016
Name and title	**Bands of £5,000 £'000s**	**Total to nearest £100**	**Bands of £5,000 £'000s**	**Bands of £5,000 £'000s**	**Bands of £2,500 £'000s**	**Bands of £5,000 £'000s**
Harry Holden Chairman	45-50	0	0	0	N/a	45-50
Linda Agnew Director of Corporate Development (2) In post to 31/07/15	30-35	17	0	0	7.5-10	40-45
Mike Treharne Director of Finance and Performance (3) In post to 31/07/15	30-35	17	0	0	2.5-5	35-40
Stephen Ward	5-10	0	0	0	0-2.5	5-10

Medical Director In post to 31/05/15						
Colin Scales Chief Operating Officer In post to 31/3/15 Chief Executive In post from 1/4/15	145-150	57	0	0	217.5-220	370-375
Christine Samosa Deputy Chief Executive Executive Director of People, and Organisational Development	95-100	0	0	0	52.5-55	150-155
Neil Fisher Medical Director In post from 01/04/15 to 31/12/15	40-45	0	0	0	10-12.5	55-60
Esther Kirby Chief Nurse and Director of Quality In post from 1/4/15	85-90	57	0	0	185-187.5	280-285
Caroline Williams Associate Director of Operations - Children In post from 1/4/15	85-90	0	0	0	20-22.5	110-115
Carole Hugall Associate Director of Operations - Adult In post from 01/04/15	80-85	0	0	0	5-7.5	85-90
Wendy Hull Interim Director of Finance (4) In post from 01/08/15 to 31/01/16	80-85	0	0	0	0-2.5	80-85
Michael Barker Executive Director of Strategic Development In post from 24/10/15	40-45	24	0	0	27.5-30	70-75
Gareth Davies Executive Director of Finance In post from 01/02/16	15-20	10	0	0	35-37.5	50-55
Karen Slade Medical Director In post from 01/03/16	0-5	5	0	0	15-17.5	20-25
Bob Saunders Non-Executive Director	15-20	0	0	0	N/a	15-20
Karen Bliss Non-Executive Director	15-20	0	0	0	N/a	15-20
Steve Cash	15-20	0	0	0	N/a	15-20

Non-Executive Director						
Dorothy Whitaker Non-Executive Director	15-20	0	0	0	N/a	15-20
Sally Yeoman Non-Executive Director	10-15	0	0	0	N/a	10-15
Margaret Pearson Non-Executive Director In post from 01/09/15	5-10	0	0	0	N/a	5-10
Marian Carroll Non-Executive Director In post from 01/09/15	5-10	0	0	0	N/a	5-10
Band of Highest Paid Director's Remuneration (£'000s)		150-155				
Median Total Remuneration (£)		28,180				
Ratio		5.4				

All of the above Directors were in post for the year ended 31 March 2016 except where indicated.

(1) Calculated in line with the prescribed guidance in Chapter 7 of the NHS Annual Reporting Manual for Foundation Trusts

(2) Linda Agnew left the Trust on 31/07/15. Final payment includes £160,000 redundancy payment which is excluded from the 'Salary' disclosed in the above table but is included in the total of 'Exit Packages' referred to later in this report.

(3) Mike Treharne ceased his duties as a director of the Trust on 31/07/15, but continued in the employment of the Trust in an alternative role until 31/01/16.

(4) Wendy Hull was engaged in an off payroll arrangement.

Pay Multiples

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisation's workforce.

The mid-point of the banded remuneration of the highest paid director in Bridgewater Community Healthcare NHS Foundation Trust in the year ended 31 March 2017 was £152,500. This was 6.9 times the median remuneration of the workforce which was £22,161 for the same period.

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

Exit Packages

During the year ended 31 March 2017 there were no exit packages.

Appointments & Remuneration Committee

The Appointments and Remuneration Committee is attended by all Non-Executive Directors and is chaired by the Chairman of the Trust. Throughout the course of the year, the Chief Executive, Director of People and Organisational Development and the Medical Director also attended the committee to provide advice or services. The committee sets the levels of pay for Executive Directors - and senior managers not remunerated under Agenda for Change pay arrangements. The committee approves the proposed appointment of Executive Directors. Contracts for Executive Directors are substantive unless or until the individual elects to resign the role or is removed from the role. Notice periods for such Directors are six months. There are no contractual provisions for the early termination of Executive Directors.

The Appointments Commission appoints Non-Executive Directors, generally on three year contracts which can be renewed on expiry. Notice periods are generally one month. There are no contractual provisions for the early termination of Non-Executive Directors. Furthermore the committee operates an annual Performance Development Review process whereby each individual has a named "parent". At the outset, the postholder and parent jointly agree the objectives for the following year and performance against these is then jointly assessed after the twelve month elapses. The cycle is then repeated on an ongoing annual basis.

Service Contracts

Name and Job Title	Date appointed to Trust Board	Tenure	Notice Period
Colin Scales, Chief Executive Officer	1 November 2014*	Permanent	6 months
Christine Samosa, Director of People and Organisational Development, Deputy Chief Executive	1 November 2014*	Permanent	6 months
Gareth Davies, Director of Finance	1 February 2016	Permanent	6 months
Karen Slade, Medical Director	17 March 2016	Permanent	6 months
Esther Kirby, Director of	1 April 2015	Permanent	6 months

Quality and Chief Nurse			
Mike Barker, Director of Strategy	24 October 2015	Permanent	6 months
Caroline Williams, Associate Director of Operations	1 April 2015	Permanent	6 months
Carole Hugall, Associate Director of Operations	1 August 2015	Permanent	6 months

*This is the date that Bridgewater became a Foundation Trust, both Colin Scales and Christine Samosa were members of the Board of its predecessor organisations.

Pension Benefits

Period from 1 April 2016 to 31 March 2017

Executive Directors

Name	Real increase in pension at pensionable age	Real increase in pension lump sum at pensionable age	Total accrued pension at pensionable age at 31 March 2017	Lump sum at pensionable age related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Cash Equivalent Transfer Value at 31 March 2017	Real increase in Cash Equivalent Transfer Value
	Bands of £2,500 £'000s	Bands of £2,500 £'000s	Bands of £5,000 £'000s	Bands of £5,000 £'000s	£'000s	£'000s	£'000s
Colin Scales Chief Executive	2.5-5	0	25-30	65-70	373	408	35
Christine Samosa Deputy Chief Executive Director of People and Organisational Development	5-7.5	15-17.5	45-50	135-140	770	889	119
Esther Kirby Chief Nurse and Director of Quality	2.5-5	12.5-15	40-45	120-125	714	833	119
Caroline Williams Associate Director of Operations - Children	2.5-5	0	20-25	50-55	236	272	36
Carole Hugall	2.5-5	7.5-10	30-35	90-95	504	567	63

Associate Director of Operations - Adult							
Michael Barker Director of Strategy	2.5-5	2.5-5	15-20	35-40	166	205	39
Gareth Davies Director of Finance	0-2.5	0-2.5	5-10	0	49	77	28
Karen Slade Medical Director In post from 01/03/16	12.5-15	32.5-35	25-30	75-80	212	415	204

There are no entries in respect of pensions for Non-Executive Directors as they do not receive pensionable remuneration. Additionally there were no contributions to Stakeholder Pensions on behalf of any of the Directors of the Trust.

Cash Equivalent Transfer Values (CETV)

The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when a member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

Colin Scales

Chief Executive **26 May 2017**

3.3 Staff Report

Staff Analysis

As at 31 March 2017 (Actual FTE and Headcount as at 31st March 2017), Bridgewater employed staff 3209 (2664.87 FTE), the majority of whom are clinically trained, including district nurses, health visitors, specialist nurses, occupational therapists, speech and language therapists, physiotherapists and assistant practitioners. Our staff numbers by staff group is as follows:

Audited	**Headcount**	**FTE**
AHP	384	319.29
Clinical Support	554	438.89
Admin/Managers/Estates	847	715.27
Healthcare Sci	19	18.17
Medical & Dental	102	67.05
Reg Nursing	1299	1102.7
Students	4	3.5
Total	3209	2664.87

Of these staff, people 3118 (2583.66WTE) have a permanent contract of employment and 91 people (81.21 WTE) have a fixed term/temporary contract of employment.

The breakdown of male and female employees is as follows:

	Male		**Female**	
	HC	**FTE**	**HC**	**FTE**
Directors	3	3.00	3	3.00
Other Senior Managers	18	17.80	77	73.71
Employees	253	228.60	2855	2338.77
Total	274	249.40	2935	2415.48

Audited Staff Costs	Group			
			2016/17	2015/16
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	83,495	1,587	**85,082**	81,252
Social security costs	7,470	151	**7,621**	5,303
Employer's contributions to NHS pensions	10,810	316	**11,126**	10,574
Pension cost - other	-	-	**-**	4
Termination benefits	-	-	**-**	763
Temporary staff	-	7,083	**7,083**	7,442
Total gross staff costs	**101,775**	**9,137**	**110,912**	**105,338**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**101,775**	**9,137**	**110,912**	**105,338**
Of which				
Costs capitalised as part of assets	442	-	**442**	800

The sickness absence rate for the Trust for this period was 5.50%. This equates to a Long Term Sickness Absence rate as 4.15% and Short Term Sickness Absence rate as 1.25%.

The top three reasons for sickness absence are stress/anxiety (31.00%), other musculoskeletal problems (8.60%) and Back problems (7.00%).

Modern Slavery Act

We are committed to improving our practices to combat slavery and human trafficking. We are fully aware of our responsibilities we have towards patients, service users, employees and the local community. We have a robust set of ethical values that we use as guidance for our commercial activities. We also expect all suppliers to the Trust to adhere to the same ethical principles.

Our policies on slavery and human trafficking

We are committed to ensuring that there is no modern slavery or human trafficking in any part of our business and in so far as is possible to requiring our suppliers hold similar ethos. Human Trafficking and Modern slavery guidance is embedded into Trust Safeguarding and Vulnerable Adults policies. We adhere to employment checks and standards which includes right to work and suitable references.

We are committed to social and environmental responsibility and have zero tolerance for Modern Slavery and Human Trafficking. Any identified concerns regarding Modern Slavery and Human Trafficking would be escalated as part of the organisational safeguarding processes, in conjunction with partner agencies where appropriate such as Local Authorities and Police.

Our guidance on Modern Slavery is to:

- Comply with legislation and regulatory requirements
- Make suppliers and service providers aware that we promote the requirements of the legislation
- Consider modern slavery factors when making procurement decisions
- Develop awareness of modern slavery issues

We will:

- Aim to include modern slavery conditions or criteria in specification and tender documents wherever possible,
- Evaluate specifications and tenders with appropriate weight given to modern slavery points,
- Encourage suppliers and contractors to take their own action and understand their obligations to the new requirements,
- Expect supply chain/ framework providers to demonstrate compliance with their obligations in their processes

Trust staff must:

- Contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Procurement staff will:

- Undertake awareness training where possible.
- Aim to check and draft specifications to include a commitment from suppliers to support the requirements of the act.
- Will not award contracts where suppliers do not demonstrate their commitment to ensuring that slavery and human trafficking are not taking place in their own business or supply chains.
- Communicate clear expectations to our supplies through a 'Supplier Code of Conduct'

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ending 31 March 2017.

Equality, Diversity and Inclusion

As a Trust, Bridgewater is committed to providing health care services that recognise, value and meet the diversity and differing individual challenges and needs faced by people in our communities and to providing employment that is equitable and free from discrimination.

There are significant numbers of people within our boroughs who suffer inequalities that lead to the early onset of long term ill health and disability and ultimately shorter life expectancy. Equality and the reduction of health inequalities are fundamental to all aspects of the NHS - the Health & Social Care Act, Constitution and Five Year Forward View for example all highlight the need to improve accessibility and reduce health inequalities.

The Equality Act 2010 and the Human Rights Act 1998 provide the legal frameworks within which the Trust operates its equality governance. Board level responsibility for equality sits with the Director of People and Organisational Development/Deputy Chief Executive, whilst day-to-day work and support sits with the Equality and Human Rights Officer.

In 2016, to meet our legal and contractual duties and to further promote equality, diversity and inclusion in the Trust our work has included:

- Analysis and publishing of data related to staff and patients in our annual Public Sector Equality Duty Report.
- Assessment and grading of our equality performance in partnership with external organisations and Trust members using the Equality Delivery System (EDS2) toolkit.
- Production and publishing of new specific and measurable equality objectives for 2017.
- Continued work on embedding and furthering implementation of the Accessible Information Standard.
- Addition of Browsealoud software to the Trust website to increase accessibility to webpages and associated documents, for example through translation into other languages, and screen changes that support access for people with disabilities such as sight loss.
- Analysis and submission of data to NHS England for the NHS Workforce Race Equality Standard, and action planning as a result of this analysis and the results of the 2015 NHS Staff Survey.
- Completion of production of the borough health inequalities document series.
- Production of information for staff on religion and belief in health care.
- Support for staff with disabilities through Access to Work.

- Production of an equality and diversity calendar for staff use.
- Support in the creation of the first Wigan Pride event.

A highlight of 2016 was the announcement that the Equality and Diversity Team were winners in the Greater Manchester Clinical Research award for Best Community Research Project for their work on the Extending Working Lives project of the University of Bath and the Medical Research Council. This research project sought staff views on the impact of pension reforms and working longer in the NHS. As the only community provider, the 130 staff who took part provided a valuable insight into the potential impacts on staff working in community settings. Once the project is completed the information provided will be shared with the NHS Working Longer Group and the DWP. The Trust specific data will be used in planning staff support for now and in the future, and also for workforce planning for the future, both the recruitment and retention of younger staff and also recruitment and retention of older staff.

There are a number of planned actions for 2017, these include:

- Regional work on EDS2, detailed within the 2017 Equality Objectives, and seeking to ensure a region wide and measurable approach to reducing health inequalities in protected characteristic groups. This work is taking place with other Merseyside Trusts, Merseyside HealthWatches and CCGs.
- Completion of a new Equal Opportunities Policy for the Trust that will replace the existing Equality Statement.
- Publication and implementation of a new Equality Impact Assessment Policy and Toolkit.
- Assessment and resubmission to the Mindful Employer Charter.
- Work on the Disability Confident Campaign that is replacing Two Ticks.
- Completion of guidance and policy to support transgender staff and patients.
- Submission to the 2017 Navajo Charter for LGBT staff and patients.
- Continuing work on staff wellbeing initiatives, in particular in relation to mental health, the menopause, dementia and carers.

In addition we have been set a challenging reasonable adjustments project by our CCG commissioners that work will continue on through 2017. Gender Pay Gap reporting and Workforce Disability Equality Standard reporting will commence from April 2017. Migrant Health Charging is likely to come into effect for all out of hospital health care from 2017. The Fluency Duty and right to work and immigration changes will increasingly become a priority within recruitment and employment.

Further information on our planned work around equality, diversity and inclusion can be found in our Health Inequalities and Inclusion Action Plan which can be viewed on our webpages along with our published reports and contact details for the team.

Employee Engagement

Within Bridgewater there are a range of communications channels designed to keep staff informed and to support two-way dialogue and engagement. These include a monthly Team Brief presentation from the Chief Executive. This contains key messages to keep staff informed on new developments, performance (including HR performance measures, financial and quality performance). From March 2017, this was piloted by way of video. Staff also receive a weekly Bridgewater Bulletin e-newsletter and are encouraged to access to the Trust intranet "The Hub" which contains a range of information on Trust policies, corporate services, key initiatives within the Trust. The Chief Executive and Chief Nurse also share their views on key achievements, priorities and provide news updates through regular blogs.

Every other month the Chief Executive hosts a half day Open Space event to which all staff are invited. The purpose of the event is to give staff a chance to suggest key themes for discussion and raise issues or interest of concern. The format is to encourage creative and dynamic small group conversations which result in agreed actions. During 2017, we will be considering guest speakers being present.

Director walkabouts and drop-ins enable staff to meet members of the Executive Team to discuss the quality of services they deliver and listen to their views, ideas and what it is like to work for the Trust.

During the year the Trust launched an 'It All Counts' campaign to encourage staff to submit ideas to help contribute towards making savings and also to encourage them to share items of unused stock and equipment which has proved popular.

The Trust has involved staff in the formulation of the Trust's strategy through a '*Vision into Action'* session, where staff could help to shape the aspirations and strategic direction of the Trust. Staff views have been sought on the Trust's values and 'what the values mean to me'. An interactive social media forum has been used to collect staff views on service developments and strategy.

Clinical strategies have been developed in partnership with clinical teams and the Director of Strategic Development. Professional forums, which are made up of clinical staff, include presentations and workshops on national regional and local issues and initiatives, best practice and networking opportunities.

The Trust shares its performance metrics with all staff through the Team Brief and staff have the opportunity to ask questions during the briefing session or through a Question and Answer section. Any questions and answers are shared through the following month's team

brief. In addition there is a facility for staff to ask questions through the Intranet (The Hub) through a section entitled 'Ask the Boss'. The Integrated Performance Report is on the intranet and the public web site.

During the past year a vast amount of work has been undertaken to develop the Trust's Staff Engagement Strategy. A series of events were well attended by staff. The Strategy was launched in March 2017. Its implementation is being overseen by a Staff Engagement Strategy Steering Group who meet regularly. Staff Engagement Champions throughout the Trust will also support this agenda.

Listening into Action

Listening into Action (LiA) has been running since 2014 and is a proven programme of staff engagement, whereby staff identify and implement new ways of working that will:

- Improve patient care
- Improve the patient experience
- Enable staff to do their jobs more effectively

At the end of year two the CEO asked that a staff engagement strategy be developed to plan building upon positive work environments and inspire leadership and trust across the organisation. A draft staff engagement strategy was agreed by the Executive Management Team in June 2016. Six staff engagement strategy events, in each borough, were held throughout November/December 2016 and January 2017, using the LiA approach. Three questions were posed that asked for feedback on the draft strategy and around engagement improvement and staff was also asked if they would like to form local LiA teams to work on the issues specific to their boroughs.

For staff who weren't able to attend these events, a survey was launched that asked the same questions and managers also asked their staff in team meetings. In total, 461 staff contributed their ideas to the strategy and its action plan, and the strategy was launched in March 2017. The action plan for the staff engagement strategy is monitored and reviewed by a staff engagement strategy steering group which reports to the Workforce Committee. Local teams have begun to work on their local issues and their progress will report up to the Trust's LiA sponsor group. In addition to the local teams, staff have been invited to become

local voluntary staff engagement champions to support staff involvement and local messages in their boroughs/teams. These champions will be supported by the LiA trust sponsor group and the staff engagement strategy steering group.

Celebrating our staff

At Bridgewater it is important for us to recognise when our staff go above and beyond the call of duty, demonstrate a willingness to innovative and make significant strides to delivering improvements in services.

Our "Stars of the Month" scheme allows staff to recognise the work of colleagues by nominating them for an award each month. This scheme continued to be popular amongst staff and more than 250 separate nominations for individual colleagues or teams were made during the year.

The highlight of the Trust's staff reward and recognition programme is the annual Staff Awards ceremony. During the 2016/17 financial year, the Trust agreed on a new approach to this successful event and will combine it into a single event with our Annual General Meeting to encourage greater participation in the latter by our staff. This event is to take place on 18 September 2017.

A number of our staff were recognised by a range of national award schemes during the year:

- The Paediatric Continence team in Halton and St Helens received a British Journal of Nursing Award for Urology and Continence. This recognised innovative work to help diagnose and treat children with bladder problems outside of hospital.
- The Trust's Equality and Diversity Team was named winner at The Greater Manchester Clinical Research Awards 2016 in the Best Community Research Contribution category. They were recognised for their work to involve Bridgewater in a high-profile national research project on working lives in the NHS.
- School nurses Sarah Logan and Sarah Deakin from St Helens were honoured for their passion, commitment and leadership skills by the Cavell Nurses' Trust Leadership in School Nursing Award. Following this they were invited to speak at a national conference on "The Future of School Nursing".
- Paula Wright, Clinical Systems and Performance Lead won an award for the development of a Ready for School app This is an electronic interactive game/activity for parents to use with their children to prompt them to discuss skills that will enable their child to be prepared for school

Health and safety performance and occupational health

Information on accidents and incidents are included in the Integrated Performance report and therefore are available for all staff. Services that are available to staff from our Occupational Health provider are available in leaflet form for staff and details are on the intranet.

Sickness absence data is provided to each clinical and service manager on a monthly basis and this is discussed at Divisional Management team meetings.

Health and wellbeing data is also available in the Integrated Performance report.

Anti-Fraud, Bribery and Corruption Measures

Fraud against the NHS results in taxpayer's money intended for things like nurses, doctors and healthcare facilities being lost to criminals and, ultimately, less resources for patient care. Every NHS organisation in England and Wales is required to appoint a nominated Anti-Fraud Specialist in accordance with the NHS Standards Contract. The role of the Anti-Fraud Specialist is to deliver NHS Protect's wide-ranging strategy for combatting fraud, bribery and corruption. The Trust has a contract in place with Mersey Internal Audit Agency [MIAA] to provide an Anti-Fraud service, whose programme of activity is overseen by the Executive Director of Finance and the Audit Committee, ensuring that the Trust remains compliant with NHS Protect's standards for providers.

The Trust works closely with its Anti-Fraud Specialist to protect staff and resources from fraudulent activities and all NHS employees have responsibilities when it comes to reporting concerns or suspicions relating to fraud, bribery or corruption.

The Anti-Fraud Specialist undertakes a programme of work raising fraud awareness which includes the delivery of Corporate Induction presentations and the Trust-wide circulation of articles and newsletters through Bridgewater Bulletin, as well as taking action to prevent and deter fraud by reviewing Trust policies and procedures and ensuring that they contain adequate anti-fraud, bribery and corruption measures. All allegations of fraud, bribery and corruption received by the Trust are dealt with and investigated in line with the Trust's Anti-Fraud, Bribery and Corruption Policy.

Information relating to policies and guidance, including the Anti-Fraud, Bribery and Corruption Policy and the Whistleblowing Policy, is available on the Trust's Anti-Fraud intranet page for staff.

Staff Survey

The Trust takes part in the national annual NHS staff survey, and this year received a response rate of 46%. As well as providing us with feedback on how we are doing and how staff are feeling in relation to 32 'Key Findings', we are provided with a national 'staff engagement' score. The key findings are grouped. There are 9 themes:

- Appraisals and support for development
- Equality & Diversity
- Errors and incidents
- Health and wellbeing
- Working patterns
- Job satisfaction
- Managers
- Patient care and experience
- Violence, harassment and bullying

As described in the staff engagement section, the Trust promotes effective employee engagement to create a motivated and valued workforce which ultimately leads to better patient care and service experience. Engagement, consultation and ensuring effective communications with our staff is of paramount importance. During the past 12 months we have continued to improve our methods of communication, involvement and engagement with staff to enable them to understand the aims and objectives of the Trust, its mission, vision and values.

The key performance indicators help the Trust to continually measure the quality of staff experience. Data relating to workforce indicators are reported to the Trust Board, as are the annual national NHS staff survey results.

We enjoy effective partnership working with our Trade Unions and Staff-side colleagues and believe this is critical to our success.

Summary of Performance – NHS Staff Survey

Top 5 ranking scores	**2015**		**2016**		**Trust Improvement/ Deterioration**
	Trust	National Average	Trust	National Average	
*KF16: Percentage of staff working extra hours	72%	74%	67%	71%	5% improvement
*KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	6%	7%	6%	7%	Same
*KF28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	19%	21%	18%	20%	1% improvement
**KF2: Staff satisfaction with the quality of work and care they are able to deliver	3.85	3.86	3.89	3.85	.04 improvement
***KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	83%	90%	90%	90%	7% improvement

* the lower the score the better

**score out of 5 - the higher the score the better

***the higher the score the better

Bottom 5 ranking scores	**2015**	**2016**	**Trust**

	Trust	National Average	Trust	National Average	**Improvement/ Deterioration**
***KF6: Percentage of staff reporting good communication between senior management and staff	22%	30%	24%	32%	2% improvement
***KF24: Percentage of staff/colleagues reporting most recent experience of violence	62%	61%	58%	72%	4% deterioration
*KF18: Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	65%	58%	70%	56%	5% deterioration
**KF19: Organisation and management interest in and action on health and wellbeing	3.52	3.81	3.57	3.69	.05 improvement
**KF31: Staff confidence and security in reporting unsafe clinical practice	3.77	3.76	3.65	3.76	.12 deterioration

* the lower the score the better

**score out of 5 - the higher the score the better

***the higher the score the better

Future priorities and targets

Having reviewed the NHS staff survey the key priority areas for the Trust to focus on are:

- Communication between senior management and staff - work is ongoing as per the Trust's Listening in Action (LiA) programme. A range of communication methods have been introduced
- Staff/colleagues reporting most recent experience of violence – a revisit of the Trust's Zero Tolerance Policy and its provisions, including incident reporting regimes
- Staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves – there will be a focus on presenteeism as per the Trust's staff health and wellbeing agenda
- Organisation and management interest in and action on health and wellbeing – the staff health and wellbeing agenda will be further promoted, along with all of the health and wellbeing activities that have taken place and will take place over the coming months
- Staff confidence and security in reporting unsafe clinical practice – there will be a revisit of the Trust's incident reporting regimes, systems and processes

The Trust is developing an action plan to review, monitor and put in place measures to address these key priorities. This will be reviewed by the Trust on a regular basis, including:

- Bi monthly HR Team Meetings
- Bi monthly Corporate Partnership Meetings, comprising of Senior Management and Staff-side colleagues
- Quarterly reviews with Executive Management Team
- Quarterly reviews with CCGs

The Trust will use its Listening into Action (LiA) Programme to address some of the themes.

Expenditure on consultancy

The Trust spent £0.9m on Consultancy. Approximately half of this was related to the support and due diligence requirements of the preparation for the Liverpool Community Healthcare transaction.

Off-payroll engagements

The Trust had the following off-payroll engagements as at 31 March 2017, for more than £220 per day that last longer than six months.

No. of existing engagements as at 31 March 2017	31
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	7

Number that have existed for between two and three years at the time of reporting	2
Number that have existed for between three and four years at the time of reporting	7
Number that have existed for four or more years at the time of reporting	14

All of these off-payroll engagements have been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax, and where necessary assurance has been sought. Off-payroll engagements are regularly reviewed to ensure that they are appropriate and provide value for money for the organisation.

New off-payroll engagements, or those that reached six months in duration, between 1 April 2016 and 31 March 2017, for more than £220 per day and that last for longer than six months:

	No. of engagements
Number of new engagements, or those that reached six months in duration between 1 April 2016 and 31 March 2017	1
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	-
Number for whom assurance has been requested	1
Of which:	
Number for whom assurance has been received	-
Number for whom assurance has not been received	1
Number that have been terminated as a result of assurance not being received	-

Exit packages

There were no exit packages paid during 2016/17.

3.4 The disclosures set out in the NHS Foundation Trust Code of Governance

Bridgewater Community Healthcare 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, most recently revised in July 2014 is based on the principles of the UK Corporate Governance code issued in 2012.

The Trust Board and Council of Governors are committed to the principles of best practice and good corporate governance as detailed in the NHS Foundation Trust Code of Governance (the Code). The Trust Board regularly review metrics in relation to regulatory obligations, contractual obligations and additional internal performance targets/standards of the Trust. To review the performance and effectiveness of the Trust, a number of arrangements are in place including governance structures, policies and processes to ensure compliance with the code. These arrangements are set out in documents that include:

- The constitution of the Trust
- Standing orders
- Standing financial instructions
- Schemes of delegation and decisions reserved to the Board
- Terms of reference for the Board of Directors, Council of Governors and subcommittees
- Role descriptions
- Codes of conduct for staff, directors and governors
- Annual declarations of interest

In accordance with the code, all directors and non-directors of the Trust Board scrutinise and constructively challenge the performance of the Trust to drive improvement and achieve high quality safe care. The non-executive directors of the board are held to account by the Council of Governors who are responsible for ensuring that non-executive directors (individually and collectively) are exercising their duty in constructively challenging executive directors, developing strategic proposals and ensuring the on-going effectiveness and performance of the Trust Board. The chairman of the Trust ensures that the Council of Governors meet on a regular basis and are fully consulted on areas of potential development or change in a timely manner. Thus supporting the Governors to fulfil their role and discharge their duties of representing the interests of members within their constituencies to whom they are accountable. NHS foundation trusts are required to

provide (within their annual report) a specific set of disclosures in relation to the provisions within schedule A of the code of governance.

Where applicable, the Trust complies with all provisions of the Code of Governance issued by NHSI (as Monitor) and updated in July 2014.

3.5 Regulatory Ratings

Single Oversight Framework

NHS Improvement's (NHSI) Single Oversight Framework (SOF) 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 segmented from 1 to 4 where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The SOF 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 relating to the RAF has not been presented as the basis of accountability was different. This is in line with NHSI's guidance for annual reports.

Segmentation

The Trust is currently placed in segment '2' by NHSI which means that the Trust is offered targeted support by NHSI for the areas of concern but the Trust is not obliged to take advantage of this support. The Trust has applied to take part in FIP2 (Financial Improvement Programme Wave 2) during 2017/18 to help it to achieve its ambitions.

This segmentation information is the Trust's position as at 7th April 2017. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHSI website.

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 give an overall score. Given that finance and use of resources is only one of the five themes feeding into the SOF, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	1	1
	Liquidity	3	2
Financial efficiency	I&E margin	3	2
Financial controls	Distance from financial plan	2	1
	Agency spend	3	3
Overall scoring		**2**	**2**

3.6 Statement of Accounting Officer's Responsibilities

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 Bridgewater Community Healthcare 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 Bridgewater Community Healthcare 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 Monitor, 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 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.

Colin Scales

Chief Executive Officer

The Accountability Report for Bridgewater Community Healthcare NHS Foundation Trust was approved on behalf of the Board on 24 May 2017.

Accounting Officer Colin Scales (Chief Executive)

Date 26 May 2017

3.7 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, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the 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 the NHS Foundation Trust Accounting Officer Memorandum.

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 to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Bridgewater Community Healthcare 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 Bridgewater Community Healthcare NHS Foundation Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Directors oversaw all aspects of organisational performance and foreseeable risk, including challenges in achieving financial duties, ongoing financial sustainability, service pressures and maintaining key relationships and partnerships across the wider local health economy and with our commissioners, including engagement with integrated commissioning plans and the sustainability and transformation plans. Executive Directors' performance appraisals were undertaken by the Chief Executive, and personal objectives have been set for 2017/18. The Nomination and Remuneration Committee of the Board oversees the outcome of these meetings.

As set out in the Risk Management Policy, the Director of People, Planning and Organisational Development had responsibility for directing that a sound risk management process is in place. This entails directing and monitoring the systems and tools in place to effectively identify, record, monitor, and influence risks to the objectives of the Trust. In 2017/18 the Chief Nurse will undertake the executive leadership of risk management within the Trust.

The Head of Risk Management and Patient Safety has responsibility for developing, embedding, and advising on risk management systems and tools for operational risks identified by clinical and non-clinical support services and strategic risks developed by the Board.

The Medical Director offered leadership as the Medical Responsible Officer (MRO) and has responsibility, together with the Chief Nurse, for monitoring and improving clinical service delivery, safety, and quality. The Medical Director role encompasses the role of Controlled Drugs Accountable Officer (CDAO) as set out in the Medicines Policy, and provides the executive lead on medical equipment as set out in the Medical Devices Policy. The Medical Director holds the role of the Caldicott Guardian as set out in the Information Governance Policy, and is responsible for the process for revalidation of medical (doctors) staff across the trust. She is the designated Chair of the Information Governance Group and the vice-Chair of the Clinical Governance Committee (CGC) reporting to the Quality and Safety Committee.

The Chief Nurse, together with the Medical Director, has responsibility for monitoring and improving clinical service delivery, safety, and quality. This includes ensuring mechanisms are in place for reporting clinical incidents and identifying opportunities for service improvement as identified from incident investigations. They have responsibility for monitoring of trust achievement against the Care Quality Commission standards, supported by sound clinical governance systems across the trust. The Chief Nurse is the Chair of the Incident review group (IRG - monitoring Serious Incidents) and the CGC reporting to the Quality and Safety Committee. She is responsible for the process for revalidation of nursing staff across the trust and holds the role of Nominated Senior Officer as set out in the Safeguarding Children Policy.

During 2016/17, two Area Directors of Operations have ensured a focus on the boroughs, both in terms of service delivery and the needs of the commissioners. Their monthly Directorate Management Team (DMT) meetings received reports and offered leadership on incidents and risk issues within those services. These two overarching DMTs explain any exceptions and describe the planned responses in the Integrated Performance Report (IPR) received by the Board. The Director of People and Organisational Development chairs a Corporate DMT where those functions that support clinical services appraised their effectiveness and discussed risk issues.

Directors and managers were supported by the Head of Risk Management and Patient Safety who offered specialist advice and leadership on risk register and incident system management, and facilitated monthly training for all managers with responsibility for risk management within their service and to support to their staff.

The Risk Management Policy and the Incident Reporting Policy were reviewed during the year and contained the mechanisms for staff to employ to identify and manage risk. The

web-based Ulysses 'Safeguard' Risk Management system accommodated the Risk Register, incident reporting, medical equipment, and central alert management functions. The system also hosted safeguarding, complaints, and Freedom of Information data.

The Clinical Governance Sub-committee (CGC), provided support to the Lessons Learned Group during the year to identify and cascade identified areas of improvement across the trust using electronic bulletins, intranet, and Team Brief from the Director Team. Recommendations from investigations into serious incidents also feed directly back to local teams and services.

The risk and control framework

The Risk Management Policy differentiates between strategic risk (the principal risks to the strategic objectives of the organisation as set out by the members of the Board) and operational risk (risks to the delivery of safe and high quality care on a day to day basis as identified by operational staff).

It sets out the range of sources for risk identification, where these are documented, the responsibility and authority, expected responses, and escalation by managers to different levels of risk, and a consistent methodology for prioritising and reviewing risks based on the NHS standard 5 x 5 matrix of scoring.

The documented risk assessments set out in policy, whether manual or electronic (using the Ulysses 'Safeguard' risk module), require the assessor to document primarily:

- the foreseeable hazard placing an objective at risk,
- the potential impact should the hazard occur,
- existing controls that are currently mitigating the likelihood or impact,
- means of assurance on the efficacy of those controls,
- gaps in controls or assurance that has increased the level of risk,
- a plan in place to address these gaps

Policies, procedures, and clinical guidelines and associated staff training/implementation are the most common form of control for the majority of both strategic and operational risk. The Policy Approval Group has delegated responsibility for establishing policy development guidelines, reviewing, and approving the policies for the trust. Built into the process for policy development, each document is approved with evidence of an Equality Impact Assessments being completed.

The Risk Management Policy also sets out the threshold of the Board's appetite (strategic and operational) for tolerating what it deems to be high risk based on a 5 x 5 scoring matrix:

- any risk with an overall score greater than or equal to 12, or
- any overall score below this but retaining a potential severity score of '4 Major'

Any risk that reaches this threshold is escalated to the directors for support and constructive challenge as these are seen as exceptional.

Operational risks and incidents were monitored monthly by the Area Directors at the DMTs which then escalated exceptions to CGC (which, in turn, escalated exceptional information to the committee of the Board: the Quality and Safety Committee). Controls and assurance that affected local operational process were managed and recorded by managers at an operational level within the directorate.

The Trust employs specialists (Health and Safety, Medicines Management, Information Governance, Security, and Equality and Diversity etc.) to maintain Trust adherence to regulations and additionally offer advice to staff and management on expected operational controls and assurances to mitigate and monitor risks.

Our Head of Information Governance (IG), in conjunction with the Information Security Manager, has reviewed and updated the following policies; Confidentiality & Information Sharing, Information Asset & System Audit, Registration Authority, Corporate Records Management, Health Records, Information Security, Anti-virus and Data Encryption. They also oversee the completion and monitoring of the Information Governance Toolkit, reviewing this at the quarterly Information Governance Subgroup meetings chaired by the Caldicott Guardian, with the Director of Finance in his role as Senior Information Risk Owner (SIRO) in attendance and providing exception reports to the Clinical Governance Subcommittee. They are in automatic receipt of all Information Governance incidents reported by staff on Ulysses, maintain their own set of risks on the Risk Register, and are able to access all IG risks documented by all services. IG breaches are assessed by the Head of Information Governance and submitted to the Information Commissioner if significant, uploaded as Serious Incidents to STEIS and investigated. Investigations are submitted to commissioners and lessons learned cascaded to staff with bespoke training as required.

All managers across the Trust maintain a responsibility for the safety of their staff and patients, and the safe and effective delivery of care as part of the Trust objectives. Foreseeable hazards were risk assessed and documented on the risk register residing on the Ulysses Risk Management System or, if something adverse occurred it was recorded on the same system as an incident.

Risks, complaints, and incidents are monitored and triangulated by the CGC with any thematic lessons to be learned for trust-wide dissemination reported via the Team Brief cascade and via the trust Intranet.

Monthly operational performance, finance, human resource, incident, and patient experience, information is collated by the Performance Team for reporting to the Board in a single Integrated Performance Report (the IPR). As gatekeepers of all contributions to the IPR, the Performance Team will only include data on the understanding that local quality checks by services have taken place, and that figures and supporting narratives have been reviewed by the relevant director before publication. This data is aggregated against KPIs and submitted back to services for explanatory narrative. Additionally, specific reports are collated for the Board monthly and quarterly encompassing infection control, incidents, CQUINs, complaints, clinical audit etc. All information is reviewed by respective DMTs and the CGC.

The Board and directors are accountable for the establishment and ongoing delivery of services within the requirements of the Provider Licence, risk assessment framework, and maintained regulatory compliance, including against CQC ratings and feedback from inspections. As a committee of the Board, the Quality and Safety Committee obtains routine assurance on compliance with CQC registration requirements from the CGC. Services are subject to objective visits by managers and findings collated for the DMTs to review and challenge. As a committee of the Board, the Finance and Investment Committee monitors and challenges the robustness of financial controls and escalates significant risks and actions where they do not appear robust.

Operational risks as identified by operational staff and managers are those that may foreseeably impede the safe delivery of high quality service to patients on a day to day basis. The implication is that a significant operational risk could adversely affect a service's ability to meet the organisational objectives.

Operational risks are identified, assessed, and documented at service level and monitored by the DMTs with any significant issues escalating to the CGC and the Quality and Safety Committee (with strategic risks) for assurance.

During 2016/17 the Trust recognised the most routinely reported significant operational risks likely to remain the focus of treatment during 2017/18 were:

- Demand and capacity issues within both clinical services and also corporate support functions. This was identified as a strategic issue and systems put in place referred to in the strategic risk referred to below.
- Potential breaches of waiting times for assessment and treatment. As these breaches occur they are now being reported via Ulysses as incidents to establish whether any harm has occurred and form part of monthly monitoring via the IPR.
- Information technology issues. These were identified as symptoms of more strategic issues and systems put in place referred to in the strategic risks 15/16.3 and 15/16.4 referred to below.

- Operational finance risks. These were acknowledged and reported to the Finance & Investment Committee during 2016/17 as follows:

    - **Deterioration of working capital balances leading to minimal cash balances**. This has been addressed by a number of measures aimed at building cash resilience. The trust has obtained agreement from its main commissioners to receive contractual income on the first of the month its due rather than previously on the fifteenth of the month. Reporting to the Finance and Investment committee, a cash sub-committee is in place which meets monthly to review the Trust's cash position, examines age of debt, outstanding payables, accrued income levels, and impact on our Finance and Use of Resources measure. In addition, the minimum cash balance was set at plan plus £0.5m. Working capital is managed accordingly to ensure that this is met. The Trust strengthened control on legacy debt through the establishment of the weekly aged debt meeting, leading to significant improvement in working capital balances.

    - **Pay/agency expenditure exceeds budget**. The need to strengthen controls on agency expenditure continued during 2016/17. As a consequence an executive-level panel was set up to consider and approve requests for engagement of agency staff. An agency tracker was set up to monitor expenditure, and a single vendor relationship set up to ensure procurement of agency staff at competitive rates.

    - **Efficiency programme not delivered**. Meetings have been established to monitor the trust's cost improvement (CIP) schemes via the Transformation, Improvement and Finance Group. A summary position is taken to the Finance & Investment Committee on a monthly basis. The trust's procurement team has a work plan in place with targets attached for the delivery of non-pay CIP. All schemes continue to be assessed by a Quality Impact Assessment panel to ensure clinical safety. In addition to the controls on agency spend, the top 25 overspending cost centres are reported each month for review at the Finance and Investment Committee.

    - **Other finance risks including impacts of budgetary overspends and commercial tenders**. The Finance and Investment Committee receive a detailed financial report on a monthly basis explaining the financial position and potential financial risks.

Strategic risks are those principal risks recorded on the Board Assurance Framework (BAF) that may foreseeably impede the ability of the organisation to deliver its objectives. Each of these retains controls, assurances and any gaps that are the responsibility of a lead director.

The assurances are within those documents received by the Board. The strategic risk profile as at the end of March 2016 appears:

- 2 Extreme Risks
- 3 risks scoring High (12)
- 2 risks scoring High (8 to 10)
- 0 risk scoring Moderate (4 to 6)
- 0 risks scoring Low (1 to 3)

Risks scoring Extreme (15):

Failure to have an appropriately resourced, focussed, resilient workforce, organisation and culture in place to deliver statutory, professional and contractual obligations
Operational and corporate services support the delivery of clinical care and are made possible by people who are critical to the success of the organisation. Failure to attract and retain staff and lack of investment in training and development potentially reduces the efficiency and sustainability of the Trust.

Failure to implement sound systems of Quality
The business of the organisation must be founded on clear accountability structures supported by sound financial, quality and governance systems, and regulatory compliance, in order to remain sustainable. Failure to evidence this, or to respond to gaps or inefficiencies in these systems, destabilises the business framework of the whole organisation.

Risks scoring High (12)

Failure to implement sound systems of Finance
The business of the organisation must be founded on clear accountability structures supported by sound financial, quality and governance systems, and regulatory compliance, in order to remain sustainable. Failure to evidence this, or to respond to gaps or inefficiencies in these systems, destabilises the business framework of the whole organisation.

Failure to deliver a balanced and sustainable portfolio of services
Contracts are in place for the Trust to deliver services for commissioners, and also with third-party suppliers who deliver services to Bridgewater. In order to successfully operate commercially the Trust must identify, tender, gain, monitor, retain and (at times), decide to

dis-invest in contracts. Failing to have systems in place that do this adequately place the Trust at risk of poor returns, poor service safety or quality, and reputational damage.

IM&T systems that fail to meet the current and future needs of the organisation
We are dependent on IT systems for most of our principal business processes. The failure of a key system may cause significant disruption to our operation and/or lost data integrity or information governance issues. Opportunities may be missed to improve systems and/or reduce cost.

Remaining risks not prioritised as Significant but remaining under review during the year and as a foundation for considering the 2016/17 Strategic Risks:

Failure to influence, shape and respond to the needs of our communities and wider health and care systems
Community care is commissioned within a broad and complex scope of health and social care that can change quickly. Inadequate and/or slow response to change, or not recognising a change in service provision, reduces the credibility and role of the organisation in planning and providing healthcare which strikes a balance between the sustainability of the organisation and healthcare systems. Our organisational culture and structure shape our ability to adapt to market changes with pace.

Failure to implement sound systems of Corporate Governance
The business of the organisation must be founded on clear accountability structures supported by sound financial, quality and governance systems, and regulatory compliance in order to remain sustainable. Failure to evidence this, or to respond to gaps or inefficiencies in these systems, destabilises the business framework of the whole organisation.

The Board meets on a monthly basis and delegates specific monitoring responsibilities in order to receive assurance reports from the Quality and Safety Committee as a committee of the Board. The Trust Chair was responsible for the leadership of the Board and ensured that members of the Board had access to relevant information to assist them in the delivery of their duties. Records of Board attendance are reported in the Annual Report and these confirmed that their attendance ensured that all the twelve meetings of the Board were quorate. All fourteen members of the Board attended the required number of meetings. The NEDs actively provided scrutiny and contributed challenge at Board and Board Committee level. The Board and its committees comprised membership and representation from appropriate staff and non-executive directors with sufficient experience and knowledge to support the committees in discharging their duties. The Board was well attended by all executives and non-executives throughout the year, ensuring that the Board was able to make fully informed decisions to support and deliver the strategic objectives.

Governors attend Board meetings as observers and are therefore party to the presentation of information and assurance that relate to Trust risks and incidents. Routine quality meetings, and also performance meetings, are held with each of the Trust's commissioners (Clinical Commissioning Groups or NHS England depending on the service) in order that they receive assurance on service quality, risks, and are challenged on any exceptions are being addressed.

In 2016/17 the Trust completed a Corporate Governance Statement (required under NHS foundation trust condition 4(8) (b)). The Board was satisfied that systems and standards of corporate governance are sound. The Trust Secretary engages with the NHS Providers Company Secretaries Network and routinely checks the NHS Improvement website and publications to ensure the trust remains compliant and responsive to any new information or requirements. Terms of Reference for the Board and committees were reviewed during 16/17 and governance and organisational structures from front line services down to the Board also reviewed and published. External audit reports support the annual financial accounts and quality report, despite the qualification of the value for money conclusion due to the CQC rating of Requires Improvement. The Finance & Investment Committee, as a committee of the Board, routinely scrutinises the Trust's financial decision-making, management, and control. The Board receives annual confirmation that the Trust complies with the conditions of its licence. There is an Accountability Framework and Escalation Framework in place to ensure the Board is sighted on significant issues and risks in an appropriate manner. The Trust undertook a review of its senior structures to ensure suitable leadership was in place across the organisation. The Trust undertakes a range of engagement with its stakeholders, through Patient Partners, via Health Watch. The Listening into Action programme is a Trust-wide staff engagement programme, and directors regularly undertake drop-ins to team meetings. Non-executives take part in Quality visits to services and engage with staff and service users to gauge the effective delivery of a service on site.

Policies, procedures, and clinical guidelines and associated staff training/implementation are the most common form of control for the majority of both strategic and operational risk. The Policy Approval Group has delegated responsibility for establishing policy development guidelines, reviewing, and approving the policies for the Trust. Built into the process for policy development, each document can only be approved once evidence of an equality impact assessment has been completed.

The IPR and quality dashboard continue to be reviewed regularly by Board and the Director Team. Each responsible director reviews his/her component contribution and these are triangulated to provide a rounded picture of risks, outcomes, and impact on service safety and delivery, and the strategic objectives of the organisation.

All services are encouraged to report incidents and team leaders and managers have access to monthly face to face training with the Head of Risk Management and Patent Safety to

cascade and engender a culture or incident reporting, including drafting trigger lists for staff to adhere to. Generic usernames and passwords are in use for staff and incidents can be reported anonymously if they wish. They can also use the Ulysses incident report form to maintain a record of apologies or acknowledgement to patients or relatives in accordance with the Being Open Policy and as part of the Trust's Duty of Candour requirements.

There was an escalation framework that ensured Board members were briefed on any significant events or risks between Board meetings. When this happened, Board members received an email entitled 'Flash Report' from the Trust Secretary, with detail including the nature of the issue, immediate remedial action, any likely media interest, long-term action, and to which Board or committee meeting a formal report on the issue will be presented.

The Audit Committee oversees a programme of counter fraud arrangements, including the contract with MIAA for a Counter Fraud Officer. An MIAA Internal Audit Plan was developed and produced to address and ensure coverage of key risk areas of the trust, with reference to strategic risks identified within the BAF, management requests into areas of potential gaps and weaknesses etc.

The Trust engaged KPMG to undertake a financial governance review over the summer of 2015/16. It made thirty-five recommendations across ten domains to improve financial governance. The work to address these was overseen by the Finance and Investment Committee. A follow up review was undertaken by the same firm during the summer of 2016 and confirmed that against the ten domains used to assess the trust, it scored either green or amber green, significant progress from the previous year, with ongoing continuous improvement work to further strengthen the arrangements. This improvement was sufficient to remove any governance concerns held by the Trust's regulator, NHSI, with the rating returned to 'green' and no immediate concerns.

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust continues to strive to deliver high quality services and has arrangements in place to monitor ongoing compliance with the Care Quality Commission Fundamental Standards.

During 2016/17, the Trust was subject to a full announced inspection by the CQC. Immediate feedback given by the inspection team led to some rapid improvement work undertaken to the satisfaction of the team. The full report was published in February 2017 and gave the Trust a rating of Requires Improvement, based on one 'Outstanding' score, 27 'Good' scores and 12 'Requires Improvement' scores. The Trust has action plans in place against each of the recommendations made and is expecting further visits to re-inspect areas identified in the report. A full re-inspection, which should lead to an improved rating will take place in approximately twelve months' time.

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 the organisation's obligations under 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 this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are met.

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

The Trust's Finance & Investment Committee oversaw delivery of the Trust's efficiency programmes, and provided appropriate assurance directly to the Board that delivery was on track. Reporting to this committee, the Cost Improvement Programme (CIP) group (now the Transformation, Improvement and Finance group) was responsible for ensuring that cost improvement programmes remained on target and was able to take remedial action when it became apparent that plans were not going to deliver their targets. The Finance and Investment Committee received regular reports on the top twenty five overspending budgets throughout the year and were assured as these deficits were driven down. Throughout the year, there has been significant focus on workforce, and the use of agency and locum staff in particular. The vacancy approval panel extended its remit to agency and locum usage, and the Trust engaged a broker (DePoel) to improve its governance arrangements and to ensure that the Trust benefitted from the best available rates for the staff it required.

Whilst the Finance & Investment Committee provided assurance to the Board from a financial standard point, integral to the delivery of efficiencies was the Trust's rolling Quality Impact Assessment (QIA) programme. QIA panels met at the beginning of each efficiency project (at project scope change), at the design stage, and immediately prior to sign off. If a scheme was foreseeably deemed to have an adverse impact on quality or patient safety, then the sponsor was required to address the concerns of the QIA panel and to resubmit for further assessment. If the panel's concerns prevailed, the scheme would be replaced with another scheme. Overall responsibility for each project proceeding to implementation rested with the Medical Director and the Chief Nurse. The Quality and Safety Committee was in receipt of quarterly QIA summaries for monitoring and assurance purposes. After the initial sign off of an efficiency initiative, there was an ongoing process in place to monitor

the progress and efficacy of the initiative on service quality and delivery, the frequency of review determined according to the level of risk they present. An Internal Audit review of the CIP and QIA process received significant assurance. Finally, the Board took assurance from the fact that the Trust met its planned financial target at the year-end without compromising quality, evidenced by we met our statutory targets.

NHS Improvement award a rating for finance and use of resources based on the scoring of measures from '1' to '4' where '1' reflects the strongest performance. These scores are then weighted to give an overall score, one of the five themes feeding into the Single Oversight Framework. The Trust's scores are shown below.

Area	Metric	2016/17 Q3 score	2016/17 Q4 score
Financial sustainability	Capital service capacity	1	1
	Liquidity	3	2
Financial efficiency	I&E margin	3	1
Financial controls	Distance from financial plan	2	1
	Agency spend	3	3*
Overall scoring		**2**	**2****

*The agency score reflects the Trust's continued use of agency, particularly medical locums in hard to recruit posts to ensure safe service provision. All agency posts have been assessed by the Board to justify the expenditure versus the NHSI agency cap.

**1.6, uncapped and unrounded.

Information governance

Bridgewater Community Healthcare NHS Foundation Trust Information Governance Assessment Report for 2016/17 is graded green and validated as satisfactory.

The Information Governance Toolkit (IGT) provides an overall measure of the data quality systems, standards and processes. The score a Trust receives is therefore indicative of how well the Trust has followed guidance and good practice. An audit was conducted by Mersey Internal Audit Agency during February/March 2017 to evaluate and validate the Trust's self-assessed scores. The final report from Mersey Internal Audit Agency granted the Trust "Significant Assurance".

There were two information governance serious incidents during 2016/17 that required reporting to the Information Commissioner's Office, they were:

- Information relating to staff was accidently disclosed to another member of staff during a Subject Access Request
- The Trust was subject to a ransomware attack during May 2016

Both incidents were investigated by the Information Commissioner's Office and closed with no further action. The information accidently disclosed was destroyed and not shared further and the process deployed during the ransomware attack resulted in no information loss or compromise. It was the Commissioner's opinion that the Trust acted appropriately on both occasions with good policies and processes already in place.

After the reporting period, in common with many other NHS organisations, the Trust was subject to a further ransomware attack during May 2017. This has been reported to Information Commissioner and investigation is ongoing at the time of writing. The Trust was minimally affected and suffered no data loss.

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.

The trust published an annual quality report in line with the requirements set out in the NHS Improvement Detailed Requirements for Quality Reports 2016/17. All contributors to the report are responsible for ensuring the accuracy of the data reported. This includes ensuring that data are consistent with the data reported throughout the year as part of the on-going assurance processes and systems. External assurance is obtained in order to provide independent assurance of the accuracy of the data and the results are published in the quality report as required.

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 managers and clinical leads within the NHS foundation 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 risk/ clinical governance/ quality committee, if appropriate] and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During the year, the Board undertook a review of its effectiveness, with the output of the exercise used to inform the board development programme in place throughout the year. The Trust has used a combination of internal subject matter experts and external development support. All Board members have an appraisal with the Chair or Chief Executive, and the Council of Governors oversee the performance review of the Chair and the Non-executive directors of the trust to help inform their decisions on the re-appointment or termination of Non-executives as necessary.

The Audit Committee has separate internal and external audit plans. The Committee meets on a quarterly basis with representation from both internal and external audit functions. An annual work plan is produced. The Audit Committee's primary role is to conclude upon the adequacy and effective operation of the organisation's overall internal control system.

The main focus of an Audit Committee's work is related to internal financial control matters, the maintenance of proper accounting records, the reliability of financial information, and a wider focus on the safety and quality of patient care. However, the trust's Audit Committee also considers the findings of clinical audit across operational services.

During the financial reporting period for 2016/17 the Audit Committee have complied with 'good practice' recommended through:

- Agreement of Internal and External Audit and Counter Fraud plans.
- Regular review of progress and outcomes, i.e. risks identified and action plans agreed.
- Private meetings with External and Internal Audit.
- Regular review of the Audit Committee work plan.
- Review of the Committee's Terms of Reference.

The overall opinion from the Director of Audit was:

"Significant Assurance can be given that that there is a generally sound system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently."

Throughout the year the Audit Committee has worked effectively with the internal auditors to strengthen the Trust's internal control processes. The Internal Audit Plan has been delivered in accordance with the schedule of days agreed with the Committee at the start of

the financial year. During the year, some agreed amendments to the plan had been approved by the Audit Committee. The Committee Chair reported these amendments to the Board.

During the year MIAA has completed 15 internal audit reviews, covering both clinical and non-clinical systems and processes and formed a view on the level of assurance as follows:

INTERNAL AUDIT PLAN OUTPUTS	ASSURANCE LEVEL
Nurse Revalidation	Significant
General Ledger	Significant
Accounts Receivable	Significant
Accounts Payable	Significant
Capital Asset Management	Significant
Information Governance Toolkit	Significant
Cost Improvement Programme & Quality Impact Assessments	Significant
IT Virtual Desktop infrastructure	Significant
Feedback of Learning to staff	Significant
Mobile Computing	Limited
Payroll	Limited
IT Asset Management	Limited

There were no reports were issued with No Assurance during the year and no reports were issued with High assurance during the year.

Three reports were issued which did not contain an assurance opinion; these were Assurance Framework, Cyber Security and a briefing note issued on Wound Management.

These audits were all supplied to the Audit Committee for oversight and to provide assurance. The Audit Committee and the Quality and Safety Committee were also in receipt of the progress of Clinical Audit programmes across the trust. .

All audits carry responses to any risks identified in internal audits. Those receiving Limited assurance carry High risks with responses as follows: -

Mobile Computing A risk assessment process is underway to develop a comprehensive approach for the future. Risk assessment information will form a baseline. Policy update will be required, and Airwatch skills development. PIN length to increase to 6 digits. The strategic domain password length and complexity cannot be changed currently as it has a domain trust dependency with a legacy domain which is due to be decommissioned. A 90 day check and reconciliation process is being developed with an interim check process to attempt to control what is known and possible. A deployment checklist is to be developed.

Payroll The Trust has republished deadline dates and process via the global email and bulletin. Email reminders of dates to the Assistant Directors for cascade to all team leaders. Forms are sent electronically to the Finance ESR box. Sanctions for managers who continue to fail to adhere to the agreed timeframes are being agreed**.**

IT Asset Management The Trust is in contact with suppliers to agree appropriate contractual constraints. A consultation process is underway with IG to agree specific wording to enable the correct security protection. Asset management is to be subject to a complete overhaul that will result in procedure rewrite that will incorporate management checks. Asset database containing an accurate reflection of this requirement is in development and will be released along with comprehensive procedures incorporating review checks.

Conclusion

The systems of internal control are sound and they have been reviewed and are able to identify and escalate any significant issues speedily and appropriately to the proper level. The trust identified risks associated with the CQC rating of Requires Improvement during 2016/17. All of the 'musts' have been addressed in 2016/17 and the entire action plan will continue to be addressed throughout 2017/18. Although they remain a significant risk to the organisation, suitable controls are in place to mitigate the effect on the organisation and assurance available to monitor or receive any significant risks.

Accounting Officer: Colin Scales (Chief Executive)

Organisation: Bridgewater Community Healthcare NHS Foundation Trust

Signed: 

Date: 26 May 2017

4. Quality Report 2016/17

Quality first and foremost

Contents

Part 1

Statement on Quality by Chief Executive

Bridgewater Community Healthcare NHS Foundation Trust has focused on delivering quality first and foremost during 2016/17. This latest report is a review of how we have performed during the year and it looks forward to the year ahead, setting out the quality priorities we will be focusing on.

In June, the Care Quality Commission (CQC) carried out their comprehensive inspection of the Trust. The overall rating for the Trust from this inspection is *requires improvement*. The CQC's Quality Report identified many areas where we have improved since their last inspection visit in 2014; it is a valuable source of information about where and how we can do better to provide high quality care for all patients.

I was impressed by the commitment and dedication shown by all of our staff in the weeks building up to the inspection, during the inspection and subsequently.

Everyone who came into contact with the inspectors did themselves, their patients, their colleagues and the Trust proud. I am also proud and delighted that the inspectors rated our services as caring without exception and that the report highlighted the compassion and dedication of our staff and the difference that they make providing care to patients every day. I am really pleased that they have been publicly recognised for this and that our outstanding clinical practice has attracted the praise it deserves. Of the 40 service ratings we received, one was outstanding, 27 were good and only 12 were deemed to require improvement. That is something that we can all be very proud of indeed. Here are a few stand out points from the report for me:

- During our inspection we gathered many examples of instances of staff going the extra mile for their patients which demonstrated their commitment and a desire to give the very best care to their patients.
- We were told all the nursing staff visiting patients' homes were 'brilliant', 'wonderful' and 'superb'.
- In all services, we were told staff involved patients and carers in planning and where possible delivering their care and treatment.
- We observed staff interacting with children and their families in a caring and respectful manner.
- In community End of Life services one patient said "she is here for me, I can ask anything and really appreciate her coming, she understands what is happening

and I can ask her anything, I have no fear, I have confidence in her that she's not hiding anything from me."

The last year has seen a number of new posts within the senior nurse leadership. The appointments included two Associate Chief Nurses, Associate Director Quality Governance, Associate Director for Safeguarding and Associate Director for End of Life Care. These roles will make an invaluable contribution to shaping and enhancing services across the Trust.

The notion of devolved autonomy is something that the director team and I have given much thought to over the year. With the refreshed operational structures in place, it is increasingly important that decisions are taken as close to the patient as possible. That means operational teams, including their administrative and support teams, working closely with their colleagues in corporate services, being empowered to manage their services with increasingly less recourse to the corporate body.

One of the intentions behind this approach is to develop a system of truly empowered, collective leadership which will break down some of the bureaucracy that clinicians tell me sometimes gets in the way. Governance keeps us safe, but too much of it will stifle innovation and progressive leadership amongst our clinicians and teams.

As Chief Executive I am confident that the Trust provides a high quality service and that this Quality Report demonstrates this. To the best of my knowledge the information in this account is accurate and fairly reflects the quality of the care we deliver.

Colin Scales

Chief Executive

A bit more about us…

We seek to provide high quality community and specialist services to 945,200 people living in:

- Runcorn & Widnes (Halton)
- St Helens
- Warrington
- Wigan Borough
- Oldham
- Bolton

Bridgewater also provides community dental services in all of the above areas (except Oldham) plus Bolton, Tameside, Trafford, Glossop, Stockport and western Cheshire which covers a population of 2.1m. The majority of our services are delivered in patients' homes or at locations close to where they live, such as clinics, health centres, GP practices, community centres and schools. We also provide offender health services.

As a provider of both mainstream and specialist care our role is to focus on providing cost effective NHS care by keeping people out of hospital and supporting vulnerable people throughout their lives. As a dedicated provider of community services our strategy is to bring more care closer to home – this means providing a wider range of services in community settings to keep people healthier for longer and developing more specialist services to support people to live independently at home.

We employ 3212 staff and have an income of £164m which comes from our commissioners, who include Clinical Commissioning Groups (CCGs), NHS England and local authorities.

- **NHS Warrington CCG** represents 26 GP practices, acting on behalf of over 216,000 patients living in Warrington
- **NHS Halton CCG** represents 16 GP practices, acting on behalf of over 130,000 patients living in Halton
- **NHS St Helens CCG** represents 35 GP practices, acting on behalf of over 196,000 patients living in St Helens
- **NHS Wigan CCG** represents 63 GP practices, acting on behalf of over 325,000 patients living in Wigan

In a typical week Bridgewater delivers around:

- 5,990 patient contacts in our walk in centres
- 200 bed days in our community hospital (Newton)
- 12,600 patient contacts in our district nursing services
- 1,300 patient contacts in our community dental services
- 22,830 patient contacts in our other services

Part 2

Review of progress against the 2016/17 Priorities for Improvement

Priority for Improvement	Update
Improve the quality of record keeping - legally defensible documentation as this is a recurring matter in complaints and investigations.	The organisation commissioned defensible record keeping training. A number of managers attended the session in order to gain the knowledge and skills to provide cascaded training sessions across the organisation. There is now a group of record keeping trainers identified and a rolling programme of training is in place with identified levels of training and competence per staff band. Band 6 and above staff receive a full days training session as they are responsible for monitoring the quality of record keeping locally within their teams and address any issues in line with the organisational standards communicated within the training. This is also audited as part of the monthly record keeping audit with action plans developed for any gaps identified. Band 5's and below receive a half day training session. This training is identified as essential training for all clinical staff who would document, review or audit records as part of their role. Record Keeping compliance at the end of March 2017 was 24.07% for the new face-to-face sessions. There are plans in place to improve this compliance in 2017/18.
Reduce medication errors – continue to reduce internal drug errors and effectively handle third party incidents. Medication errors are consistently in the top 3 of reported incidents.	There has been an increase in the number of reported medicines incidents. Increased visibility of the medicines management team appears to be directly linked to the increased numbers of reported incidents. The medicines management team have developed good working relationships with teams both internally and externally. Incidents are shared with third parties as they occur. The Medicines Interface Group has been re-established so that lessons learnt are shared and discussed. Medication incidents remain in the top three of reported incidents and the severity increased in 2016/17 (2015/16 grade 0=93, 1=187, 2=63, 3=1 2016/17 grade 0=127, 1=185, 2=79, 3=19)
Reduce harm from pressure ulcers – continue to reduce Bridgewater Pressure Ulcers. Reducing the number of grade 3 and 4 pressure ulcers and increase the use of the Trusts pressure ulcer reporting tool.	Harm Free Group established, with initial focus on pressure ulcer quality work streams. Pressure ulcer improvement plan developed with a focus on: ▪ ensuring accurate reporting and recording of data ▪ ensuring effective systems and processes are in place to investigate pressure ulcer incidence ▪ providing a framework for learning from pressure ulcer incidents ▪ Please see the section on pressure ulcers for further information.

Review of progress against the Unmet 2015/16 Priorities for Improvement

Priority for Improvement	Update
Sign up to Safety	An extensive action plan with a work programme for 2015/16 was agreed. This has been updated on a quartile basis and reported to the Trust's Quality and Safety Committee. In addition reports have also been received at the Clinical Quality Review Meetings with Commissioners. The work programme for 2016/17 included: 1. Medication Safety - Continue to reduce internal Trust drug errors and effectively handle third party incidents. See previous page and the Medication Safety section for further information. 2. Pressure Ulcers - Continue to reduce avoidable Bridgewater pressure ulcers and audit the use of the Trust's pressure ulcer reporting tool. See the Pressure Ulcer section for further information. 3. Evaluate the "fallsafe" data and identify key priorities for the reduction of falls in Newton Community Hospital and Padgate House. See the Falls section for further information. 4. Implement the Bridgewater Food and Drink Strategy. The Bridgewater Food and Drink Strategy outlines our ambitions over the next four years to provide high quality and nutritious food to our in-patients, and support healthy eating for our community patients, clients and all our staff. Community trusts are in an ideal position to support patients in the community to prevent malnourishment. When a patient is discharged from hospital it is important that the patient is supported to continue to monitor their nutritional needs. A number of initiatives have been undertaken in 2016/17: ▪ Oldham Children's services took part in the Big Brush Week which gave an opportunity to reinforce with parents the importance that every child should have their teeth brushed with family fluoride toothpaste at least twice a day as soon as the first tooth appears. The initiative is part of on-going work in Oldham to give parents advice, help and support so that they can make the right choices for keeping their children's teeth decay free. ▪ Bosom Buddies in Warrington continued to support volunteers to help other breast feeding women. A training package is available to help women become a Bosom Buddy Volunteer. ▪ Right Start Oldham received international recognition from UNICEF (United Nations Children's Fund) by receiving the Baby Friendly Award for their work to increase breastfeeding rates and improve

	care for mothers. ▪ The Bridgewater health hub for staff was launched on the Trust intranet. It is designed to help staff improve or maintain their physical and mental health by offering lifestyle tips as well as useful advice and information. 5. Improve rates of training compliance with both children and adult safeguarding. The Safeguarding Training Needs Analysis now reflects the intercollegiate document 2014. See the Safeguarding section for further detail.
Improvement in the handling of serious and untoward incidents	The Associate Chief Nurses introduced a Quality and Safety Meeting for each of the Directorates. These meetings provide the opportunity for clinical staff to work with senior nurses to scrutinise and challenge their reporting of serious and untoward incidents. A Case Note Review checklist was developed for pressure ulcer Serious Incidents (SIs) during 2015/16 and then revised in 2016/17. Based on the information provided in the investigation, if it was felt that there were any lapses in care, quality, or service delivery, it could progress to a Root Cause Analysis (RCA) investigation. There are weekly SI meetings which involve senior nurses and the risk team. This is an opportunity to review all SI's to ensure that all risk management processes have been followed, that Case Note Reviews and RCA's have been completed, provide assurance that staff have followed protocols and procedures and that lessons learnt have been identified. Once information has been checked and verified it is then shared with our commissioners. Lessons learnt are shared via team meetings and on the intranet and internet. The lessons learnt framework has undergone an internal audit process (2016/17) whereby the Trust received Significant Assurance.
NHS Safety Thermometer improvements in care	The NHS Safety Thermometer enables nursing teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (patients who have a catheter) and venous thromboembolism. Known as a point prevalence audit this is undertaken for all patients who are seen by nursing services in their own homes or bed based units on a specified day each month. Refer to Safety Thermometer section for more information.
Newton Hospital Vision and Strategy	The Commissioners undertook a review of intermediate care services in St Helens which has now been shared and sets out clear commissioning intentions. The services including Newton Hospital inpatient unit where put out to tender by the commissioners in September 2016. Following a bidding process, St Helens and Knowsley Hospitals NHS Foundation Trust was identified as the organisation that will provide these services from the 1 April 2017. The new service specification will give the receiving

	organisation a direction as to the future intentions for the service and provide clarity for any future strategy/operational plan. In the meantime, staff working in the inpatient facility have participated in several initiatives throughout the year to equip them with the confidence and competence to improve services for patients. The ward recently achieved an overall Good rating following a recent CQC inspection with an Outstanding rating in the domain of caring.

Review of progress against the Unmet 2014/15 Priorities for Improvement

Priority for Improvement	Update
To develop an innovative evidence base, self-care approach to the treatment of atopic eczema in Children	The Eczema Expert pilot has not progressed in the last 12 months due to a number of internal and external issues. It will remain under review by Community Dermatology Specialist. No further update will be included in the next Quality Report.

Priorities for Improvement in 2017/18

Quality priorities for 2017/18 include:

- Continue with the Fall Safe programme in Padgate House and implement the programme for Alexandra Court. These services offer in-patient intermediate care services. This is a priority as falls continue to be in the top three of reported incidents.
- In 2016 there was a national drive, and therefore this is deemed to be a priority, to improve the management of sepsis within the NHS. This was due to the delayed identification of sepsis when treating patients. The Trust has developed guidance in the management of sepsis. Training will be provided for appropriate clinical staff in the management of sepsis and clinical audit will be undertaken to ensure staff are compliant against the standards. The Trust will promote this via social media so that the wider public is made aware of sepsis.
- The CQC identified that there was a requirement to coordinate End of Life Care (EOL) across the boroughs and therefore this is deemed to be a priority. There were a series of workshops across the boroughs in which patients, staff and local agencies were involved in developing the strategy. The EOL strategy was then launched throughout the Trust led by the Associate Director of EOL services. It sets out our commitments to our communities and provides information as to how end of life care will be addressed and the tools that will be used to support this. It also provides information on how training, education and support will be provided to the staff.

During 2016/17 a series of workshops were held with clinical directorates (comprising of clinical and service managers) which were supported by corporate teams (planning, commercial, finance, contracting, human resources, information). The workshops identified the services' strategic direction and clinical operational development opportunities for 2016/17 and up to 2020/21. The above three priorities are a sub-set of the 23 that were agreed during this process.

The priorities will be monitored through the Trust governance infrastructure. Information is gathered by triangulating data and quality reports which are discussed and monitored at monthly Quality and Safety sub groups, Directorate team meetings and the Trust Clinical Governance Sub Committee.

To give assurance to the Trust Board they monitor performance on a monthly basis by receiving regular reports on all quality and operational issues. This enables the Trust to demonstrate its commitment to encouraging a culture of continuous improvement and accountability to patients, the community, the commissioners of its services and other key stakeholders.

Statements of Assurance from the Board

Review of Services

During 2016/17 Bridgewater Community Healthcare NHS Foundation Trust (Bridgewater) provided and/or sub-contracted 283 relevant health services.

Bridgewater has reviewed all the data available to them on the quality of care in 100% of these relevant health services.

The income generated by the relevant health services reviewed in 2016/17 represents 98% of the total income generated from the provision of relevant health services by the Bridgewater for 2016/17.

Participation in Clinical Audits

During 2016/17 one national clinical audit and one national confidential enquiry covered relevant health services that Bridgewater provides.

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

The national clinical audits and national confidential enquiries that Bridgewater was eligible to participate in during 2016/17 are as follows:

- (COPD) - Pulmonary Rehabilitation

- NCEPOD Child Health Clinical Outcome Review Programme: Chronic Neurodisability

The national clinical audits and national confidential enquiries that Bridgewater Community Healthcare NHS Foundation Trust participated in during 2016/17 are as follows:

- (COPD) - Pulmonary Rehabilitation
- NCEPOD Child Health Clinical Outcome Review Programme: Chronic Neurodisability

The national clinical audits and national confidential enquiries that Bridgewater participated in, and for which data collection was completed during 2016/17, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry. NB - None of the national clinical audits and national confidential enquiries that participated in during 2016/17 have completed the data collection period.

The reports of one national clinical audit was reviewed by the provider in 2016/17 and Bridgewater intends to take the following actions to improve the quality of healthcare provided:

	Title	Actions
1	2015 National Audit of Parkinson's – local report published April 2016	The service undertook a local audit following national audit findings. The patient feedback and the review of patient records in the local audit showed that the quality of both oral and written communication could be improved. The information pack which is given to patients on an annual basis has been enhanced to include the Parkinson's society and other support organisations.

The reports of 30 local clinical audits were reviewed by the provider in 2016/17 and Bridgewater intends to take the following actions to improve the quality of healthcare provided – please see Clinical Effectiveness section of this report for further detail.

The reports from all clinical audits completed across Bridgewater are detailed in the Trust's clinical audit annual report (anticipated completion date July 2017). To request a copy of the report please contact clinical.audit@bridgewater.nhs.uk

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by Bridgewater in 2016/17 that were recruited during that period to participate in research approved by a research ethics committee was 150. The number of new studies approved during 2016/17 was 21.

Goals agreed with Commissioners - Use of the CQUIN Payment Framework

A proportion of Bridgewater's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between Bridgewater 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.

For further details regarding the agreed goals for 2016/17 please see the CQUIN section and for the following 12 month period the information is available electronically at: www.bridgewater.nhs.uk/aboutus/foi/cquin/

Bridgewater is currently reporting a monetary total income of £1.723m subject to final confirmation from commissioners regarding quarter 4 data.

The monetary total for the associated payment in 2015/16 was £2.873m.

What others say about the Provider - Statements from the CQC

Bridgewater is required to register with the Care Quality Commission and its current registration status is full and unconditional registration.

The Care Quality Commission has not taken enforcement action against Bridgewater during 2016/17.

Bridgewater has not participated in any special reviews or investigations by the CQC during the reporting period.

CQC Inspection Rating

	Safe	Effective	Caring	Responsive	Well-led
Adult community	Good	Good	Good	Good	Good
Children	Good	Good	Good	Requires Improvement	Requires Improvement
Inpatients	Good	Good	Outstanding	Good	Good
End of Life	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Dental	Requires Improvement	Good	Good	Good	Requires Improvement
Midwifery	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement
Sexual Health	Good	Good	Good	Good	Good
Urgent Care	Requires Improvement	Requires Improvement	Good	Good	Good

The Trust was inspected by the CQC between 31 May and 3 June 2016. The CQC report was published on the 6 February 2017.

Overall the Trust received an outcome of Requires Improvement. Of the 40 domain ratings there was one outstanding, 27 good and 12 requires improvement scores and ratings of good across our adult community, inpatient and sexual health services.

Since the inspection and receiving the outline feedback, we have been making improvements; there have been some great strides made in community paediatrics, dental, end of life care and midwifery in particular to address areas raised by the CQC.

Our full action plan went to the CQC on the 20 March 2017. The action plans are reviewed by the Directorate Management Teams on a monthly basis. The CQC Hub meetings that were utilised to prepare for the inspection have also been reinstated in order to ensure progress against the required improvements.

All staff continue to a have a key role in ensuring that the standards they measure are maintained on a daily basis. The Trust continues to strive to deliver high quality services and has arrangements in place to monitor ongoing compliance with the CQC Fundamental Standards e.g. Quality Support Visits and monitoring of CQC action plans.

The Trust is fully compliant with the registration requirements of the CQC.

NHS Number and General Medical Practice Code Validity

Bridgewater submitted records during 2016/17 to the Secondary Uses service 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:

- 100% for outpatient care; and
- 99.1% for accident and emergency care

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

- 100% for outpatient care; and
- 100% for accident and emergency care

Information Governance Assessment Report

Bridgewater's Information Governance Assessment Report for 2016/17 was 75% and is graded green and validated as satisfactory.

The Information Governance Toolkit (IGT) provides an overall measure of the data quality systems, standards and processes. The score a Trust receives is therefore indicative of how well the Trust has followed guidance and good practice. An audit was conducted by Mersey Internal Audit Agency during February/March 2017 to evaluate and validate the Trust's self-assessed scores. The final report from Mersey Internal Audit Agency granted the Trust "Significant Assurance".

There were two information governance serious incidents during 2016/17 that required reporting to the Information Commissioner's Office, they were:

- Information relating to a few staff members was accidently disclosed to another member of staff during a Subject Access Request.
- The Trust was subject to a ransomware attack during May 2016.

Both incidents were investigated by the Information Commissioner's Office and closed with no further action. The information accidently disclosed was destroyed and not shared further and the process deployed during the ransomware attack resulted in no information loss or compromise. It was the Commissioner's opinion that the Trust acted appropriately on both occasions with good policies and processes already in place.

Clinical Coding Error Rate

Bridgewater was not subject to the payment by results clinical coding audit during 2016/17 by the Audit Commission.

Statement on Relevance of Data Quality and your actions to improve your Data Quality

Bridgewater will be taking the following action to improve data quality.

The Trust recognises the need to ensure that all Trust and clinical decisions are based on sound data and has a number of controls in place to support the process of ensuring high quality data.

The Trust has used MIAA to audit performance reporting since May 2011. The overall objective of the audits is to provide assurance that the Trust has an effective process-controlled system for performance reporting.

The Trust has agreed and published a data quality policy to complement its data quality strategy and has also embarked on a data consistency programme that aims to ensure a consistent 'One Bridgewater' approach to recording data across all its Boroughs.

A data consistency implementation group was inaugurated and is chaired by the Area Director of Operations, who oversees data consistency progress aligned with service redesign and SystmOne roll-out across the Trust.

The Trust has continued to be proactive in improving data quality by providing:

- system training (and refresher training available on request)
- drop-in sessions for assistance with system use for data recording
- guidance and frequently asked questions (available on the Trust intranet).
- activity and data quality are to be standing items on clinical team meeting agendas
- activity recording and data quality will be referenced in Knowledge and Skills Framework and Performance Development Reviews
- Patient Access Policy reminders are being distributed to staff via the monthly Bulletin and Team Brief.

Reporting against Core Indicators

In accordance with NHS England requirements Bridgewater is able to provide data related to the following core indicators using data made available by the Health and Social Care Information Centre (HSCIC).

Core Indicator	2016/17	2015/16	2014/15
The percentage of patients aged 16 or over, that were readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting.	1.16% There were 343 discharges and 4 readmissions within 28 days	3% There were 323 discharges and 8 readmissions within 28 days.	2% There were 343 discharges and 7 readmissions within 28 days

NB – The above figures relate to Newton Community Hospital which is an intermediate care facility and only admits patients aged 18 or over. Therefore, direct comparison with the national comparative data below is not possible.

The National average for Emergency 28 day Readmissions for patients over 16 years of age for the 2011/12 reporting period (latest available data) is 11.45% and the North West average is 11.8%.

Bridgewater considers that this data is as described for the following reasons:

Reason	Days to readmission back into Newton Community Hospital
Fall	1
Carer breakdown	3

Bridgewater intends to take the following actions to improve this score, and so the quality of its services by:

- Continuing to implement the FallSafe care bundle
- Review carer assessment and support processes.

(NB – This service will be transferring to another provider on 1 April 2017 and the data above will be shared with the new provider.)

Core Indicator	Bridgewater 2014	Bridgewater 2015	Bridgewater 2016	National Average for Community Trusts	Highest Community Trust	Lowest Community Trust
If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation (Q21d NHS Staff Survey)	70%	78% (reported as 79% in last year's report)	71%	73%	86%	65%
% of staff that would recommend the Trust to friends and family as a place to work. (Q21c NHS Staff Survey)	49%	49%	49%	55%	70%	43%

Bridgewater considers that this data is as described for the following reasons:

- There has been continuous organisational change affecting staff. A restructure of senior management roles within operational services took place during 2016. It is recognised that change of this nature and scale can affect staff morale and their perceptions of the organisation. Work has been on-going during 2016 to try to improve this and whilst there has been no change with regards to the Trust as a place of work there has been a 7% deterioration in staff recommending the Trust as a place to receive treatment. Although we have seen a reduction in percentage, this is just 2% below the national average of response rates for Community Trusts.

Bridgewater intends to take the following actions to improve this score, and so the quality of its services by:

- continuing to undertake quarterly on-line surveys asking staff if they would recommend Bridgewater as a place of work. The survey is anonymous and enables staff to add their feedback/comments when responding. We will review these comments and further explore these with staff via our established mechanisms such as Open Space, Big Conversations etc.
- putting various initiatives into place to work further on staff engagement and these include: updating the intranet site – "The Hub", Director Quality Visits, Open Space Events, Professional Forums, Chief Executives Blog, Team Brief and Trust Bulletin,

Star of the Month, Annual Staff Awards and "you said, we did…..are doing" cascades and 'Listening into Action' groups.

Core Indicator	2014/15	2015/16	2016/17
Percentage of patients who were admitted to hospital (Newton Hospital only) and who were risk assessed for venous thromboembolism during the reporting period.	98.75%	98.47%	99.79%

VTE Screening Performance	Average % of VTE Patients Screened	Lowest Performance %	Highest Performance %
Bridgewater Average Full Year 2016/17	99.79%	97.07%	100%
National Average All Trust (April 2016 – Dec 16)	95.63%	95.47%	95.71%

(NB – the data in the above table from UNIFY2 relates to both Newton Hospital and our intermediate care service in Padgate House. Therefore a direct comparison is not possible. The table has been added to provide indicative data regarding the national average and the highest and lowest scores for this core indicator).

Bridgewater considers that this data is as described for the following reasons:

- One patient was not risk assessed due to being readmitted into the acute hospital within 24 hours.

Bridgewater has taken the following actions to improve this percentage, and so the quality of its services, by ensuring that all patients are risk assessed and appropriate actions/treatment for all patients within 24 hours of admission are completed where their length of stay is longer than 24 hours.

Core Indicator		2014/15	2015/16	2016/17
The number and, where available, rate of patient safety incidents reported within the trust during 2016/17, and the number and percentage of such patient safety incidents that	The number and, where available, rate of patient safety incidents reported within the trust during 2016/17	3999 incidents reported of which 1321 (33%) were submitted to the NRLS as patient safety incidents	3986 incidents reported of which 1293 (32%) were submitted to the NRLS as patient safety incidents (as of 6/4/16)	4676 incidents reported of which 1217 (26%) were submitted to the NRLs as patient safety incidents (as of 31/03/17)
	The number and percentage of such patient safety	There were 24 incidents resulting in	There were 20 incidents resulting in severe harm or	There were 16 incidents resulting in severe harm or

resulted in severe harm or death	incidents that resulted in severe harm or death	severe harm or death, 11 of which met the criteria for a patient safety incident	death, three of which met the criteria for a patient safety incident	death,12 of which met criteria for patient safety incident

Bridgewater considers that this data is as described for the following reasons, compared to 2015/16:

During 2016/17, 4676 incidents were reported (as of 31/3/17); 1217 (26%) of these were submitted to the National Reporting and Learning Service (NRLS) as Patient Safety Incidents. There were seven Patient Safety Incidents that resulted in severe harm or death that were treated as Serious Incidents and came under the Trust's Root Cause Analysis investigation.

From 2015/16 the volume of Patient Safety Incidents has decreased by 76 (6%) and the Trust continues to encourage staff to report incidents in order to prevent recurrence where possible and to promote opportunities to support staff learning and support service improvement.

The Trust considers that this data is as described for the following reasons, compared to 2015/16:

- The volume of Patient Safety Incidents has decreased by 76 (6%) and is a negligible difference due to maintaining closer scrutiny and more accurate reporting. Of these:
  - the overall volume of Patient Safety Incidents slightly decreasing, the ratio of No Harm incidents (Near Miss, Insignificant outcomes) increased by 13% through better reporting and more accurate recording
  - there was an increase of 61 Serious Incidents from 2015/16. The top three cause groups were slips, trips and falls, medication errors and pressure ulcers. From 2015/16 to 2016/17 there was an increased training programme delivered by the Risk Manager which incorporated root cause analysis template training and case note reviews for pressure ulcers. There has also been the introduction of weekly patient safety meeting to review pressure ulcers and weekly serious incident reviews. All of these factors have led to a positive increase in reporting.

Bridgewater has taken the following actions to improve this data and indicators, and so the quality of its services, by:

- maintained monthly training of investigators and managers in completing investigation documentation, incident management, risk assessment, and risk register maintenance

- routine scrutiny of incidents on a daily, weekly, and monthly basis by the Risk Team and senior clinicians which increases data quality and accuracy
- establishing weekly and monthly automated aggregate reports to assist monitoring by managers and the Trust.

Part 3 – Quality of Care in 2016/17

Trust Quality Measures

In 2013/14 Bridgewater agreed the following Quality Measures. They were chosen to reflect patient safety, patient experience and clinical effectiveness, and to measure the quality of care provided by a broad range of our services. Providing data on the same set of indicators over a number of years demonstrates where the care we have provided has either improved or declined.

Indicator to be measured	Change compared to previous year	2016/17 full year position	2015/16 full year position	2014/15 full year position	2013/14 full year position	Comments
Patient Safety						
Number of pressure ulcers which developed whilst patients were under our care	↓	39%	42%	38%	33%	The overall number of reported incidents increased, but the % ratio of reported pressure ulcers decreased.
No. of serious untoward incidents (SUIs)	↑	106	45	80	54	The volume of reported SIs increased by 61. The top three cause groups were slips, trips and falls, medication errors and pressure ulcers.
Proportion of incidents with outcome of "No Harm "	↑	53%	40%	45%	34%	Reported patient safety incidents with "No Harm" (near miss, insignificant) outcomes increased by 13% due to staff being encouraged to report all incidents.
CDI reported as lapse in care and apportioned to the Trust	↑	2	0	2	4	For further information please see HCAI section
MRSA reported as lapse in care and apportioned to the Trust	↔	0	0	0	0	For further information please see HCAI section
Ratio of patient falls (in-patient facilities)	↓	5%	6%	5%	3%	The number of reported falls incidents has decreased due to implementation of a FallSafe care bundle to help support the risk assessment and management of falls within all the inpatient units.
Percentage of admitted patients that have been risk assessed for VTE (Newton Hospital)	↑	99.79%	99.19%	98.75%	99.46%	One patient was not risk assessed as they were readmitted into the acute hospital within 24 hours

Clinical Effectiveness						
Percentage of patient facing staff that have been vaccinated against flu	ALW ↑ Warrington ↑ Halton ↑ St Helens ↑ Dental ↓ Total ↑	59% 51% 52% 47% 45% 52%	49% 50% 41% 38% 52% 46%	60% 48% 45% 47% 53%	56% 46% 36% 36% 45%	National average across all trusts 50.8% (NB the national figures are provisional and may vary slightly after further data validation)
Percentage of school age children immunised	HPV TD/IPV MenACWY					Please see appendix C NB – This indicator has been changed as Bridgewater no longer delivers the preschool immunisation programme
Number of patients re-admitted to the service within 28 days (Newton Hospital only)	↓	4	8	7	1	4 patients readmitted within 28 days to Newton one patient had a fall and there was a breakdown in carer arrangements for three patients. They were readmitted back into Newton Community Hospital which avoided admission to an acute bed
Patient Experience						
Staff who would recommend our services to friends and family	↓	3.61	3.63	3.55	3.48 (reported as 3.47)	The minimum score is 1 and the maximum score is 5.
End of life – Percentage of patients being cared for in their Preferred Place of Care (PPC)	Warrington ↓ ALW ↓ Halton ↑ St Helens ↑	95% 78% 91% 93%	97% 89% 85% 82%	97% 87% 81% 95%	95% 86%	Halton and St Helens have demonstrated an increase in the number of patients supported to achieve their PPC by District Nursing teams. Warrington has reduced slightly and Wigan borough has seen a reduction of 11%. In Wigan borough those who did not achieve their PPC because they were acute admissions for symptom management.
Percentage of patients indicating they had a good overall experience	↔	99%	99%	99%	98%	For further information please refer to patient survey and Friends and Family Test results sections of this account
No. of complaints	↑	94	88	91	88	The main drivers for the increase number of complaints was due to: ▪ Attitude of staff. ▪ Length of time waiting in the Walk in Centres. ▪ Communication/ information to

						patients.

Patient Safety

Implementation of Duty of Candour

Bridgewater is committed to supporting a culture of openness and transparency across all its services. The Trust has implemented the Duty of candour and staff receive face to face training in order to ensure that they are empowered to be open and honest with patients and carers in relation to care and treatment. It also ensures that patients receive accurate and timely communication, an apology and the support they need when things go wrong. The Trust recognises that patient safety incidents provide an opportunity to learn and ensures that learning is shared and embedded within the organisation.

All serious patient safety incidents are managed by clinical managers and assessed by the Associate Chief Nurses. The incidents which meet the criteria for the specific duty of candour are uploaded onto STEIS and monitored by the Risk team.

Duty of Candour issues are reported monthly to Board and all the Commissioners.

Patient Safety Improvement Plan as part of the Sign up to Safety Campaign

Some key aspects of our Sign Up to Safety Campaign included:

- NHS Safety Thermometer – see the NHS Safety Thermometer section for an update.
- Health Care Acquired Infections (HCAI) – see HCAI section for an update.
- Pressure Ulcers – see the Pressure Ulcer Section for an update.
- Falls – see the Falls section for an update.
- Open and Honest Care Reporting – On the Trust website we report monthly data on safety, infections, pressure ulcers, patient experience, staff experience, a patient's story and a synopsis of an area where we have improved care.
- Competency framework for all clinical disciplines – Since April 2015 we have been issuing the Care Certificate Workbook to new staff at Bands 1- 4, commencing in clinical support roles for example: Healthcare Assistants, Assistant Practitioners and Health Support Workers. We also offer this as a development opportunity for any other eligible staff. The Training Needs Analysis has been reviewed to identify what competencies are needed by staff roles in services.

Safety Thermometer

The NHS Safety Thermometer enables nursing teams to measure harm and the proportion of patients that are 'harm free' from pressure ulcers, falls, urine infections (patients who have a catheter) and venous thromboembolism. Known as a point prevalence audit this is undertaken for all patients who are seen by nursing services in their own homes or bed based units on a specified day each month.

The data tables below show the Trust data for harm free, all harms (harms experienced by patients prior to being cared for by the Trust) and new harms (harms experienced whilst a patient of the Trust) for 2016/17 compared to the national average.

Percentage of harms (all)	Apr 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
National	5.99%	5.92%	5.79%	5.66%	5.67%	5.85%	5.70%	5.66%	5.67%	5.76%	5.97%	5.87%
Bridgewater	5.15%	4.05%	4.60%	4.46%	4.49%	4.88%	4.01%	4.00%	4.40%	4.24%	4.24%	6.08%

Percentage of harms (New)	Apr 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
National	2.16%	2.13%	2.10%	2.02%	2.05%	2.18%	2.08%	2.05%	2.08%	2.10%	2.16%	2.15%
Bridgewater	0.88%	1.28%	1.50%	1.87%	1.41%	1.05%	1.59%	1.05%	1.80%	1.64%	0.91%	2.75%

Percentage of harmfree	Apr 16	May 16	June 16	July 16	Aug 16	Sept 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17
National	94.01%	94.08%	94.21%	94.34%	94.33%	94.15%	94.30%	94.34%	94.33%	94.24%	94.03%	94.13%
Bridgewater	94.85%	95.95%	95.40%	95.54%	95.51%	95.12%	95.99%	96.00%	95.60%	95.76%	95.76%	93.92%

In 2015/16 we identified that our data collection and reporting processes were not as effective as they needed to be, therefore in 2016/17 we have worked to improve this. We have done this by introducing a central point of coordination and clinical overview which means that data is shared back with teams to be checked for accuracy and evaluated. Recognising that the point prevalence approach to the survey means that not all patients with a harm will be captured each month and that this data is designed to highlight areas that we may need to look more closely at, we have also introduced quarterly reports. These are received by our Quality and Safety Sub Groups which means that this data set is now considered as part of our wider quality monitoring processes.

Between April 2016 and February 2017 our level of harm free care has remained consistently above the national average which means that patients receiving care from the Trust experienced less harms. This positive situation is also reflected in our levels of 'All' and 'New' harms which remained consistently below the national average between these dates. In March 2017 however we have seen a change in this trend through a significant rise in the number of harms reported as a result of pressure ulcers and falls which is reflected in a decrease in our level of harm free care. This therefore highlights, as described above, areas that we need to look more closely at and we will work with teams to understand the reasons for this. This evaluation will then be shared with our harm free care group to agree and implement any quality improvement actions we identify and share any learning across the Trust.

Falls

We record the incidence of falls in our inpatient units to improve patient safety and reduce harm. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients. For example, other hospitals/inpatient units may have younger or older patient populations, who are more or less mobile, or are undergoing treatment for different illnesses.

The recommended benchmark for recording falls is per 1,000 bed days. Not all Trusts report falls consistently, so the National Patient Safety Agency does not recommend comparing Trusts' recorded falls rate. Bridgewater do not currently report falls rates per 1000 bed days but report actual numbers of falls per month.
This is a future development to enable reporting in line with other NHS trusts.

Total Falls Rates	Padgate House	Newton Community Hospital	Maple Unit
2014/15 = 193	71	122	0
2015/16 = 245 (NB - this figure was incorrect in last year's account – previously stated as 215)	106	125	14
2016/17 = 225	96	114	15

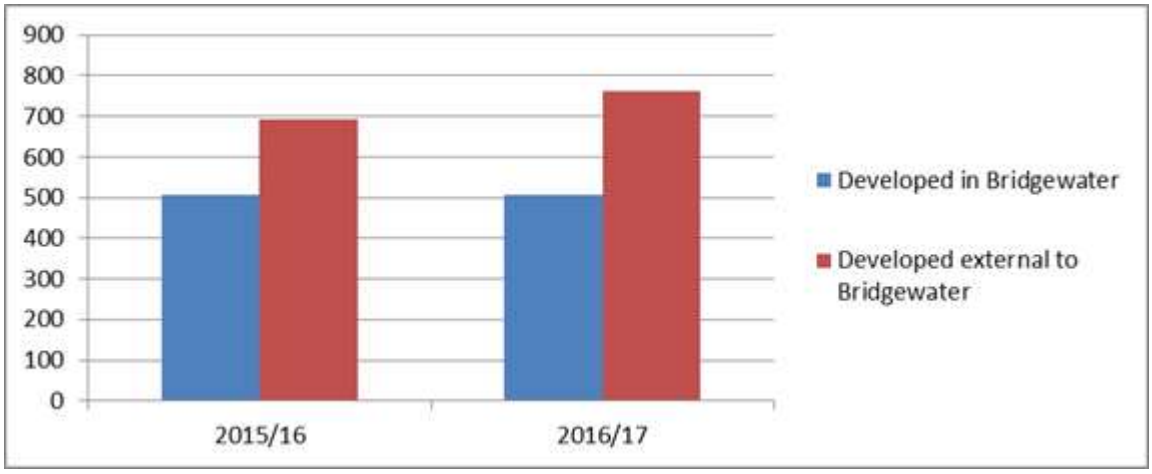
Newton Hospital – 8.8% decrease (Reduction of 11 falls for 12 month period)
Padgate House – 9.5% decrease (Reduction of 10 falls for 12 month period)
Maple Unit - 7% increase (Increase of 1 fall for 12 month period)

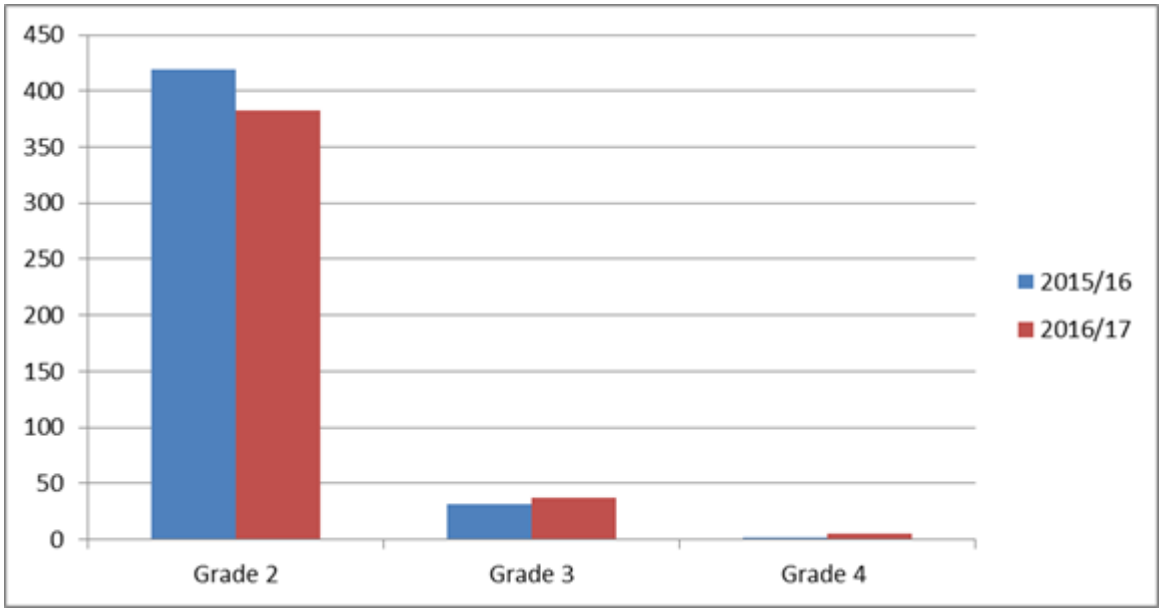
In 2016/17 there appears to have been an 8.2% decrease across all three units combined compared to falls rates from 2015/16. Maple unit are showing a slight increase of 7%; however this equates to one additional patient fall compared to 2015/16.

Over the past 12 months the inpatient units have implemented a FallSafe care bundle to help support the risk assessment and management of falls within all the inpatient units. FallSafe aims to "close the gap" between the evidence base for effective care and the care that patients actually receive. It involved educating, inspiring and supporting registered nurses and therapy staff to lead their local multi-disciplinary teams in reliably delivering these assessments and interventions through a care bundle approach.

Pressure Ulcers

Between 2015/16 and 2016/17 the number of reported pressure ulcers, that had developed within the Trust, was not significantly different. However, the proportion of more severe ulcers (grade 3 and 4) slightly increased. The Trust continues to actively encourage reporting of all grade 2 and above pressure ulcers in line with national requirements. All reported pressure ulcer incidents are reviewed as part of our commitment to maintaining patient safety through reducing harm and learning from incidents, identifying themes and trends and improving the quality of care. This will ensure that the right wound care product is being used as well as pressure relieving equipment. The review process enables us to identify ways in which we can improve the practice.





Over the last year the Trust has introduced weekly meetings which provide an opportunity to review moderate and severe pressure ulcers i.e. those categorised as grade 3 or 4. They must be reported externally to Clinical Commissioning Groups (CCGs) via a national reporting system. This has resulted in improved documentation which also captures areas of good practice and/or areas for improvements including learning which is beneficial to the

team and/or the Trust. These weekly patient safety meetings are chaired by the Associate Chief Nurses for each Directorate and include representation from the clinical teams involved and tissue viability specialist nurses. They carry out an initial review of Trust acquired or deteriorated pressure ulcers and establish the required scope of the investigation, areas of good practice and any learning which is summarised below.

Positive practice has included:

- Patients assessed to ensure appropriate wound products used.
- Taking a photograph of the wound to support the clinical assessment process and also to monitor wound healing and/or deterioration.
- Open discussion and communication with carers/care agencies to share advice regarding regular repositioning of patients.
- Close working with patients and their careers when the patient has several and differing health needs.

Learning has included:

- Sharing of the pressure care leaflet with carers, aiding carer understanding of ways to promote pressure relief.
- Improvement in the standard of record keeping evidencing care delivery.
- Scheduling of visits in line with planned care.
- Proactive escalation and risk assessment to support patients with the process of informed decision making in those instances where a patient, with capacity, declines repositioning advice or to accept equipment.

The Trust are collaborating with NHS Improvement who are leading a systems approach working across acute and community providers and in collaboration with key partners in social services and care home settings. The *Stop the Pressure* programme links with other pressure damage programmes such as the wound care programme, one of the ten commitments of *Leading Change Adding Value* being led by NHS England which incorporates “React to Red”.

Bridgewater has developed a pressure ulcer quality improvement plan which focuses on:

- ensuring accurate reporting and recording of data
- ensuring effective systems and processes are in place to investigate pressure ulcer incidence
- providing a framework for learning from pressure ulcer incidence
- developing a competent workforce to support patients who are at risk of or have pressure ulcer damage
- providing an accurate baseline from which an improvement trajectory can be set.

During 2016 we completed an annual audit of our compliance with the standards set out of in our Pressure Ulcer Policy. Areas where we performed well relate to skin integrity risk assessment, senior nurse review and use of appropriate equipment. We also identified areas where we could improve e.g. provision of written patient information. The standards will be re-audited in 2017/18.

Quality of care relating to pressure ulcer incidence will continue to be monitored through the Quality and Safety Subgroups which are chaired by the Associate Chief Nurses for each of the Directorates.

Medication Safety

The Trust continues to support an open culture encouraging the reporting of medication incidents and learning lessons to avoid possible future errors.

Since March 2016, a number of key appointments have been made, to strengthen the Medicines Management Team and provide it with strong leadership and a clear clinical and strategic direction. In keeping with the Trust's strapline, "Quality First and Foremost", the Medicines Management Team are working to promote and support the safe and effective prescribing, use, storage and supply of medicines and vaccines in the organisation. The team has been able to engage a number of services and positively contribute to developing assurance around the use of medicines within the Trust. The safe and secure handling of medicines audit was carried out and will be reported on during April 2017.

Medicine incidents are reported on the Trust's incident reporting system (Ulysses), and are reviewed when possible by a member of the medicines management team, who provide on-going advice and support on any action and investigation which may be needed.

On a quarterly basis the risk management team also identifies all medicines incidents and further incidents which may involve medicines which may have been classified with an alternative "main cause". These incidents are then reviewed by the medicines management team and those which are identified as medicine incidents are added to the figures reported. Quarterly figures for all medicines incidents are reported to the Clinical Governance Sub Committee and the Medicine Management Interface Group. Controlled drug incidents are reported within the Medicines Incidents reports and also separately as a standalone report. This report is shared at the Clinical Governance Sub Committee, the Quality and Safety Committee and the Medicines Interface Group. Work has been carried out on the Ulysses system to make all the fields in relation to the medicine involved mandatory and so all of the required information is recorded.

In 2016/17, 419 medication related incidents (8.8% of the total incidents reported over this period) were reported by the Trust staff including 93 involving controlled drugs. Monthly

attendance at the Quality & Safety Subgroups was planned from May 2016 onwards, to present the learning points and to discuss ways of improving the quality of reporting. However this has not been possible due to lack of capacity within the team.

Around 30% of the medication related incidents continue to be classified as third party incidents i.e. those which Bridgewater staff identify and originate from other healthcare providers e.g. hospitals, community pharmacies, GPs, care agencies or individuals. The review and reporting of third party incidents includes a check that the medicine incident has been notified back to the originator. The most frequent themes for both third party and Bridgewater incidents are:

- omitted doses due to lack of information when patients are referred to community staff for administration of medicines
- system processes where patient visits are missed because staff members were not aware they had been discharged from hospital or the patient information was not transferred to work sheets

Development and implementation of electronic patient records and software systems is on-going to help to reduce this.

Links continue to be developed between the Trust's medicines management team, local trusts, local clinical commissioning groups and other relevant local agencies to report relevant third party incidents for appropriate investigation and to facilitate lessons learnt being put into practice and shared across the health economy.

Near miss review and reporting continued over the year with a total of 127 near misses (an average of approximately 11 per month) reported for 2016/17. There is some confusion surrounding what a near miss is with some staff reporting this when an incident of no harm has actually occurred; work is ongoing with staff to encourage accurate recording of harm levels.

The Trust has continued with its excellent record for medicines related never events with none occurring.

Non-Medical Prescribing

Bridgewater has approximately 570 Non-Medical Prescribers (NMPs) comprising of 120 independent/supplementary prescribers and 450 community formulary non-medical prescribers on its NMP register. New NMPs meet with the NMP Lead to go through NMP policy, procedures, security, formulary compliance and continued professional development upon first allocation of prescription forms. The register is maintained and prescribers authorised with NHS Business Services Authority and prescription forms ordered via the

secure stationers Xerox and issued for NMPs alongside other medical services using them such as out of hours, child development and specialist services etc. Prescribing rights for smartcards SystmOne access is authorised for NMPs by the NMP Lead. Information is shared with all prescribers including medics via email when any Medicines Healthcare Regulatory Agency (MHRA) alerts or other relevant information needs circulation. British National Formulary and Nurse Prescriber's Formulary books are distributed and all new prescribers issued with the latest available from the Department of Health.

There are a number of regular activities undertaken by the NMP Lead and Senior Technician to provide assurance on the safety of NMPs. Prescribing data is reviewed quarterly for compliance against area prescribing formularies (Pan Mersey and Greater Manchester) and Bridgewater Wound Care Formulary. Off-formulary prescribing is recorded and shared with individuals, any off formulary prescribing highlighted and individuals asked to provide a rationale. Repeat off-formulary prescribing is currently being collated using a spread-sheet and repeat infringements will trigger escalation to clinical managers. Prescription queries are checked with prescribers and prescriptions recalled from the NHSBSA if required. Two prescriptions have been recalled this quarter and further information requested against prescribing incorrectly attributed to a Bridgewater cost centre code. Compliance reports are shared with CCG medicines management.

15% of all NMPs prescribing portfolios were called for review in March 2017. These prescribers were randomly selected and were asked to prepare their portfolio and personal formulary in line with the recently issued Bridgewater guidance. A specific staff designation (district nurse, health visitor, school nurse and independent prescribers) peer review meeting followed to go through the individual portfolios to ensure that they met the required standards and to share ideas and areas of learning. There was a variable standard to the materials contained in the portfolios and it appears that there have been some differences in the interpretation of the guidance. Standard feedback forms have been used to provide feedback information to the individuals whose portfolios have been reviewed. Examples of the best portfolios will be shared at future NMP meetings.

Additional funding for NMP Training has been allocated by Health Education England in recognition of the value NMP provides; information obtained from the Clinician's Audit and the i5 Economic Evaluation report (a commissioned piece of work which corroborates from other independent sources) were significant in providing the supporting evidence. NHS Healthcare Organisations across the North West were invited to take part in a regional clinician's online audit for non-medical prescribers (NMP) during October 2016. The audit has been undertaken for a number of years now and has provided a valuable resource for evaluating the impact of non-medical prescribing on patient care and its potential economic value to the health service. This has been further expanded upon and underpinned by a report that was commissioned by NHS Health Education North West and undertaken by i5 Health.

Bridgewater 2016 highlighted results:

- Bridgewater was 10th highest out of 50 plus organisations participating with 883 audits inputted
- 65% by independent/supplementary non-medical prescribers
- 35% by community formulary nurse prescribers
- The split between community formulary prescribers and independent and supplementary prescribers was 44%, 54% and 5% respectively
- 43% of contacts prevented a GP surgery appointment
- 22% of contacts prevented a GP home visit

Safeguarding

Bridgewater is committed to safeguarding people who come into contact with our services. We aim to achieve this through working with partners in a co-ordinated way, in an area of care where demands are increasing locally and nationally.

The Safeguarding Service provides the following across the Trust:

- Advice, support and training to all Trust staff in relation to all aspects of safeguarding
- Safeguarding supervision for staff within the Trust
- Supports the services for children in care to ensure health needs are identified and care plans monitored
- Supports teams in multiagency work for serious case reviews, local case reviews, and domestic homicides reviews
- A robust process for review and approval of policies and procedures, ensuring they are up to date and available for all staff to access

2016/17 welcomed the internal promotions of two Named Nurses for Safeguarding, one in Bolton and one in Halton. The previous Associate Director for Safeguarding retired in August 2016 and a new Associate Director for Safeguarding, commenced in post in December. The Associate Director for Safeguarding and the Named Nurses are responsible for safeguarding surveillance across the organisation to identify trends, themes and any areas of concern.

The Trust safeguarding assurance is provided through the quarterly Safeguarding Team Assurance Group (STAG) meetings, reporting to the Trust's Clinical Governance Sub Committee which then feeds into the Quality and Safety Committee. The STAG monitors training, incidents, risks and also supports the partnership working in relation to safeguarding children and adults at risk.

As a health provider, the Trust is required to demonstrate safeguarding leadership and commitment at all levels of the organisation, and that there is full engagement in support of

local accountability and assurance structures; in particular via the Local Safeguarding Children Boards (LSCB), Local Safeguarding Adult Boards (LSAB) and Commissioners of services. Safeguarding assurance is provided to Commissioners through the KPIs and Safeguarding Audit Tool which is completed annually with quarterly reviews and a challenge of performance undertaken by the Commissioners. One such challenge resulted in a performance notice being issued in one borough in relation to health assessments for children in care. This has been reviewed and monitored both internally and externally with significant improvements in process and timeliness of information sharing. This notice was subsequently closed in March 2017.

Throughout the year there has been a continued emphasis on training to ensure increased compliance in respect of Safeguarding Adult and Children training at all levels. The Safeguarding Teams have been working in collaboration with the Education and Professional Development (EPD) Team to target services, staff and relevant line managers to improve compliance rates. This is evidenced in an improved rate of attendance at training sessions and a more educated, confident workforce identified from evaluations of training delivered. A contracts performance notice was issued in one of the Boroughs in July 2016 which related to safeguarding training compliance. Action plans were submitted and monitored and this notice was subsequently closed in March 2017.

Current safeguarding training figures are given below and indicate an overall improved position on training compliance compared with the previous year.

Safeguarding Children Level 2

Borough	Total Eligible	No. Compliant	% Compliant
Wigan	862	775	89.91%
Halton	383	334	87.21%
St Helens	403	372	92.31%
Warrington	487	426	87.47%
Oldham	196	179	91.33%
Bolton	82	78	95.12%
Dental	169	157	92.90%
Bridgewater	**3105**	**2766**	**89.08%**

Safeguarding Adults Level 2

Borough	Total Eligible	No. Compliant	% Compliant
Wigan	862	782	90.72%
Halton	383	330	86.16%
St Helens	403	374	92.80%
Warrington	487	433	88.91%

Oldham	196	181	92.35%
Bolton	82	77	93.90%
Dental	169	160	94.67%
Bridgewater	**3105**	**2787**	**89.76%**

Safeguarding Children Level 3

Borough	Total Eligible	No. Compliant	% Compliant
Wigan	314	276	87.90%
Halton	158	139	87.97%
St Helens	66	56	84.85%
Warrington	141	125	88.65%
Oldham	160	116	72.50%
Bolton	55	46	83.64%
Dental	2	0	0.00%
Bridgewater	**962**	**801**	**83.26%**

Safeguarding Adults Level 3

The Named Nurse for Safeguarding Adults developed a training package and commenced delivery of this training in October 2016. Dates for training are available throughout 2017. Compliance rates should therefore improve month on month throughout the next financial year.

Borough	Total Eligible	No. Compliant	% Compliant
Wigan	140	33	23.57%
Halton	58	9	15.52%
St Helens	56	3	5.36%
Warrington	72	6	8.33%
Oldham	N/A	N/A	N/A
Bolton	N/A	N/A	N/A
Dental	56	11	19.64%
Bridgewater	**446**	**76**	**17.04%**

Overall PREVENT Compliance by Borough

Combined PREVENT WRAP 3 & Basic Prevent Awareness for non-clinical staff was as follows:

Borough	Total Eligible	No. Compliant	% Compliant
Wigan	862	670	77.73%
Halton	383	240	62.66%
St Helens	403	282	69.98%

Warrington	487	323	66.32%
Oldham	196	29	14.80%
Bolton	82	80	97.56%
Dental	169	138	81.66%
Bridgewater	**3105**	**2147**	**69.15%**

Safeguarding supervision is a requirement for all staff who come into contact with adults at risk or who have face to face contact with children and young people. The revised Safeguarding Supervision policy ensures there is consistent practice across all boroughs and that the policy is in line with national guidance and local commissioner's requirements. Each of the safeguarding teams provides planned, individual, group and also reactive safeguarding supervision at the request of practitioners, ensuring support and guidance are available to identify risk and protect vulnerable adults, children and young people.

The Associate Director for Safeguarding represents the Trust on each of the 10 LSCBs and LSABs across the boroughs. Our safeguarding team contributes to the LSCBs and LSABs and work in partnership with the statutory and voluntary agencies across the Trust footprint, to discharge its responsibilities in relation to the safeguarding of children and adults. This is achieved through attendance at sub-groups of the various Boards, Serious Case Reviews/Case Reviews, Multi-Agency Case File Audits, Multi Agency Risk Assessment Conferences (MARAC) and Child Sexual Exploitation (CSE) meetings.

Section 11 (Children Act 2004) places a statutory duty on organisations to make arrangements to ensure that in discharging their functions, they have regard to the need to safeguard and promote the welfare of children. Compliance is mandatory**.** The Section 11 Audits are submitted to the LSCBs at varying stages throughout the year depending on each borough. Scrutiny panels provided by LSCBs assist in the monitoring of action plans developed through the identification of gaps in service, ensuring progress and development of services is achieved. All requested Section 11 submissions have been made this year. This includes submissions in Bolton, Oldham, St Helen's, Warrington and Wigan. To date, limited formal feedback has been received in relation to Section 11. However, informal verbal feedback has been generally positive and a rolling programme of submission will continue in the next financial year.

The Care Quality Commission (CQC) visited Bridgewater four times during 2016/17:

- In Warrington; *Children Looked After and Safeguarding Review* was undertaken in April 2016 by the CQC. The grading was good overall and has led to the success of a business case to secure funding to enhance the delivery of service to children in care by a bespoke team of specialist nurses dedicated to school age children and care leavers.

- The CQC announced inspection across Bridgewater, took place in May and June 2016; Safeguarding actions were to ensure all relevant staff have received Level 3 safeguarding training. This work required a review of the training strategy and training needs analysis which was subsequently completed.
- The CQC undertook an inspection of *Children Looked After and Safeguarding* (CLAS) across the Oldham health economy in August 2016. No grading was associated with this and children were deemed to be safe within Oldham. Voice of the child was an area identified for improvement. Workshops to develop staff understanding of capturing wishes and feelings of children have been undertaken. Their impact is reflected in documentation of the voice of the child which has been identified as significantly improved in record keeping audits.
- The CQC undertook a SEND (Special Educational Needs and/or Disabilities) inspection within the Halton Borough at the end of March. The SEND inspection is a joint CQC and OFSTED inspection and focuses on how well local areas fulfil their responsibilities for children and young people with special educational needs and/or disabilities. The outcome of this inspection will not be available before the next financial year and therefore will be included in the 2017/18 report.

During 2016/17, Bridgewater was involved in a total of three LADO (Local Authority Designated Officer) referrals. This was a decrease from five referrals during 2015/16. All cases are now closed.

Management and oversight of allegations against staff who work with children are dealt with by safeguarding and human resources, working alongside the LADO in assessment of risk.

The LSCB is responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by CDOP (Child Death Overview Panel). The LSCB Chair generally makes the final decision regarding whether a child death case reaches the Serious Case Review (SCR) criteria. The reviews provide learning which continually informs best practice in the organisation. The safeguarding team continue to contribute to SCRs and Learning Reviews, embedding the learning into their training, policy and practice.

Safeguarding Children within the Boroughs

Oldham Safeguarding Children Team joined the Trust on 1st April 2016 as part of the Oldham Right Start and School Nursing 0-19 Service.

Oldham Local Authority currently has 465 children in care; health visitors and school nurses complete their review health assessments. Oldham Right Start and School Nursing 0-19 Service do not deliver any adult focused services.

There have been three Serious Case Reviews and one Multi Agency Learning Review in Oldham. None have been published to date, however, action plans have been written and lessons learnt which will be reflected in training and safeguarding supervision.

Wigan has had one Serious Case Review published in August 2016 which is available on the LSCB website (www.wigan.gov.uk/WSCB/), one is currently ongoing and a third will commence in 2017. There are several other cases that are pending decisions about whether or not they will also progress to a Serious Case Review.

All safeguarding adult concerns and enquiries raised within Bridgewater are addressed by the Adult Named Nurse as appropriate.

Bolton has a 5-19's service. During April 2016 to 1 August 2016 the Safeguarding Bolton Children service was covered by the Named Nurse in Wigan but now has a dedicated Named Nurse seconded into this role. One Serious Case Review was published in July 2016; there was learning for Bridgewater which focussed on timely information sharing between professionals and agencies. Action has been taken to address this.

The **St Helen's** Safeguarding Children Team transferred over to 5 Borough Partnership along with the 0-19's service on the 1 September 2016, leaving the remaining services without a dedicated Safeguarding Children Team. The Named Nurse in Wigan currently covers this service supported by her Named Nurse colleagues in the Warrington and Halton Boroughs.

In 2016/17, two SCR's were completed; however neither was published due to issues about identification of the children/families involved.

All safeguarding adult concerns and enquiries raised within Bridgewater are addressed by the Adult Named Nurse as appropriate.

Warrington had a joint Domestic Homicide Review / Serious Case Review (DHR/SCR) undertaken in 2016/17 where the family were accessing universal services. Publication of the review occurred in March 2017. There were no recommendations identified for Bridgewater staff but a review of domestic abuse awareness was undertaken with practitioners to ensure assessment tools and referral pathways are easily accessible.

Successful achievement of a business case for children in care enabled the recruitment of additional nursing and administrative staff into the team who have case responsibility for all children once they commence education and young people not in education. They have been actively involved with the caseload since January 2017 and we have had excellent feedback from partners in relation to the improved communication and timeliness of information sharing. Additionally, the children themselves, many of whom have been

difficult to engage previously, have praised the team who have identified unmet health needs, actioned referrals and ensured their voice is heard which is impacting on their care.

The voice of our client group is documented from feedback from clients/professionals/carers, within health assessments, recorded within records as observations and through supervision with staff. Staff are guided to listen to clients, recognise children at risk and act on concerns promptly.

All safeguarding adult concerns and enquiries raised within Bridgewater are addressed by the Adult Named Nurse as appropriate.

Halton has had no Serious Case Reviews initiated during 2016/17. However, the LSCB have published a Serious Case Review in March 2017. This review relates to events occurring in 2014 but the publication was delayed by the LSCB due to unforeseen circumstances. Bridgewater had an internal action plan in place but this was closed in January 2017. There are no recommendations for Bridgewater from this Serious Case Review.

All safeguarding adult concerns and enquiries raised within Bridgewater are addressed by the Adult Named Nurse as appropriate.

Safeguarding Adults

The focus of work for the Adult Safeguarding Named Nurse in 2016/17 has been to ensure that systems and processes are in place to enable all staff to know what to do and what support to offer to patients, if they suspect or identify abuse or neglect of an adult at risk. The Team also seeks to promote positive outcomes for adults at risk by early identification of safeguarding issues and timely intervention when appropriate. Extensive work has been carried out to ensure that processes are integrated across the Trust to benefit staff and patients.

The Safeguarding Adults Team aims to ensure that Bridgewater employees are equipped with safeguarding knowledge and skills and supported through supervision and training. This has enabled the organisation to fulfil its statutory duty to safeguard and promote the welfare of adults at risk in all areas, providing assurance that the Trust has met its safeguarding responsibilities, specified of the Care Act (2014).

Our aim is to promote good outcomes for adults at risk by ensuring that when working with adults at risk, families and carers, their needs remain paramount and their wishes and feelings are heard and taken into account by health professionals to ensure that safeguarding remains personal to the patient involved.

The team has reviewed documentation used within adult safeguarding to ensure recording 'Making Safeguarding Personal' standards are met and recorded to ensure that the voice of the adult at risk is heard.

Achievements in adult safeguarding 2016/2017:

- The Named Nurse for Safeguarding Adults has improved working relationships, integrated approaches to safeguarding record keeping and documentation and a combined vision for delivering safeguarding training, advice, support and supervision across the Trust
- Bi monthly adult safeguarding level 3 training is offered to Trust clinical staff including bespoke sessions. Level 3 training now includes domestic abuse, which provides staff with the skills to support victims and their families in addition to completing risk assessments for referrals onto MARAC multi-agency systems
- E-learning package for Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS) (2009) as mandatory training for all clinical staff, to ensure staff are aware and consider in their clinical practice.
- The team offers daily reactive safeguarding supervision to staff. One to one or group supervision is offered in cases that are particularly complex or challenging. This receives good feedback from staff and assists in the development of adult safeguarding skills within clinical areas and ensures the right support is given to patients.
- Safeguarding has been embedded into clinical processes such as pressure ulcer identification and management to ensure concerns of neglect are identified in even the most complex of clinical cases and lesson learnt are shared.

Priorities for 2017/18

To continue to work in partnership with the Local Safeguarding Boards in providing commitment and leadership in the safeguarding agenda:

- Identify and escalate the key changes in training and organisational staffing expectations within the expected Adult Safeguarding Intercollegiate Document and ensure compliance with safeguarding adult and children training is achieved.
- Fully participate, review and learn from local and national Serious Case Reviews and Domestic Homicide Reviews.
- Work to achieve the CQC action plans in a timely and efficient manner.
- Increase the number of safeguarding supervisors in Bridgewater.
- Continue to work with LSAB's to ensure that any service development in the Trust is reflective of multi-agency safeguarding practices both locally and nationally.
- Work with health service commissioners to ensure that the service remains responsive to changing population needs.
- Monitor, identify and implement changes in line with key legislation.

Infection Prevention and Control

Hygiene Code

The Trust is responsible for meeting the standards within the Hygiene Code (Health and Social Care Act Hygiene Code 2008 (updated 2015). The Hygiene Code sets out the 10 criteria against which the Care Quality Commission (CQC) will judge that a registered provider is complying with best practice in infection prevention and control. During 2016 the Trust were visited by the CQC and they reported the following:

Infection, prevention and control practice

- "We saw good infection control practices. The trust infection control policy was available to staff on the Trust intranet and staff were aware of its contents. Infection control was part the staff mandatory training program and the Trust indicated 89% compliance with mandatory training".
- "Overall, dental staff adhered to infection prevention and control procedures, such as safe disposal of sharps and handwashing practices".

Cleanliness

- "Walk in Centres and clinic areas were visibly clean. The inpatient environment was clean and hygienic with low levels of healthcare associated infection and high levels of harm free care".

Patient information

- "Leaflets and notice boards with information about infection control were accessible and visible to patients".

Infection, Prevention and Control Programme of Work

An annual infection, prevention and control programme of work is developed and monitored throughout the year. The work programme has a primary focus on policy development, education and training. It also outlines the structures required to share information across the Trust from the chief executive to staff in the community and vice versa.

This year the infection, prevention and control team were able to meet the majority of the goals set within the programme, with the exception of a review of clinical staff aseptic non touch technique (ANTT). This is not to say that asepsis is not being undertaken rather that the infection, prevention and control team believe it is time to review practice and improve upon it. The review of ANTT across the Trust is a priority for 2017/18.

Aspects of the infection, prevention and control programme that have been met, include completion of clinical audits, improvement in hand hygiene, ensuring all policy and guidance is up to date and meeting with other providers to support a collaborative approach to infection prevention.

Healthcare Associated Infection (HCAI)

These are infections that occur in healthcare that were not present before the patient entered the care setting. Patients are more likely to be vulnerable to infection due to their illness, their age, or the treatment for their condition.

Where Trust staff have been providing care to patients who are then diagnosed with a either Clostridium difficile or MRSA infection, a full root cause analysis (RCA) or Post Infection Review (PIR) is always undertaken. These assessments are often complicated, as frequently patients have seen a number of different care providers.

This year two cases of Clostridium difficile infection were linked to inappropriate prescribing of antibiotics by our staff and therefore key lessons were learned. We have ensured that the staff who prescribed these antibiotics have received guidance for future prescribing practice and shared the lessons with all staff.

Whilst we are able to report that there have been no MRSA blood stream infections linked to a lapse in care across the Trust, at the beginning of 2016 one case that was investigated has highlighted areas for improvement across the health economy. The learning is in relation to urinary catheter care and management. A multi-agency meeting to support joined up working for people with urinary catheters has been arranged.

Outbreaks

During December 2016 Newton Community Hospital staff informed the Infection, Prevention and Control Lead Nurse that three in-patients were suffering diarrhoea and samples had grown Clostridium difficile. The patients were not infected with the toxin producing bacteria that can cause severe infection, but the team were concerned there was a lapse in either infection prevention or environmental hygiene. The infection, prevention and control team quickly instigated the DH 'Clostridium difficile Care Bundle', which supports extra vigilance in patient management, hand hygiene, environmental cleaning and daily review of antibiotic prescribing. Two of the three cases notified were linked by type, however no further cases were found once the concern had been raised and all cases recovered from their symptoms. An action plan was developed following the incident which included improvements in staff training for bowel care.

Environmental Cleanliness

Cleaning across the Trust clinical and treatment rooms is provided by two cleaning companies, this is via a national cleaning contract. Cleaning contractors are asked to share their own environmental cleaning audits and the Trust infection, prevention and control team are working with them to ensure the environment is fit for practice.

Dental

Dental health care and practice is monitored against the standards within 'HTM 01-05: Decontamination in Primary Care Dental Practices Guidance'.

During the CQC visit in 2016 note was made for improvement in the management of dental instruments:

- "Ensure the safe infection control management of used dental instruments in localities where cleaning and sterilisation of dental instruments is provided by a third party company".

This applies to a small number of dental practices that outsource their equipment to a central sterilising unit, as they are not equipped to decontaminate instruments on site. This is still in line with HTM 01-05 guidance; however the Trust has accepted the need to improve practice regarding the storage of instruments prior to transfer to a third party company and steps have already been put in place to improve this practice.

Influenza Vaccination for Staff

Frontline health and social care workers should be provided with a flu vaccination. Trusts must ensure that a 100% offer of flu vaccination is made for all frontline staff, with the aim of reaching a minimum uptake of 75% uptake. At the end of the 2016/17 flu campaign, over 95 flu vaccine sessions were advertised and undertaken across the Trust. Sessions were also carried out by nursing colleagues in Bolton, and Oldham. Further ad-hoc sessions were provided to support the dental network and where possible the IPC team engaged with Trust events to offer the vaccine.
Despite the number of arranged sessions the uptake did not meet the 75% target. However, there was a slight increase over the past year with 46% of frontline staff being vaccinated in 2015/16 and 52% vaccinated 2016/17. Steps are being taken to review the campaign to improve uptake in 2017/18.

Leaflets Guidance and Policies

Having the best information at hand to help staff and patients manage infection is crucial. The infection, prevention and control team ensure that their contact details are shared across the Trust and are happy to answer questions and concerns. To support this, the infection, prevention and control team have developed a number of policy and guidance documents.

This year leaflets regarding Clostridium difficile and 'Carbapenemase Producing Enterobacteriaceae' or CPE (an emerging resistant bacterium) have been developed and are now available for staff and patients to download.

Work carried out by the Infection, Prevention and Control Team

Whilst the infection, prevention and control set an annual work plan, there are often opportunities to take part in new initiatives to prevent infection.

The Infection, Prevention Society is an organisation that promotes best practice in infection, prevention and control both nationally and internationally. Last year an 'Olympic style torch relay' became the focus for best practice in hand hygiene. The Trust infection, prevention and control team were fortunate to take part; putting on events within schools and hospitals, and using the torch to 'shed light' on best practice. The torch relay stopped off in Wigan before going to Scotland, Canada, America, across Europe and Africa.

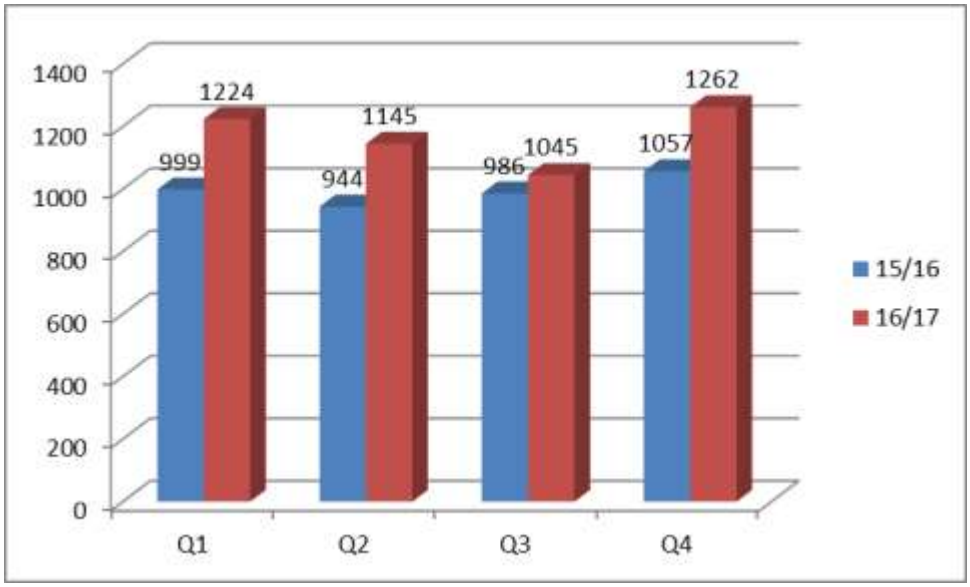
Last year the infection, prevention and control team made a pledge to improve staff and patient knowledge of the best use of antibiotics. Antibiotics are important medicines for treating bacterial infections in both humans and animals. However, bacteria can adapt and find ways to survive the effects of an antibiotic. The concern is that we may soon find ourselves in a world where antibiotics don't work.

This year Public Health England have launched a campaign aimed at the public and health care professionals entitled 'keep antibiotics working'. A number of public information advertisements were shown on regional television and Trusts were asked to support this work. The infection, prevention and control and medicines management teams were eager to take part and have signed up to the campaign. The teams have already taken part in a local radio discussion and visited the Trust walk in centres to discuss antibiotic use with patients, the public and staff.

Patient Safety / Incident Reporting

The Trust utilised the web-based Ulysses Safeguard Risk Management System for reporting all actual incidents and near misses, where clinical service delivery or patient safety may have been compromised.

There was an increase in 2016/17 reporting compared to 2015/16 due to more staff recognising when an incident should be reported. With the introduction of the weekly Patient Safety meetings and the monthly Quality & Safety Sub Groups the Associate Chief Nurses are supporting staff in identifying and reporting incidents.



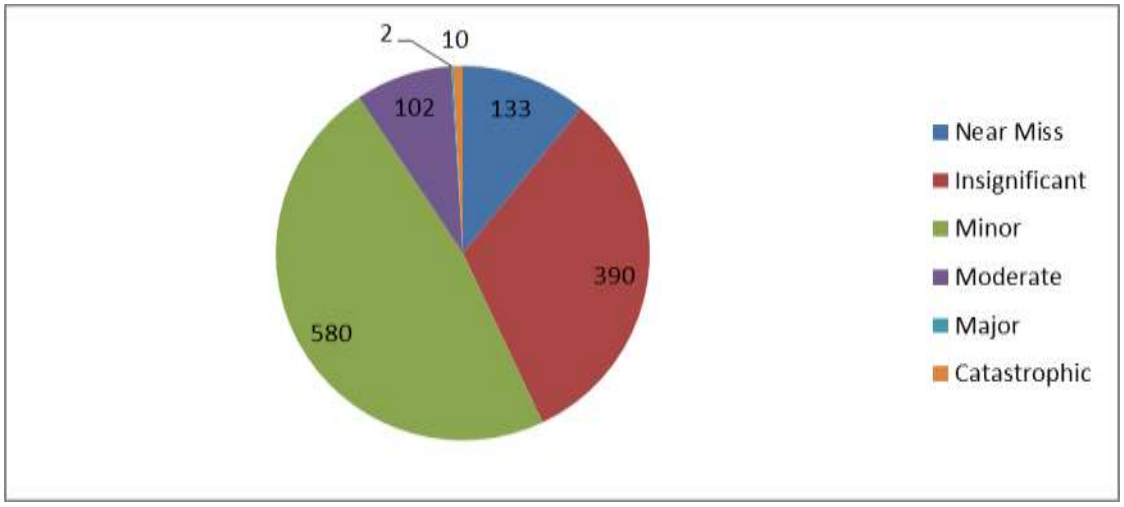
Commissioner	2015/16	2016/17
Bolton	11	113
Cheshire	10	77
Corporate	6	13
Dental	141	137
Halton	823	1020
Knowsley	3	
NHS England		5
Health for Justice	42	
Oldham		146
Southport		2
St Helens	872	806
Trafford	1	16
Warrington	950	1114
ALW	1127	1227
Total	**3986**	**4676**

Due to weekly and monthly incident data reviews by senior clinicians and managers introduced during 2015/16, and maintained during 2016/17, the quality and accuracy of data has continued to improve. Along with daily checks undertaken by members of the risk team, this process also ensures that any serious incidents are identified early and escalated as quickly as possible for management attention.

The 'Care Indicator Tool for Pressure Ulcers' demonstrated quarterly improvements in pressure ulcer management by clinicians and continued to be utilised during 2016/17 to the benefit of patient outcomes. The added value of this data resulted in improved investigations and identified gaps for service change, notably, the frequency of review of patients' pressure ulcers.

There were 12 patient safety incidents that were recorded as [4] Major or [5] Catastrophic. For the Catastrophic category three out of the 10 were serious incidents and were uploaded onto the Strategic Executive Information System (STEIS). The remaining seven were unexpected deaths in the patient's own home. Staff reported 4676 incidents during 2016/17 (as of 31/03/17), 523 (11.18%) of which were categorised [1] Insignificant or [0] near misses effecting patient safety. These are submitted to the National Reporting and Learning Service (NRLS), from which the CQC nationally monitors all Trusts' patient safety incidents. The following table represents the number of patient safety incidents reported to the NRLS by level of actual impact.

Patient Safety Incidents by Actual Impact	2015/16	2016/17
	Total	Total
Near Miss	112	133
Insignificant	405	390
Minor	722	580
Moderate	51	102
Major		2
Catastrophic	3	10
	1293	1217



The overall volume of reported incidents (4676 - as of 31/03/17) has increased compared to last year by 690. The volume of Patient Safety Incidents (1217) has decreased by 76 (6%) compared to 2015/16.

The table below demonstrates the number and percentage of all incidents and patient safety incidents in relation to the borough contacts.

Borough	Patient Contacts by Borough	Incidents by Borough	Incidents % of Contacts by Borough	Patient Safety Incident by Borough	Patient Safety Incident % of Contacts by Borough
Wigan	766606	1227	0.16%	249	0.03%
Halton	310790	1020	0.33%	280	0.09%
St Helens	397521	806	0.20%	258	0.06%
Warrington	531393	1114	0.21%	367	0.07%
Other		509		63	
Total	2006310	4676		1217	

All incidents were routinely investigated and, in some cases, serious incidents may have been escalated into a full root cause analysis based on a consistent national methodology.

The following work streams continued during 2016/17 to improve our management of incidents:

- All 'cause groups' (used to aggregate and monitor incident trends) were reviewed and updated to be more accurate and representative, and also to enable direct comparison with risks on the operational risk register.
- The Directorates established Quality and Safety sub-Groups to analyse and escalate significant incidents, complaints, or risks for support from the directorate team meetings and to direct service change in response.
- Weekly Incident Review Group that monitors and considers all serious incidents and investigations.
- Weekly Patient Safety meeting to review and monitor pressure ulcers.
- Automated monthly incident reports to senior managers at the beginning of each month.
- Pairing up experienced RCA investigators with newly-trained investigators (those trained in quarter 4 in 2014/15) to gain practical knowledge.
- Ongoing improvement in the number of pressure ulcer photographs attached electronically to incidents in order that the tissue viability nurses can provide early advice remotely.

- Established a consistent documented 'case note review' checklist (with commissioner input) of serious pressure wounds within 72 hours, to identify any learning points or lapses in care at an early stage, any identified lapses progressing to an RCA investigation if required.
- The Incident Reporting Policy was reviewed and updated during 2016 and takes into account some new guidelines from NHS England, including an extension of the RCA investigation period from 45 working days to 60 working days.

MIAA carried out an audit in 2016 to demonstrate that when serious incidents occur, organisations have a responsibility to ensure that there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes the responsibility to learn from the incidents to minimise the risk of reoccurrence and to make changes in practice to achieve sustainable improvements in care. The result of this audit was **Significant Assurance.** The audit highlighted that the Trust had an established corporate system for the identification and dissemination of sharing lessons from serious untoward incidents, claims and complaints. The Trust had established a number of forums in which to disseminate lessons learnt to all Directorates utilising its governance structure, email communications and intranet. Overall, the review found the systems and processes to be operating effectively at a corporate level, whereas within the clinical teams there were areas which could be strengthened to ensure that Trust wide lessons learnt are cascaded effectively. Whilst MIAA can provide assurance that the corporate control design for sharing of lessons learnt is good, there must be greater engagement from the clinical Teams to ensure that lessons learnt are received.

Never Events

Never Events are serious, largely preventable patient safety incidents that may result in death or permanent harm, that should not occur if the available preventative measures have been implemented. The Department of Health reviews a list of these each year and, at the beginning of 2015/16, the list of 25 different events that all Trusts continually monitor was reduced to 14. If they occur, we are required to report directly to the Care Quality Commission and our commissioners as Serious Incidents and investigate. There were no such events occurring during 2016/17.

Central Alerting System

Using incident data from across England, the NHS develops national initiatives and training programmes to reduce incidents and encourage safer practice. Alerts are released through a single "Central Alerting System" (CAS) to NHS organisations which are then required to indicate their compliance with these safe practice alerts. They cover urgent regional or national matters concerning faulty medical devices, medication, estates and other patient safety issues. The Trust for 2016/17 received four clinical alerts, and four non-clinical alerts

that were applicable to the Trust. The Patient Safety Advisor cascaded the alerts to each Directorate in order that they could be actioned.

Safer Caseloads in District Nursing (DNs)

District nursing teams in the Trust are made up of DNs (those with a specialist practitioner qualification), registered community nurses and health care assistants. The service provides nursing care and support for patients, families and carers at home and in community settings. This means that the service experiences frequent fluctuations in the size and complexity of the caseloads as it is not limited, like hospital settings, by the number of beds. Therefore methods used to plan staffing within hospital settings cannot be transferred into the community and there is currently no one national tool recommended for this purpose.

In recognition of this the Trust has begun to develop its approach to monitoring and reporting our DN staffing levels. Using a recognised evidence based tool we have worked with a national expert to undertake a comprehensive audit of our district nursing teams to look at caseload, staff activity, service quality and staffing establishments. Recommendations made highlighted a need to continue to monitor our patient case mix to show the type of need and complexity of our patients and work load index to show the resource required to respond safely and effectively. Regular monitoring of these two elements will allow us to build up themes and trends that we can use to inform the deployment of staff to the busiest areas, the skill mix of the workforce so we have the right balance between registered and non-registered staff and our future workforce planning.

To support us to achieve this we are now implementing a monitoring tool which again is a nationally recognised element of the comprehensive audit tool. This implementation is planned to commence in May 2017.

Freedom to Speak Up – Raising Concerns

Further to Sir Robert Francis's recommendations following his review at the Mid-Staffordshire NHS Foundation Trust, he published "Freedom to Speak Up". This outlined twenty principles and associated actions to allow a consistent approach to raising concerns.

One of the actions was for all NHS organisations to appoint a Freedom to Speak up Guardian. The Trust appointed a Guardian in December 2016 and the Freedom to Speak Up - Raising Concerns (Whistleblowing) Policy was refreshed and updated in 2016/17. As part of the development of a Trust App for mobile devices there will be a section on the APP for staff to be able to make contact with the Guardian if they wish to raise a concern. There will also be links to the Trust policy and videos to help staff understand how they can raise a concern.

Bridgewater had two Raising Concerns issues raised in 2016/17 which were investigated and were related to behavioural/relationship issues.

Mortality Reviews

Unexpected deaths of patients under the care of Bridgewater services are routinely reviewed by the Trust's Serious Incident Review Panel. The panel determines whether a root cause analysis is applicable in each case. In 2016/17 there were 22 deaths reported through this route. Of these 22 deaths:

- Eight were deaths in custody and non-attributable to Bridgewater.
- Three were deaths at other providers and reported and investigated by them.
- Five were considered by the Serious Incident Review Panel and no further investigation was recommended.
- For six of the deaths the Serious Incident Review Panel requested the completion of a root cause analysis. To date, two of these have been completed and learnings identified and shared.
- Fourteen deaths were reported onto the Strategic Executive Information System (STEIS) to formally notify commissioners of the serious incident. These included the eight deaths in custody. Families and carers of all deaths reported on STEIS were notified by the relevant agency.

Following the Mazaars report (an independent report into the deaths of people with a learning disability or mental health problem at Southern Health NHS Foundation Trust), the organisation closely monitors any deaths in patients with learning disabilities under the care of its services. The Trust is part of the Greater Manchester LeDeR (Learning Disability Review) programme. There were no deaths reported to the Trust in patients with learning disabilities in 2016/17.

The Trust also contributes to Serious Case Reviews at the request of the Local Safeguarding Children's Boards. The Trust contributed to two Serious Case Reviews during 2016/17 for child deaths which occurred in the localities it serves. The Trust is also contributing to two ongoing local case reviews and working with local agencies to implement actions and learning.

The Trust also contributes to mortality investigations at the request of the Coroner. During 2016/17, the Trust was asked to contribute to coroner's investigations for 12 deaths. Six of these were deaths in custody. To date, five cases have been heard at inquest, none of which identified any concerns about the quality of care the deceased received from the Trust.

During 2017/18 we will be implementing a number of requirements for all NHS Trusts in response to the CQC's review - *Learning, Candour and Accountability: A review of the way NHS Trusts review and investigate deaths of patients in England*. These include strengthening our governance arrangements for mortality reviews, collecting and publishing

quarterly data about deaths of patients under our care, and ensuring we have appropriate engagement processes in place for bereaved families and carers.

Quality Impact Assessments

The Trust Quality Impact Assessment (QIA) process has been developed to ensure that we have the appropriate steps in place to safeguard quality when making significant changes to service delivery. This process has been established in order to assess the impact of individual Cost Improvement Projects (CIP) or service developments within the Trusts Cost Improvement Programme on the quality of care provided by the Trust.

Our QIA panel has been established to oversee the Trusts QIA process, which is chaired by the Executive Medical Director. The panel agrees the arrangements for monitoring risks and stipulates the frequency of reviews and future reporting. The Trusts Executive Medical Director and Chief Nurse are the final arbiters for all QIAs, once presented to the QIA Panel.

The Area Directors are responsible for ensuring that the quality impact of all CIP/service developments is discussed as a standard agenda item within the monthly Directorate Management Team (DMT) meetings.

The QIA panel reports on a quarterly basis to the Quality and Safety Committee.
The report includes/highlights the following details:

- The number of QIAs completed.
- The assigned level of risk to quality for each QIA undertaken.
- The outcome for each QIA, i.e. approved, further clarification required or not approved.
- Arrangements for on-going monitoring of the quality impact of CIP/service developments approved by the panel and in accordance with the panel risk rating process.

In 2016/17, as part of Trust's audit plan, MIAA was commissioned to undertake a review of the Trust's arrangements for its CIP and QIA Process. The overall objective of the audit was to assess the robustness of the Trust's Cost Improvement Programme and to confirm whether the QIA Framework had been embedded and was operating effectively. The overall rating for the audit was "Significant Assurance" indicating a high level of rigour, stating "that the QIA Framework itself sets out clear guidance for users, including the purpose of a QIA process".

The main areas of good practice are as follows:

- Information and documentation for the QIA submission.

- Rigorous process – preventing progression to QIA Panel unless fully completed.
- Accurate tracking of the QIA form against CIP schemes.
- Active approach to quality improvement (e.g. revising the QIA form to improve quality of submission).
- Governance through the QSC.

The single area of weakness identified within the audit of the QIA process (with a risk rating of Low) was that the Quality & Safety Committee (QSC) terms of reference fail to state the QIA Panel's role as an advisory group to QSC. The terms of reference have been duly amended and approved by the QSC.

Clinical Effectiveness

Clinical Audit

Clinical Audit is a quality improvement process that seeks to improve patient care. This means the care that patients receive is reviewed against standards which are proven to be best practice (evidence based care). This is carefully evaluated and where required, changes are made to improve care. We believe that it is our responsibility to provide our patients with good quality, safe and effective care in order to achieve the best outcomes.

There is an annual clinical audit plan presented to and overseen by the Quality and Safety Committee. Progress is reported on a quarterly basis and includes key findings from individual audit projects along with the main priorities in the associated action plans.

The table below shows summary information relating to a sample of clinical audits undertaken during 2016/17. It shows some of the improvements achieved and where necessary shows the actions that Bridgewater intends to take to improve the quality of healthcare provided:

Audit of Acquired Brain Injury - Neuropsychology Stepped Care Model Approach (Warrington Borough)	
What we found	**Next Steps**
The locally designed psychological stepped care model was being used consistently and effectively to allocate patients to the correct level of psychological care. All patients with acquired brain injury had been offered psychology input at the level indicated by the assessment. ▪ 76% of patients received psychological care that was in line with their assessed level of	The outcome of this audit suggests that the locally adopted psychological stepped care model and the Neuro-behavioural Complexity Scale screening tool are good methods for consistent decision making when it comes to the psychological care needs of patients. The audit shows that there is value

care using the Neuro-behavioural Complexity Scale screening tool. ▪ A minority of patients (15%) declined input. This is an expected outcome as patients are encouraged to be actively involved in choosing the focus of their rehabilitation plan. ▪ The remaining 9% discontinued their treatment. Overall, the psychological support of acquired brain injury patients is in line with the NICE guidelines i.e. (CG 176) Head Injury: Assessment and Early Management (1.9.12); (CG162) Stoke Rehabilitation: Therapy Cognitive functioning.	in continuing to use these tools in order to support clinical decision making about patient's psychological needs in line with NICE guidelines. The current audit has highlighted a need for an additional audit to obtain qualitative information on the patient experience with the neuropsychology service received. This would enable a richer picture of the perceived benefits and limits of the service.

Audit of Falls at Newton Hospital - cycle 3 (St Helens Borough)	
What we found	**Next Steps**
This audit topic was originally chosen as a priority after concerns were raised following a serious incident in which a patient had fallen. The first audit was undertaken in October 2014, based on NICE guideline (CG161) Falls in older people: assessing risk and prevention. The action from this audit was to introduce the Fallsafe® initiative which is designed to minimise the risk of falling for patients in hospital. A local policy was introduced to support the initiative and set out the four standards of care that were used in the audit. The first three standards of care were met. These relate to initial assessment of risk factors, ongoing multi-professional assessment /intervention and appropriate care plans. Standard 4 was not met in full. The standard had 5 elements, 4 out of the 5 scored 100% i.e. evidence of explaining risk of falling, showing nurse call systems, how to raise and lower bed and when to call for help. However, there was little or no evidence of the fifth element i.e. evidence of distribution of a falls prevention leaflet. In addition, Fallsafe state that taking of both lying and standing blood pressures should be defined locally taking into consideration falls history, fear of falling and cognitive impairment. Although some	Introduce a weekly audit to monitor assessment and care plan evaluation. Revise care plan to be more "user friendly" and prompt for leaflet distribution. Define who should have lying and standing blood pressure, revise policy and add to weekly audit

patients did have both lying and standing blood pressures done, it was not consistent and had not been specified within the local policy.	

Audit of Antenatal and Postnatal Mental Health - cycle 2 (Halton Borough)	
What we found	**Next Steps**
Overall improvements have been made compared to the last audit. This audit achieved 79% compliance with standards overall compared to 54% in 2015. 17% of mothers were identified as having perinatal (during pregnancy) mental health concerns which is similar to the national average of 10-20%. A small number of mothers indicated possible postnatal depression but had not received a 3-4 month visit from Health Visitors. This has now been followed up. In some cases, the tool had not been completed but the auditor found that the patients were already receiving mental health support.	Ensure that the GP is informed when a mother is identified with possible postnatal depression and follow up in writing. Clearly document reasons for not completing assessment tools. Share learning with other Health Visiting teams across the Trust.

Audit of Respiratory Occupational Therapy Outcomes (Wigan Borough)	
What we found	**Next steps**
The respiratory occupational therapy service has previously used Canadian Occupational Performance Measure to assess the progress and effectiveness of treatment. In order to make this less daunting for patients, a revised tool identifying 'problems and goals' was being introduced. The use of 'Problem & Goal' has proven to be successful in ease of use and evidence of intervention. It has enabled goals to be tailored to the individuals. The majority of patients were successful in achieving their goals – 81% had improved scores following occupational therapy intervention. 62% of patients had a carer present when seen by the Occupational Therapist. Patients were asked for feedback via a questionnaire and corroborated	Continue to use 'Problem & Goal' to measure and ensure effectiveness of treatment and progress. Enquire about carers views during assessment.

that we are achieving the positive and patient centred service we aim to offer.	

There is a more detailed report available for each clinical audit that completes a cycle of audit during the year. The reports from all clinical audits completed across Bridgewater are included in the Trust's clinical audit annual report (anticipated completion date July 2017. To request a copy of the 2016/17 clinical audit annual report please contact clinical.audit@bridgewater.nhs.uk

Care Bundle Initiative

A care bundle is a set of interventions that, when used together, significantly improve patient outcomes. Evidenced based care bundles have been developed in collaboration with Halton Clinical Commissioning Group (CCG) colleagues. Each care bundle has a number of elements of care which were monitored and reported to the CCG during 2016/17. The information submitted during 2016/17 will form a baseline against which any necessary improvements can be measured using clinical audit methodology. During 2017/18 each care bundle will go through the clinical audit cycle which is:

- define standards
- measure against standards
- implement change/improvement plan where indicated
- re-measure to ensure improvement

Each care bundle will repeat the audit cycle until the standards are met to the desired level and therefore deliver improved outcomes for patients.

The care bundles relate to:

- Chronic Obstructive Pulmonary Disease
- Continence
- District Nursing Treatment Room: Skin wound care
- District Nursing: End of Life
- District Nursing: Pressure Ulcer
- Heart Failure
- Intravenous therapy
- Podiatry: Routine Care for High Risk Patients
- Podiatry: Foot Ulcer
- Podiatry: Biomechanics
- Stroke
- Tissue Viability**:** Lower Leg Ulceration

The Electronic Patient Record (EPR) was originally envisaged to be the vehicle to evidence compliance with each care bundle. However, this has not been possible as the roll out of EPR has been delayed. Clinical audit was used as an alternative mechanism to evidence and provide assurance relating to care delivery for each identified care bundle.

A comprehensive process is in place which has provided a framework for the data gathering, collation and analysis relating to an identified care bundle supported by audit methodology. This has enabled compliance reports to be shared both internally at the Clinical Governance Sub Committee and externally with Commissioning colleagues. A graded rating system (see table below) is in place to score individual standards within each care bundle. This provides a framework to assess any changes in subsequent re-audits.

Calculation of individual ratings	% measure
Green	95% and above
Amber	75% to 94%
Red	74% and below

All of the care bundles have been audited during 2016/17. All the audits have demonstrated good compliance with the required standards. However, where an individual standard within a care bundle required improvement there is an action plan in place.

For the forthcoming year an agreed process will be implemented to ensure on-going monitoring of evidence based practice standards within each of the care bundles.

Progress against each care bundle will be reported firstly through Bridgewater Clinical Governance Sub Committee on a quarterly basis and thereafter to the Clinical Quality Performance Group at Halton CCG. There will be a clinical audit report submitted for each care bundle upon completion of an audit cycle. The timetable for the audits and audit reports will be agreed in advance with Halton CCG and will be scheduled throughout 2017/18.

National Institute for Health and Care Excellence (NICE) Guidance

Every month NICE publishes guidance that sets the standards for high quality healthcare and encourages healthy living.

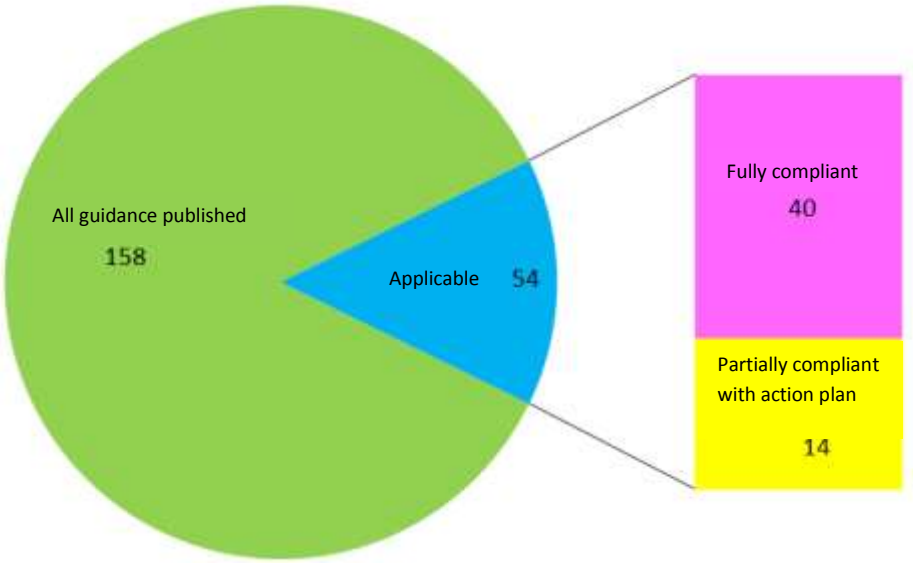
The Trust is committed to continually improving the quality of our services and the health of our patients. By adopting a robust approach to implementing NICE guidelines service users can be assured that their care and treatment is safe, up to date, and evidence based.

All newly published NICE guidance is distributed to services throughout the Trust to ensure that services are compliant with NICE recommendations. Services evaluate each piece of guidance and determine whether it is relevant to their service and if so, the service is

required to undertake a baseline assessment to state whether they are fully compliant, partially compliant or non-compliant.

Services are given four weeks to undertake baseline assessments following publication of guidance and a further four weeks if compliance is partial and an action plan needs to be developed. Partial compliance means that there is one or more recommendations that the service is not adhering to. This is to be expected in relation to newly published NICE guidance. However, an action plan must be devised in order to bring the service into full compliance.

In 2016/17 NICE published 158 pieces of guidance most of which relates to care provided in acute hospitals. There were 54 pieces of guidance applicable to services that the Trust provides. We are fully compliant with 40 and action plans are underway to bring us into full compliance with the remaining 14.



Compliance with NICE guidance is reported through the Quality & Safety Committee of the Trust Board and shared with Clinical Commissioning Groups. Clinical audits of NICE guidance are included in the annual clinical audit plan to provide additional assurance. Below is an example of an audit that was completed to check compliance with NICE guidance.

Audit of NICE compliance with CG181 Lipid modification Prison healthcare (Risley and Thorncross)	
What we found	**What we are doing about it**
All patients in the sample were offered a full formal risk assessment. Statin treatment for the primary prevention of cardiovascular disease was prescribed as appropriate, lipid measurements were taken before starting and started at the correct dose.	NICE state that follow up lipid measurement after 3 months is a 'key priority for implementation'. It is therefore important that the service implement monitoring of 3 month follow up measurements via

One patient did not have follow up lipid measurements taken after 3 months.	the electronic system.

Research and Development

Research has the potential to impact positively on the lives of the communities we serve; from improving health, promoting better understanding of conditions, along with opportunities to shape future treatments. At Bridgewater, research is everybody's business. This is reflected in our usage of a flexible definition of research to acknowledge the myriad ways in which our workforce and patients engage in, and use research and evidence in their work/contact with us. During 2016/17, 123 Bridgewater employees took part in research interviews, focus groups and questionnaires. In addition, 135 patients living in the Trust's Greater Manchester boroughs, along with Warrington have signed up to the NHS supported Research for the Future campaign, which consists of a series of 'Help BEAT' campaigns. Current campaigns are Help BEAT Diabetes; Help BEAT Heart Disease and Help BEAT Respiratory Disease. All aim to encourage our patients to get involved with research via a database of volunteers who consent to be approached in the future about studies they are eligible to participate in from filling in simple questionnaires to taking part in trials of new treatments. Information on these campaigns can be found at www.researchforthefuture.org

Research plays a central role in delivering the Trust's Strategy for Health & Wellbeing (2015-2021), particularly contributing to our Quality Priorities 2: patient experience, and 3: clinical effectiveness via standardised and evidence-based clinical practice. Our research activity also contributes to our borough Operational and Strategic Plans by supporting the following objectives: development of, and investment in workforce talent, supporting our collaboration pledge, promoting innovation, and the early adoption of technologies.
Examples of relevant research activity during 2016/17 are our falls research partnering with North West Ambulance Service, the Models of Reablement (MoRE) Study and the 'Delivering the Comprehensive Geriatric Assessment in the most cost-effective way' study. During 2016/17 the Trust refreshed its Research & Development Strategy and objective two specifically commits us to use the latest best evidence to underpin our service delivery and redesign.

In November 2016, the Trust celebrated success by winning the Best Community Research Contribution category at the National Institute for Health Research (NIHR) Clinical Research Awards. This was for our involvement in the 'Extending Working Lives in the NHS' study, which examines the impact of rises in pension age on NHS staff, including implications for their wellbeing and service delivery. Bridgewater was the only NHS Community Trust to be involved in the Medical Research Council funded four year study. This is an excellent example of how our research activity informs national policy and practice.

During 2016/17 our staff organised journal clubs, published in peer reviewed journals, and also attended conferences to present their research. Excellent examples include one of our physiotherapists presenting at the World Congress on Osteoarthritis in Las Vegas. Their research investigated the effect of a Lower Limb Exercise Programme on Kinesiophobia (a disorder where a person believes that movement can cause more injury and pain) on patients with Knee Osteoarthritis (OA). Exercise has been recommended as a core treatment for OA, however only 5% of knee OA sufferers are achieving the recommended level of activity. This is the first study of its kind to assess kinesiophobia before, during, and after a lower limb exercise programme in this patient group. Findings indicate that both kinesiophobia and pain reduces after completing an eight week exercise programme. Local and international interest has been shown in commissioning and adopting the recommendations from this research.

Staff generate research questions out of direct clinical practice. Another physiotherapist trialled a new way of delivering a Back Rehabilitation Programme in order to overcome poor patient attendance and drop out levels. They devised a new rolling programme of group exercise sessions offering patients more flexibility, which subsequently improved attendance and attrition rates. Their work can be found in the Journal of Evaluation in Clinical Practice (Vol. 22, issue 4). In June 2016, a nurse consultant spoke at the National Osteoporosis Society Conference on the Trust's Falls Prevention Service and their linked research activity.

Research at Bridgewater continues to be overseen by a Trust Research & Development Strategy Group, which met on a quarterly basis during 2016/17. Membership includes a broad range of clinical specialisms and was extended to include the new Medical Director, Non-executive Director, public and staff Governors. Research management and governance is assured via quarterly reporting to the Board via the Trust's Clinical Governance Sub Committee and Quality and Safety Committee.

Library and Knowledge Services

In 2016, as part of the Trust's Learning and Development Agreement (LDA) with Health Education North West, the Bridgewater Library and Knowledge service (LKS) submitted its annual self-assessment against the national standards contained in the *NHS Library Quality Assurance Framework* (LQAF). The service scored 95% (90% in 2015) and has consolidated their rating as a 'green' service. Bridgewater LKS were commended by the assessors for the improvements made in the last 12 months bringing them in line with the regional average. In five years, the library has steadily moved from a 'red' rating to 'green' one and continues to improve the service.

Patient Experience

The Trust recognises that eliciting, measuring and acting upon patient feedback is a key driver of quality and service improvement. The Trust has a Patient Charter outlining what people should expect from Bridgewater services and who to contact if they do not meet those standards. The Trust uses a range of methods to seek patient feedback including the use of patient stories, Friends and Family Test and patient surveys using Patient Reported Experience Measures (PREMS) and Patient Partners, as a way of involving the people who actually use the services. All feedback is closely monitored with any lessons learned identified and cascaded across the organisation.

Complaints

We aim to learn from complaints as part of improving our patients' experience.

During 2016/17 we received 94 complaints compared to 88 during the previous year. These are summarised on a Borough/Service basis below:

	Dental	Halton	Health & Justice	St Helens	Warrington	Wigan	Willaston	Total
Number of Complaints	0	23	7	16	15	31	2	94

The complaints were divided across a range of issues. The themes are summarised in the table below:

Theme of complaint	Number
Aspects of clinical treatment	58
Attitude of staff	14
Failure to follow agreed procedures	5
Aids and appliances, equipment, premises	4
Patients' privacy and dignity	4
Appointments, delay/cancellation (outpatient)	3
Communication/Information to patient	2
Admissions, discharge and transfer arrangements	2
Appointment Delay/Cancellation (In Patients)	1
Length of Time Waiting: Walk In Centres	1
Total	**94**

Every complaint received is investigated to understand fully what has happened and to seek out the lessons that can be learned. All lessons learned are discussed with the service leads at the lessons learned group and cascaded via Team Brief.

Some examples of lessons learned include:

- Integrated Community Equipment Service – Complaint about the procedure for accessing the integrated community equipment service during the out of hours period, when a relatives suction machine power supply failed. The contact information on the sticker on the machine was incorrect. No record that suction machines were checked prior to delivery.
    - Pre-delivery checklist devised for completion by warehouse staff.
    - Standard Operating Procedure (SOP) completed.
    - All staff made aware of procedures at weekly staff meeting.

  Information on how to access replacement suction machines out of hours was not clear;
    - Answer machine message updated
    - Advice sheet drafted for insertion in delivery pack
    - SOP for Out of Hours equipment reviewed and circulated to relevant clinicians and posted on MSoft News page.
- Physiotherapy Service – Complaint about the treatment provided by the community physiotherapy service following discharge from hospital after spinal surgery. Patient was unhappy that she has had to wait six weeks for treatment. Communication with newly discharged patients was insufficient;
    - Initial appointment letter updated to include an explanation regarding the purpose of the visit
    - Discussion has taken place with clinical team leaders regarding the change of wording of first appointment letter.
- District Nursing Service – Complaint regarding difficulties in accessing the district nursing service following discharge from hospital with a PICO dressing in situ. No complete record of conversation between staff nurse and patient;
    - All teams have changed how telephone messages are recorded for documenting conversations and outcomes.
    - Message books in all teams now have the same layout to capture essential information.

  Patient should have been advised to contact district nursing team if unable to obtain appointment;
    - The importance of encouraging and advising patients to contact service if unable to book treatment room appointment and ensuring patients have district nursing contact details has been cascaded at all team meetings.
    - The need for all conversations with patients to be documented has been cascaded at team meetings
- Health Visiting Service – Complaint about incorrect third party information included in child's record without being checked. Parent informed by health visitor during a

visit to the home to see the younger child. Sharing of information between health and nursing setting;

- An information sharing tool has been developed and is to be used when discussing concerns/issues that a nursery setting may have about a particular child.
- Information sharing tool must be completed, discussed and signed by both parent and key worker before passing on to health professional.
- Health professionals will not take any information from a nursery back to respective team unless this tool has been completed and signed.
- Health links with nurseries have been briefed about the incident to heighten their awareness of importance of gaining consent and to inform regarding the use of the new tool.

- Learning Disabilities **–** Complaint about the care provided to a patient by the learning disabilities team. Family feels that there had been a failure to communicate and effectively liaise between organisations thus affecting delays in admission and treatment. Clarifying of the learning disabilities team role in patient's care and what we are responsible for. Delay in communicating hospital tests and in gaining a consultant appointment. It would have been beneficial for the family to liaise directly with the hospital trust regarding this matter.
    - The service will ensure that they fully understand what a family requires from the learning disabilities service and will clearly set out what they are able to support and what support other organisations can provide, so the family are clear on who they need to contact regarding patient's care.

  Where there had been a delay in responding to requests from family, the community learning disabilities nurse appears to have been awaiting further information from the hospital trust. We acknowledge that this should have been communicated to family.
    - Mutually convenient, regular communication channels will be established with families via face to face meetings and telephone calls, even if there are no significant updates.

  There had been a delay in discussions taking place and a plan being put together for any future hospital admissions that the patient may need.
    - A meeting with professionals involved in patient's care has been arranged to discuss any plans that need to be put in place for any future hospital admissions.
- Macmillan Palliative Care Service **–** Poor experience of Macmillan nursing service and lack of communication with patient's GP practice. The requirement to ensure the role and responsibilities of a Macmillan clinical nurse specialist are communicated to patients, families and carers at the first assessment and subsequent visits.
    - Service information leaflet recently reviewed to include the following statements: "specialist palliative care focuses on patients with complex

problems". You will be allocated a dedicated nurse who works specifically with your GP practice. However, in the absence of your nurse you can contact any member of the team."

- Communication of clinical nurse specialist roles and responsibilities discussed at the team meeting.

- Sexual Health Service – Patient attending service following an assault, unhappy with the lack of confidential area for such patients to wait for their appointment and lack of confidentiality around reception area.
  Electronic patient record demographics must be checked by clinicians when any changes occur within consultations and changes must be alerted to the reception staff immediately to ensure up to date records are on the system and correct contact methods are in place;
  - Discussed as part of service business meetings
  - Senior nurse cascaded information during nurse meeting and also emails to ensure all clinical staff are aware of their responsibility related to demographics information.

  Staff training requirements need to be addressed and updated;
  - Training sessions for template training and pathways, including updates of new life server and demographic entries have been scheduled.

  Improving the patient journey;
  - Named clinician for consistency is now in place
  - Flagging on system to identify patient appropriately is currently being developed
  - Safety netting re contact by text; confirming with the patient at each visit that they wish to continue receiving information via text is now in place.

Friends and Family Test Results

Bridgewater has developed a Talk to Us… form to seek patient feedback. This includes the Friends and Family Test (FFT) as well as a number of questions which aim to ascertain how people feel about accessing Bridgewater services.

The FFT is based on a simple question *"How likely are you to recommend our service to friends and family if they needed similar care or treatment?" with answers on a scale of extremely likely to extremely unlikely.*

A total of 39,040 people responded to the friends and family question and 95.2% indicated that they would recommend Bridgewater services.

Borough/Service	Would Recommend	Would not Recommend	Number of Responses
Bolton	95.2%	0.3%	1087

Dental		98.8%	0.5%	1313
Halton		96.3%	1.2%	5754
Oldham		97.5%	0.2%	981
St Helens		98.4%	0.5%	13771
Warrington		96.8%	0.9%	3214
Wigan		96.0%	1.0%	12155
Willaston (GP)		93.2%	2.8%	178
Maternity Services	Antenatal	99.4%	0.3%	162
	Postnatal	99.3%	0.0%	425
Bridgewater Total		95.2%	1.8	39040

Patient Reported Experience Measures (PREMS)

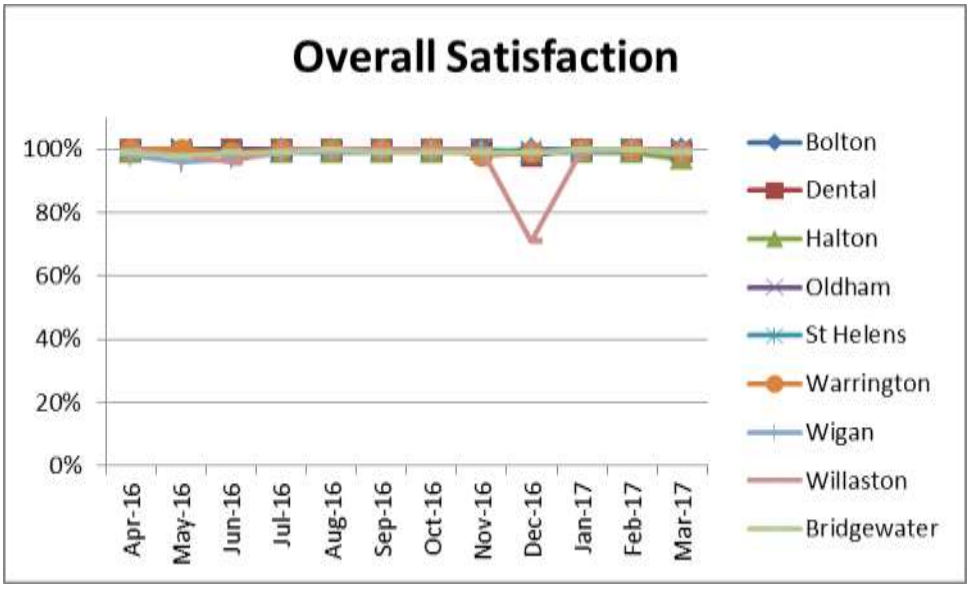
The Bridgewater Talk to Us …form also asks further questions about patients and carers experiences of Bridgewater services. The questions are based on how patients feel about the care they receive at the key touch points with the services. A total of 41,162 responses were received during the year and 99% indicated overall satisfaction with their care and treatment.

	Bolton	Dental	Halton	Oldham	St Helens	Warrington	Wigan	Willaston	Bridgewater
How do you feel about the length of time you waited to be seen?									
	92%	98%	95%	97%	97%	95%	95%	96%	96%
How do you feel about the way staff greeted you?									
	100%	100%	100%	100%	100%	100%	100%	98%	100%
How do you feel about the way staff listened to you?									
	100%	100%	99%	100%	100%	100%	100%	98%	100%
How do you feel about the information you were given (verbal or written)?									
	99%	100%	99%	99%	100%	100%	99%	99%	100%
How do you feel about the privacy, dignity and respect shown to you?									
	99%	100%	100%	100%	100%	100%	100%	97%	100%
How do you feel about the opportunity you were given to ask questions?									
	99%	100%	99%	99%	100%	100%	99%	98%	99%
How do you feel about the overall experience of your care or treatment?									
	99%	100%	99%	100%	100%	99%	98%	98%	99%
Number of responses	**1106**	**1384**	**6934**	**1018**	**14424**	**3341**	**12763**	**192**	**41162**

Overall satisfaction

Patients are asked to rate their overall satisfaction with the service. The graph below shows the results of patients who said they were either satisfied or very satisfied.

Bridgewater has set a threshold of 95% and continues to consistently exceed this.



Patient Stories

A patient story is presented to the Board each month. This is a compelling way of illustrating the patient's experience and enables the Board to gain a meaningful understanding of how people feel about using our services.

Lessons learnt from each story are identified and action plans developed which are monitored monthly to ensure that quality and service experience issues are being acted on and lessons learnt across the whole Trust.

Some examples of patient stories during the year include:

Paediatric Speech and Language Service

A family wanted to share their experience about the care and support received from the service and a dedicated member of staff who had literally made a life changing difference to their six year old daughter. She had been under the service for three years as she had developed a stammer in reception class. Her family were told that her development at school was purely related to her speech impediment and that her work would suffer.

As a result of the services work and continuous advice/support, the placing of memory games at school and at home as well as undertaking regular one to ones with this little girl, she is now stammer free, happy and extremely confident.

The family have thanked the service not only for their support but also for the belief they had in their daughter and for simply making a massive difference.

Health Visiting Service

A patient wanted to share their story regarding the care and support they received from their health visitor and how her support had made a difference, especially as she had experienced a traumatic birth.

She had met the health visitor prior to the birth of her baby which mum reported was very reassuring. The service visited on a regular basis and gave tips, information and support which helped mum to cope with her anxiety and continue to breastfeed successfully to bond with her baby.

Mum said that without the incredible support, kindness, caring and compassion of her health visitor she wouldn't have bonded so incredibly with her baby.

Dental

A family have shared their experience on behalf of their 43 year old daughter who has learning difficulties, regular and irregular epilepsy seizures and is unsteady on her feet. She has visited the community dental service for many years and initially was reluctant to open her mouth. Staff over the years have helped build her confidence to ensure regular check-ups, which are now accepted as part of life. The dentist very sensitively and patiently worked with her to achieve as much as “can be done” at each visit regarding examination and cleanliness. As a result she has built up trust in the dentist and loves praise from her that she is looking after her teeth well.

District Nursing

Patient shared her story after being admitted to hospital in May 2016 with a rare but serious bacterial infection, Necrotising Fasciitis, which affects the tissue beneath the skin and surrounding muscles and organs. Necrotising fasciitis can start from a relatively minor injury, such as a small cut but gets worse very quickly and can be life-threatening if it's not recognised and treated early on.

Nurses regularly evaluated her condition and changed her care plan as required with the discussion and agreement of the patient. She reported: “I am writing to you to inform you of the outstanding care that I have received whilst under the care of the district nurses. Initially I was seen twice daily and this is now down to just a visit three times a week. Nothing has been too much trouble for the nurses, they have kept me informed of my progress throughout and their professionalism shown to my family and has been a credit to the uniform.”

Patient Partners

Patient Partners is an approach that aims to actively encourage patients, their families and carers to work in collaboration with staff to identify areas for improvement in quality of care and service delivery.

Services invite their patients to become Patient Partners to take part in service improvement activities such as focus groups, feedback questionnaires, discussions on proposed changes and even recruitment of staff.

Some examples of Patient Partner activity include:

- Adult Learning Disability Service
  - The service has undertaken some extensive one-to-one work with a patient who was initially referred to the service for prostate awareness training. Easy read fact sheets and other resources were used to help the patient understand prostate related problems, including cancer. During the sessions the patient was able to identify a number of symptoms of potential problems and agreed to see his GP, accompanied by a member of staff. Following his experience with the service the patient became a Patient Partner and agreed to share his story to help others understand the process.
  - The service is currently working with a group of patients to look at the transition from children's to adult services.
- Adult Speech and Language Therapy Service
  - The service has collected some invaluable patient stories to enable the creation of a video, after asking the question: "What is the one thing you wish society could understand about communication difficulties". The video is helping to increase awareness around communication difficulties within the community and is shared in a variety of ways including via social media.
  - Patients have been involved in the recruitment of new therapy staff by having one-to-one conversations with prospective candidates and then providing structured feedback and scoring of their experience.
  - An 'Afternoon Tea Group' has been set up to enable patients to meet and chat outside a clinical setting.
- Community Specialist Rehabilitation Service
  - The service regularly writes up stories and case studies following informal discussions with patients. The information gained enables the service to look at the experience of its patients at a more in-depth level to assist improvement of service delivery.
- Health Visiting Service
  - The service uses a variety of methods of engagement with its Parent Partners, to be as inclusive as possible in gaining feedback including: focus groups, comment boards, one-to-one interviews, paper surveys, social media and the web.

- One Parent Partner agreed to a one-to-one interview to give her experience of support from her health visitor following diagnosis of postnatal depression. As a result of the feedback received the service has made a number of changes including: amendments to service letters and using display board information during clinic sessions.
- Following consultation and discussions with a group of health visitors looking at how to capture the voice of the child in clinical practice, the service has developed a 'Voice of the Child Forum'. The Forum brings together a number of Bridgewater children's services and partner organisations to ensure effective dissemination of good evidence based practice and embedding of new initiatives within child and family services.

- Paediatric Physiotherapy Service
  - The service has placed yes/no counter boxes within reception areas at some of its clinics whereby the service asks a specific question, displayed for a period of two months before being changed. Comment cards are also available for anyone wishing to make further comments, give a compliment or raise a concern.
  - The service has adapted the national '15 Steps Challenge' programme which looks at the patient's perspective of their first 15 steps into the service.

- Paediatric Speech and Language Therapy Service
  - The service has worked with its Patient Partners to develop a DVD, with the help of a Health Foundation Funded Programme, looking into the transition from children's to adult services. A group of young people worked with the 'People's Voice Media' company and trained to become community reporters learning skills such as interviewing, editing and production. They created a film to help others understand how transition can feel for them and their families.
  - Following the project and in light of the findings further funding has been secured to support improved information sharing between families and practitioners at transition points.

- Respiratory Service
  - The service has worked with its Patient Partners to set up a choir. As well as the benefits for breathing problems the group enables people who live alone or have little contact to meet socially. Further work has secured some funding to enable the group to be self-managed.
  - The service is currently liaising with partner organisations to look at the possibility of a bespoke befriending service and is preparing a questionnaire to gain the views of respiratory patients.

Patient Advice and Liaison Service

We recognise that when people have issues or concerns with our services we should aim to resolve these as soon as possible. Bridgewater provides a single free phone number for people to contact for advice and information or to help resolve their issues and concerns.

During 2016/17 we received 1958 contacts across Bridgewater. These are summarised below.

	Bolton	Corporate	Dental	Halton	Oldham	St Helens	Warrington	Wigan	Willaston	Total
Qtr. 1	1	7	13	80	1	111	78	178	2	471
Qtr. 2	5	18	21	69	1	115	130	178	0	537
Qtr. 3	5	9	18	63	0	109	108	164	0	476
Qtr. 4	5	5	16	76	4	76	111	180	1	474
Total	**16**	**39**	**68**	**288**	**6**	**411**	**427**	**700**	**3**	**1958**

Around 54% of the contacts were requests for advice and information, including signposting to other organisations.

Almost 29% of the contacts resulted in the department liaising between the enquirer and the service to resolve issues and concerns. Examples of the issues raised include appointment delay/cancellation and staff attitudes.

Only 11 of the 1958 contacts went on to become formal complaints.

Patient Led Assessments of the Care Environment 2016

NHS England recommends that all hospitals providing NHS funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. These assessments are referred to as Patient Led Assessments of the Care Environment (PLACE). Our assessment team consisted of both internal and external assessors.

Bridgewater has only one hospital i.e. Newton Community Hospital. The percentage summary scores for each category below have been awarded by the Health and Social Care Information Centre (HSCIC) based on the information returned by us for the 2016 assessment.

	Cleanliness	Food	Organisational Food	Ward Food	Privacy, Dignity, and Wellbeing	Condition, Appearance and Maintenance	Dementia	Disability
Newton Community Hospital	95.05%	81.19%	72.96%	88.48%	91.67%	92.31%	81.15%	80.47%
National Average	98.1%	88.2%	87%	89.3%	84.2%	93.4%	74.5%	78.8%

Further Information Regarding Quality of Services in 2016/17

Commissioning for Quality and Innovation (CQUIN)

For 2016/17, Bridgewater agreed in total 24 CQUIN schemes with our commissioners in Wigan, Warrington, Halton and St Helens.

This demonstrates our continuous commitment to improving services in terms of quality outcomes for patients, carers and service users.

These quality indicators support and ensure ongoing innovation and improvement across all of our services and in defined areas of clinical care. There are eight national CQUINS (two schemes undertaken in four boroughs) and 16 local improvement schemes.

The national CQUINs relate to:

- The health and well-being of NHS staff with the introduction of health and well-being initiatives. Providers were expected to achieve an improvement of 5% compared to the 2015 staff survey results for each of the three questions in the NHS Annual Staff survey outlined below. The Trust achieved the required improvement.

National Staff Survey Question	Results
Question 9a: Does your organisation take positive action on health and well-being?	There was a 6% improvement
Question 9b: In the last 12 months have you experienced musculoskeletal problems (MSK) as a result of work activities?	There was an 8% improvement
Question 9c: During the last 12 months have you felt unwell as a result of work related stress?	There was a 6% improvement

- Improving the uptake of Staff Influenza vaccination. The vaccine was available from October 2016 and vaccination continued throughout the flu season. Achievement of the CQUIN was based on the percentage achieved by the end of December 2016;

the target of 75% was not met. The target achieved was overall 52% which was an improvement on the 46% achieved in 2015/16.

Local CQUIN schemes

Wigan

Wigan participated in six local CQUINs in:

- Learning Disability - enhancing access to health checks and action plans
- Transition years in Learning Disability
- Improving access to Adult Social Care Targeted Early Intervention and Prevention and Health Improvement Services
- Pressure area care training & education to support safe & effective prescribing of pressure relief equipment.
- Reporting Outcomes of Care in relation to children's therapy & audiology services.
- Shared decision making in relation to adult Speech and language therapy services.

All of the above schemes were achieved.

Update on one of the schemes – The pressure area care scheme was aimed at targeting variances in the confidence and skills for the prescription of equipment within district nursing (DN) teams. The emphasis was therefore placed upon developing and delivering update training to all DN staff responsible for prescribing equipment to increase knowledge, skills and confidence. This has been achieved with 100% of staff being trained, which has resulted in an improvement in knowledge as evidenced through a pre and post training evaluation survey.

St Helens

St Helens participated in three CQUINs in:

- Shared decision making between wheelchair services and clients
- Outcomes of care for children accessing specialist services
- Delirium

All of the above schemes were achieved.

Update on one of the schemes - Following implementation of guidelines and processes for the assessment and treatment of delirium for inpatients within Newton Community Hospital, the unit aimed to improve this process by educating health care assistant staff to recognise, escalate and support the treatment of patients experiencing the signs and symptoms of delirium. 100% of healthcare assistants have successfully completed the training and required competencies. The training has been extended to therapy staff on the ward and Maple Unit (St Helens) nursing staff.

Warrington

Warrington participated in four CQUINs in:

- Integrated Frailty Scheme
- Antimicrobial prescribing for primary care and out-patient services
- Maintain enhanced IV therapy capacity and increase delivery of subcutaneous and IV fluids
- Reduction in Community Paediatrics Service follow up appointments

All of the above schemes were achieved.

Update on one of the schemes - A target was set of a 20% reduction in antimicrobial prescribing for primary care and out-patient services. Staff awareness was raised regarding the NICE guidance relating to antibiotic stewardship.

In 2014/15 the overall compliance was 75.58% and in 2016/17 the overall compliance was 95.43% i.e. there was a 19.85% increase with 95.43% of issued prescriptions being compliant with the NICE guidance. There was a 72.33% reduction in prescriptions for self-limiting upper respiratory tract infections.

Halton

Halton participated in three CQUINs in:

- Frail and Elderly
- Shared decision making in wheelchair service
- Outcomes of care for children accessing specialist services

All of the above schemes were achieved.

Update on one of the schemes – With regard to the frail and elderly scheme, Bridgewater is a member of the Warrington Integrated Steering Group which is:

- exploring potential joint working with the local authority to develop joint North West Ambulance Service Community Care Plans
- reviewing referrals across Bridgewater and Halton local authorities to avoid duplication
- supporting and sharing information with the Transformation Delivery manager-Frailty Lead with pathways and implementation of the Edmonton Frail Scale
- developing Care Home Joint Assessments (this has been paused until EMIS rollout to avoid duplication).

Further details regarding progress against all the agreed goals for 2016/17 is available electronically at: www.bridgewater.nhs.uk/aboutus/foi/cquin/

Quality Improvement Programmes

The Innovation & Improvement team offer various leadership development programmes to support staff in Bridgewater develop their leadership capacity.

A number of staff also access NHS Academy leadership programmes such as Elizabeth Garrett Anderson, Nye Bevan, and Mary Seacole and Board level developments.

There are various other leadership programmes that staff access depending on their roles and professional bodies. These are funded via the learning and development budget or through bursaries. For example, the School Nurse Association funds leadership programmes for school nurses.

Internally, leadership development and improvement is currently provided as follows:

- Leadership Development programme for Band 7 Team Leaders (ILM accredited)
- Leadership development support for Band 6 staff awaiting Specialist Professional Qualification (SPQ)
- Trust wide programme "Leading at the Speed of Trust"
- Listening in Action programme
- Team Journey – developing cohesive high performing teams through team leadership
- Compassion IN leadership approach
- System leadership for Wigan Borough
- System leadership for Warrington Borough
- Talent and succession management plan in development

Leadership Development programme for Band 7 Team Leaders

The Band 7 leadership development programme ran through 2016/17 for 52 Band 7 team leaders in community nursing and children's services. This covered all aspects of leadership and management through a series of master classes.

The programme is designed to raise understanding and awareness of the administrative aspects of leading e.g. completion of HR forms as well as the personal journey required to balance leadership and management competencies.

It focuses on the key skills and processes that all team leaders need to help them manage their teams and processes as efficiently, competently and safely as possible. A series of workshops was offered, including:

- Finance
- Information and Performance Management
- Preparation for Tenders
- Managing your Reputation
- HR Skills for Leaders, including:

- Managing Equality and Diversity
- Managing Recruitment and Selection
- Effective Line Management
- Managing Sickness Absence

This was followed up by an application process for part 2 of the programme, which specifically focuses on improvement leadership and self as a leader. This programme is currently ongoing with 15 self-selected leaders remaining on the programme for 2017.

The programme aims to support Band 7 team leaders with their roles as middle leaders. It provides a blend of tools and techniques to assist with planning and delivery of continual improvement, and self-development through the development of personal insights into self as a leader. The programme is accredited by the Institute for Leadership and Management (ILM) providing learners with certification at level 5 to support revalidation as well as improving leadership skills.

Various tools and methods are used during the programme covering:

- Local Patient Journey and experiences with our Trust
- Leadership styles and theories, including new models needed for integration
- Motivation styles and theories
- Human Factors
- LEAN methodology
- Appreciative inquiry
- Strength Deployment Inventory (SDI)
- Practical application of values elicitation into teams
- Myers-Briggs Type Indicator (MBTI)
- Duty of Candour Training (June 2016)
- Legal Aspects of Record Keeping (July 2016)
- Basic project toolkit, leading and sustaining projects, charters, driver diagrams,
- Evidence based co design
- Human Dynamics of leading change
- Measurement for improvement
- Productive tools,
- Learning set methods,
- Team coaching
- Psychometric evaluations (MBTI)
- White paper discussions

Learners also attended three master classes delivered by senior members of the executive team / external provider. The following areas were delivered:

- Implications of 5 Year Forward View
- Leadership for Partnership and Integration
- Managing Difficult Conversations

Leadership Development Support for Community Nursing Band 6 Staff preparing for Specialist Qualification

As part of a development session with Wigan community nursing coordinators, the difficulty of recruitment to Band 6 posts was identified. This programme has been devised at their request for staff who are internally promoted from Band 5 post to Band 6 to develop leadership and management skills and prepare the post holders for application on to the SPQ programmes as they become available.

This pilot programme commenced in January 2017 and will be evaluated on completion. The objectives are to:

- provide support and develop resilience on commencing the new post
- develop skills and competence in line with the requirements of the post
- develop leadership and effectiveness
- develop mind-set to unleash talent.

Non clinical elements only are part of this programme. Clinical elements are being identified by the staff members and discussed with their coordinators.

Trust wide programme "Leading at the Speed of Trust"

The Leading at the Speed of Trust Programme is a licensed programme provided by FranklinCovey and was introduced in September 2016.

Learning outcomes for Leading at the Speed of Trust enable participants to:

- gain a deeper understanding of individual credibility in terms of personal integrity, intent, capability and results
- gain a greater understanding of their own strengths and weaknesses in relation to trust as a competency, involving completion of a 360 degree Trust Quotient (tQ) on-line questionnaire producing a confidential, multiple-page report. Participants are then able to develop a personal Trust Action Plan™ to implement as part of a continued process of leading in a way that inspires trust within their teams and organisations
- gain an awareness of the negative impact lack of trust has within teams and organisations, leading to failure to deliver results and increased costs
- gain an understanding of how trust can be developed, restored and extended
- explore the 5 waves of trust: Self, Relationships, Organisational, Market and Societal and how improving trust at each level has an exponential effect.

The programme is delivered over two days as facilitated face to face learning.

Embedding and sustainability of the learning is supported through:

- access to a digital coach app that reinforces the Speed of Trust's key principles and skills over a 52 week period

- focus groups for learners exploring key behaviours.

Currently 93 staff across Bridgewater have accessed the programme including; area directors, assistant directors, clinical managers, clinical team leaders and admin team leaders. Plans are in place to continue the rollout to clinical team leaders and corporate teams.

Team Journey – Developing cohesive high performing teams through team leadership

The team journey is a bespoke approach to enabling teams to improve through inclusive leadership, utilising a range of skills and tools dependant on needs in the individual teams. Twelve teams undertook the programme in 2016/17.

Utilising lessons learned approaches from this work, the Innovation & Improvement Team are currently designing a standardised Team Journey approach using the Aston University "Team Journey" package. This will be offered as a training package to all team leaders to increase spread and capacity for delivery. The team will adopt a planned, systematic approach to rolling the programme out over 2017/18.

The first team to undergo the pilot phase are the three finance directorate teams which commenced in March 2017.

The programme covers the following elements as modular workshops:

- Team identity
- Team objectives
- Role clarity
- Team decision making
- Team communication
- Constructive debate
- Inter-team working

Compassion IN Leadership Approach

Following national and internal research during 2016, staff themselves identified some internal behaviours that did not mirror Bridgewater values, arising from and impacting upon levels of stress and distress in teams and individuals. The HR team deliver the health and wellbeing agenda, whilst the innovation & improvement team are identifying alternative methods of sharing leadership behaviours through the Emotional Intelligence and awareness raising approach. This will utilise ad hoc conversations, twitter, and an "every contact counts" approach to talk about self-care, and care of our peers. It will enable the workforce to reflect on personal and team behaviours and further enhance an atmosphere of mutual support and compassion IN leadership. The programme is being actively developed with an awareness raising-module on emotional intelligence and its impact on leadership is currently in development. This approach to compassion IN leadership supports and enables the programme "Leading at the Speed of Trust". The first group conversation

commenced at the launch of the staff engagement policy event in March 2017 with four teams following up with a request for team level support with behaviours and attitudes. Further group conversations are planned with Bolton staff and the Dental directorate via the Listening into Action programme.

Wigan & Warrington Borough System Leaders

Bridgewater is a member of the Wigan Organisational Development networks in Wigan and Warrington, which are currently developing a system leader support programme for leaders across the network. We have contributed to planning and development of the system leader's pilot that is currently ongoing, and will be contributing to the programme by delivering "Speed of Trust" at no additional cost, to support the integration approach for all system leaders. This work forms part of the wider talent plan for Wigan Borough. Six Bridgewater middle managers are included in this developmental pilot. Despite repeated efforts to identify six leaders in Warrington, there are currently two leaders participating in the system leader integrated approach in Warrington. As this is also a pilot, once completed the OD team will work with managers to identify the next cohort of Warrington facing staff who may benefit from attending this programme.

Talent and Succession Plan

The innovation & improvement team have recently presented a proposal to the executive management team to introduce a Talent strategy and operational plan within the organisation. This will align with regional and local borough Talent plans to ensure it supports the integration agenda and system leadership development, alongside improvement skills, compassion in leadership and a workforce that is equipped to lead in complexity.

Clinical Supervision

The Trust has an established programme of clinical supervision that is offered to all professionally qualified clinical staff as well as professional clinical development that supports specialist and advanced practice. During the first half of 2017, the organisation is undertaking a review of supervision and all allied systems such as preceptorship, mentorship and coaching, in order to establish a modernised approach that will support staff and enhance outcomes of care.

Quality Visits

Quality Visits have been undertaken within the Trust for some time. In October 2015 the process and documentation were revised so that they reflected the CQC five questions i.e. are services safe, effective, caring, responsive to people's needs and they well-led.

Seven visits were undertaken in 2016/17 with a variety of actions being identified and subsequently monitored through to completion. The services welcomed the constructive challenge provided by the visits.

Further work will be undertaken in 2017/18 to enhance the effectiveness and targeting of future quality visits.

NHS Alliance Work

The Trust is supporting national requirements as detailed in the Our Five Year Plan. This includes in borough integration, developing federations and/or localities that provide primary care at scale, ensuring mental and physical health sustainability and providing services based on integrated care leading to a single system model for proactive community care. The aim of the work is to redesign better health, better care and better value with a system wide model of care that enables people to live healthier lives.

The work has included working closely with commissioning colleagues, acute and primary care colleagues within Halton, Knowsley, St Helens and Warrington so that patients receive the right care in the right place. A commitment to the development and implementation of integrated neighbourhood teams within Halton by staff working closely with GP practices has been achieved.

During 2017/18, the work will focus on:

- Reducing unwarranted variation and improve service delivery by implementing system wide referral management schemes, map of medicine, RightCare and integrated multi-disciplinary teams in each borough.
- Designing and delivering clinical pathways across boroughs.
- Delivering large scale prevention and early intervention work.
- Delivering the GP Forward View.
- Delivery of care closer to home in Halton, Knowsley, St Helens and Warrington.

Delivering System Level Care

In response to a specific request from Warrington CCG, this section provides details on how we are establishing and working with other providers in delivering system level care.

The Trust is pivotal to much of the partnership work within Warrington and continues to be a full and active participant in a range of service changes to improve services for the residents of Warrington. Throughout the winter there have been consistent themes relating to urgent and emergency care, difficulties in discharging inpatients when they are ready to go home, rising demand for A&E departments with fragmented out of hospital services and complex oversight arrangements between trusts, CCGs and local authorities.

The Trust is a strategic partner in the Mid Mersey A&E board and has implemented key service changes, for example:

- An expansion to the intravenous therapy team to enable easy and direct access treatment at home or closer to home in community clinics and delivering more planned care to some of our most vulnerable populations in care homes.
- Establishment of out of hours services in a town centre location in Bath Street including extending access to evening GP appointments, accepting earlier transfer of patients from 111 to support the system in managing the most urgent patients in the emergency department.
- Working in collaboration with North West Ambulance Service to prevent unnecessary hospital admissions following 999 calls. We provide an alternative to A&E assessing and treating patients in the community.
- Bridgewater have continued to work in partnership with the Warrington and Halton Hospitals NHS Foundation Trust and 5 Borough Partnership to deliver a consistent approach to the identification and management of older frail people, signposting to a range of support services to ensure they are safe and cared for in their own homes wherever possible.
- Community nursing is delivered around practice populations and we have been creating closer links with social care to meet local population/neighbourhood needs.
- The Paediatric Acute Response Team, a collaborative approach across partners, continues to grow from strength to strength in Bath Street and has seen an extension of the service to provide dermatology services for children.

The development of our children in the early years is crucial to them achieving their full potential with partnership working having always been and will continue to be a core value, for example:

- The health visitor service has been working closely with child care settings to deliver an integrated two year check where children attend nurseries / child care providers. This is a developmental check that ensures any help a child needs is offered as early as possible to ensure children are supported to develop the best skills possible. It works really well when done jointly with the child care setting and also when the information is shared once the check is complete.
- The 0-19 model: Health visiting, school nursing and oral health for children now work as one team. This helps one main person be the lead for a family, while still retaining the overall skills needed from either the health visitor or the school nurse or assistant staff.
- Bridgewater health staff, across all professions, are working very closely with professionals from the local authority to assess and support children and their families who have additional needs or disabilities. As part of this we have redesigned our approach to have a single point of access for children who are likely to need support from a large number of our health professionals. In addition, families suggested we change the name of the panel from ‘Complex Case Panel’ to ‘Additional Needs Panel’ and we are in the process of amending our letters and our

leaflets to reflect this new name. Warrington Parents and Carers Forum (WarrPac) have helped us co-produce information for parents about the Additional Needs Panel and have also helped us to write the information for parents about alerting the local authority to children where there may be additional needs that the local authority needs to plan for, as part of supporting the children into child care provisions.

The Trust has committed fully with the Health & Wellbeing Board partners in support of Warrington's aspiration to be an Accountable Care System. The aim is to make people's lives better, helping them to live longer, healthier lives, supported by sustainable services, wrapped around individuals not buildings or organisations. This will build on the solid partnership work developed around individuals and families living in geographical populations clustered around GP registered lists. It will accelerate the use of the integrated care record to identify those most at risk, prioritise workloads and identify interventions from the appropriate members of co-located multi-disciplinary teams.

Borough Strategies

The Trust is supporting a model of providing care in the community rather than in the traditional hospital setting. The aim is to bring as much care as possible closer to home and align our services to meet the GP Federation practice populations. This will ensure that hospitals are only used for complex services or because of the seriousness of a person's illness. We have been working in collaboration with other providers through the redesign of services. The intention is to improve access and have better coordinated pathways that have a focus on prevention and reducing unwarranted variation.

End of Life

Following a CQC inspection in May 2016 our end of life services were rated as 'requires improvement'. This centred on the lack of a Trust strategy and coordinated oversight whilst recognising that services were planned and organised well at local level.

In order to address this, the Trust appointed an Associate Director for End of Life Care in November 2016 with a remit to specifically focus and lead on all aspects of end of life care for the Trust.

A programme of work has commenced including the development of a trust wide strategy which sets out key principles to directly respond to the issues. It will enable the continued development of resilient and responsive services and will be overseen by the End of Life steering group.

These principles set out our commitment to place quality at the heart of everything we do. Recognising that our patients and those important to them should be at the centre of everything we do so that end of life care becomes not only everybody's business but also everyone's responsibility.

Principle One: We will champion individualised care focusing on the priorities of the patient and those important to them

Principle Two: We will promote value based care delivery reflecting compassion and commitment

Principle Three: We will promote an open and honest culture, founded on humanity and kindness

Principle Four: We will develop and maintain a knowledgeable skilled workforce

Principle Five: We will develop mechanisms that support us to monitor and improve quality

Principle Six: We will strengthen, develop and coordinate our systems that will support us to achieve our ambitions

Midwifery (Halton)

Halton midwifery service continues to be the only midwifery service nationally that is based within a community trust. The service delivers the full remit of pregnancy care across Halton ante and post-natal care and a home birth facility. The birth rate in Halton remains static at approximately 1,600 women per year. In the past 12 months there were 13 successful planned home births and the service responded and provided care to 12 un-booked home births. The service provides care 365 days per year and has an on call facility from 5pm-9am across 365 days.

The National Screening Committee (NSC) quality assurance visit in November 2015 resulted in the development on an action plan as reported in last year's report. All actions from this action plan have now been completed and signed off by the NSC.

A CQC inspection of the Trust in May 2016 included the midwifery service. Some of the findings were rated as good and areas of good practice were highlighted by the inspection team. The inspection also identified that our systems and processes relating to audit and risk needed to be strengthened. There were also some concerns regarding the availability of oxygen and other emergency equipment for use at home births. Following the report an action plan was devised and submitted to the CQC. The actions outlined within the plan have been addressed with a lot of the actions now complete and others in progress. Emergency equipment including oxygen for use at home births was reviewed and made available from August 2016. On-going progress of the actions is being monitored within the Trust with progress reported to the Trust's Clinical Governance Sub Committee and the CQC. Progress is also discussed with staff at six weekly midwifery team meetings.

Local Supervising Midwifery Report (Halton and St Helens)

As part of the statutory requirement, the Local Supervising Authority (LSA) carry out an annual audit visit on all maternity services in the UK.

The aims of the audit are to:

- ensure that there are relevant systems and processes in place for the safety of mothers and babies
- ensure that midwifery practice is evidence based and responsive to the needs of women
- review the evidence presented to ensure standards for supervision are being met
- review the impact on supervision on midwifery practice.

Bridgewater's annual LSA audit was carried out in November 2016. The team interviewed supervisors, midwives, and student midwives on duty on the day. Service users were also invited and of the 58 women invited, three women attended and participated in a focus group with the audit team. One lady who could not attend on the day but wanted to give feedback called the audit team with her comments. Feedback from all the stakeholders was positive and the team commented on the value of this model of care for women and their families. Once again the national standards were met.

The only recommendation from the visit was generic rather than local as midwifery statutory supervision is to be replaced on 1 April 2017 by a new non-statutory 'AEQUIP' model. This model will be launched following a pilot at the end of March 2017 and published in early April 2017. The service has completed a risk assessment and will complete a paper on the new model and the way forward to be presented to the Clinical Governance Sub Committee in April/May 2017.

Delivering Same Sex Accommodation

Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to providing every patient with same sex accommodation as it helps to safeguard their privacy and dignity when they are often at their most vulnerable.

Newton Community Hospital

Other than in exceptional circumstances, patients admitted to Newton Community Hospital can expect to find the following standards for the provision of same sex accommodation:

- The room where their bed is will only have patients of the same sex.
- The toilet and bathroom will be just for one gender and will be close to the bed area.
- Patients may share some communal space, such as day rooms or dining rooms.

Occasionally, it may not be possible to care for patients in a same sex environment, e.g. in the case of an emergency or specialist care situation. The clinical (medical) need will take

priority over keeping the patient apart from other patients of the opposite sex. During 2016/17 there was one instance when this was required. On this occasion consideration was given to the clinical and best interest requirements of the individuals and a decision was made in conjunction with the individuals to allow a husband and wife to share the same bed area and bathroom facilities. This was reported via the appropriate reporting systems and was not considered to be a breach of the same sex accommodation standard.

We can confirm for 2016/17 there were no breaches to same sex accommodation.

Padgate House

Padgate House is a 35 bedded intermediate care unit based in Warrington. The building is owned and managed by Warrington Borough Council. The Trust is responsible for the provision of clinical services. The same standards are applied to this unit; however the home has 35 single bedded rooms which are not en-suite. This ensures that patients never share a bedded area. The building has 14 bathrooms which are shared by all residents meaning that males and females will share the same facilities however there are clear engaged signs on doors and they are lockable from the inside to maintain patient privacy.

As Padgate House is not a hospital they are not considered to breach under the mixed sex accommodation requirements for use of communal bathroom facilities.

Extension to the Out-Patient Clinics in Newton Community Hospital

In July 2016 St Helens commissioners changed the referral pathways for secondary care and community GPWSI (GPs with Special Interests) clinics for ENT, gynea and dermatology. The drivers for the change in referral pathway were a need to reduce inappropriate referrals to secondary care and deliver care where appropriate within a community setting. All referrals from GPs within the St Helens area are sent to a single point of access commissioned by the CCG and provided by another provider. The referrals are triaged by doctors with knowledge of the appropriate speciality and a decision is then made of whether the patient requires a review in a community or secondary care clinic. Patients are then contacted and offered where available a choice of venues by the single point of access service. Once patients have made a choice the referral is sent to the appropriate provider to allocate a clinic slot and contact the patient with the details of the appointment.

Currently the GPSWI clinics delivered by Bridgewater are not set up on the choose and book system and therefore patients are unable to choose a clinic time and date of their choice. However the service will always work with the patients if the original clinic slot allocated is not suitable and offer an alternative.

Community Dental

The Trust provides specific and specialised dental services that are commissioned by NHS England, and also works in partnership with Offender Health to provide routine dentistry in local prisons.

The core services are for patients referred from local general dental practices; children in pain who require dental extractions, adults who require minor oral surgery and adults with special needs whose treatment cannot be carried out in high street practices. Some patients with complex needs are also cared for on a long term basis.

KPI's for all services focus on the maximum times patients have to wait for assessment following referral, delivery of preventive messages and collating evidence about the complexity of care provided. The targets for children's services and for adult special needs are routinely met, but those for oral surgery have proven more of a challenge.

Senior dental nurses are responsible for regular checks of Quality Assurance processes at each of our clinics. In addition, there is a quarterly clinic review based on guidance from the CQC for primary dental care.

The Dental Clinical Governance group approves a yearly audit plan which focusses on the areas of highest risk and greatest impact; feedback is co-ordinated via local and team meetings. Audits reported this year included:

- Quality of dental radiographs showed areas for improvement.
- Sedation related incidents showed good compliance but with the need to better define the audit parameters.
- Reversal rate showed full compliance.
- Decontamination standards showed full compliance.

NICE guidance applicable to primary dental care is also addressed via the Dental Clinical Governance group and if appropriate baseline assessments are completed.

Incidents are reported via the Ulysses system and actions monitored via the Dental Clinical Governance group. Feedback to frontline staff is again via the local or team meetings.

School Readiness App

Bridgewater health visitors won a prestigious award from the Journal of Health Visiting.

They recognised that children in the local boroughs had lower than average attainment expectations after their reception year.

To address this on a universal basis they commissioned Chester University and Footsqueek, a bespoke web app design company, to develop an app.

The app was designed to help parents and carers to support children to be ready and prepared for school. The app was informed using the experiences and knowledge of parents and professionals, such as health visitors and early year's teachers.

The app focuses on three sections which were identified as the most significant "attributes" or "skills" required for children to have attained to ensure a smooth transition into school.

The sections are:

- Social Interactions
- Communication
- Self-Awareness.

Each section has simple activities for children to undertake and when they have completed the activity they receive a gold star.

The app is not designed for the child to use alone but for parents/carers to use with their child to encourage conversation and interaction. It can be used with multiple children and activities can be stored so you can build on a child's progress.

The app will soon be available to download from the Bridgewater website and works with mobiles, tablets or a computer. It will also link in to early years and education across Bridgewater boroughs appearing on their websites and documentation for school entry.

Bridgewater helps to ease pressures on busy local hospitals

During 2016/17, Bridgewater's Urgent Care Centre in Widnes and NHS Walk-in Centres in Leigh and St Helens helped alleviate some of the strain on local hospitals by assessing and treating a total of 149,000 patients.

- Leigh NHS Walk-in Centre, which Bridgewater runs in partnership with Wigan Clinical Commissioning Group, assessed and treated 43,900 patients, which is an average of 844 a week
- St Helens NHS Walk-in Centre, which Bridgewater runs in partnership with St Helens Clinical Commissioning Group, assessed and treated 61,900 patients, which is an average of 1190 a week
- Widnes Urgent Care Centre, which Bridgewater runs in partnership with Widnes Clinical Commissioning Group, assessed and treated 44,100 patients, which is an average of 848 a week

It has been another busy year for all the Bridgewater walk-in centres. During the past few months, there has been an increase in the number of patients treated with chest infections, coughs, colds and gastroenteritis.

The walk-in centres and urgent care centre have teams of specially trained and experienced nurses on hand seven days a week, 365 days a year. They treat a range of non-serious conditions ranging from suspected simple fractures and allergic reactions to injuries and infections thus helped to reduce some of the pressures on the local hospitals.

Emotional Health and Wellbeing

The Bolton 5-19 Service staff are committed and passionate about enabling the children and young people of the borough to maintain a healthy, happy and safe lifestyle. It is known that at least 1:10 children and young people will need additional support or treatment for mental health problems at some stage in their development.

The service consists of a wide range of skilled and experienced practitioners. All staff use the newly developed templates for assessments, which not only record the voice of the child but also help to gauge their current mood, understanding and wishes. At school entry, a health assessment is performed for each child. It consists of information received from parents/carers, health professionals and educational settings. This ensures appropriate interventions for any physical, emotional or developmental problems which may have been missed or not previously addressed.

Following on from the redesign of the service we are in the process of developing an integrated emotional health and wellbeing pathway which starts with the universal offer of awareness. Raising awareness sessions range from Personal, Health, Social and Economic education (PHSE) from reception age to offering individualised packages of care provided by the most appropriate member of the team for children and young people who have been identified as having issues which may be affecting their mental wellness (advanced tier 1).

Work is continuing on pathways which will enable us to reach the more vulnerable children and young people. At present we have Facebook, and twitter accounts and are looking at developing Apps specifically for young people to help support and signpost to help particularly out of hours.

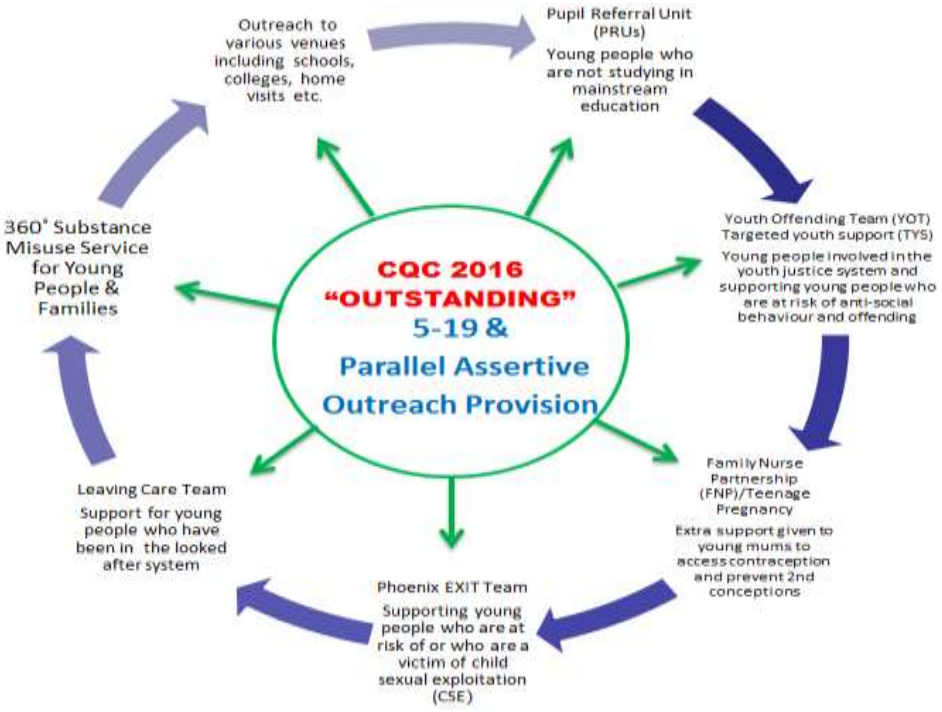
We provide an open access health provision for young people from the ages of 11-19 at the Parallel which is centrally located in Bolton. It opens outside school hours and is staffed by a GP, advanced practitioner, adolescent nurses and clerical support officers.

Each high school and college in the locality offers a weekly school nurse /adolescent nurse drop in service.

The service works very closely with multi-professional agencies including the police and social care, including Phoenix Exit, Seam and other 3rd sector voluntary agencies. It also works very closely with the CAMHs service.

The 5-19 service has developed the Bolton Schools Health Profile and Delivery plan. The document will become a school health profile and partnership agreement. It will draw on

information available locally and from within schools to create a unique Health Profile of the school community. It will help to identify the individual emotional health and wellbeing needs of the school including providing support for anger management, attachment and bonding, bereavement and loss and mental wellness. We totally understand that emotional health is a huge concern for both primary and secondary schools. With our multi-professional integrated teams with specialist skills we will be able provide and support schools address any concerns identified.



The Parallel Staff Praised by RUClear

Bridgewater staff from The Parallel in Bolton were applauded by RUClear, an organisation run by the NHS, to provide free testing for sexually transmitted infections.

The Parallel offers an adolescent health service for young people living in Bolton up to the age of 19. The Parallel works closely with school nursing and other young people's services to meet the health needs of young people on an array of issues such as sexual health and contraception, general health issues, smoking, substance misuse, relationships, bullying, food and weight problems.

The Results Team Manager at RUClear praised the "fantastic staff" and described them and the service delivered as "second to none". The manager went on to state "The work that they do with young people is commendable and out shines any other service that we deal with. The service users are obviously young people and often vulnerable but when they attend your service we know that they are guaranteed to be well looked after and if required referrals made to the appropriate services. It is well known at RUClear that young

people request to go to the Parallel for screening/treatment as they feel comfortable talking to the staff there and are never judged and many build up a good relationship with the staff".

The Wigan Health Outreach and Inclusion Service

The health outreach and inclusion service aims to tackle health inequalities within the most vulnerable communities in Wigan. The main function is supporting individuals and families, particularly from disadvantaged groups who often have difficulties accessing services.

The service aims to improve health and wellbeing outcomes and support health improvement for people who are vulnerable migrants, gypsies and travellers, people who are homeless and sex workers.

In addition to help accessing health services, the team offers:

- General physical assessment
- Blood sugar screening
- Chlamydia testing
- Screening for Blood Borne Virus (BBV) Hepatitis B, Hepatitis C and HIV and referral into specialist services if the results are positive
- Pregnancy testing
- Blood pressure monitoring
- Urinalysis
- Healthy eating, weight and BMI
- Clinic in a box
- Advocacy
- Child health advice

Staff refer and signpost to many services within and outside of Bridgewater such as health visiting, child health, school nursing, TB service, drug/alcohol services, counselling services, The Brick, Healthy Routes, food banks, GPs and many third sector services.

Staff need to be compassionate, have clinical and non-clinical skills and a knowledge of equality and diversity. They need the ability to listen and understand the problems faced by service users and a good knowledge of local services on offer in the community. Staff also endeavour to incorporate "The Deal "principles in all the do.

The service started to do outreach with the homeless every Wednesday evening in Wigan town centre. Staff go out and try to help with any health issues they may have and signpost to any other services needed.

The service utilise a new app called REF Aid that allows service users of any language to locate services across the borough and across Bridgewater.

"Share to Care" Won National Award

Wigan's 'Share to Care' digital programme, that enables health and social care staff across Wigan to securely share patient information, won a prestigious award.

Share to Care was named as the best example of "Excellence in Information sharing and Security" by iNetwork that celebrates and shares innovation in the public sector.
A number of organisations across Wigan were involved in the successful creation and delivery of Share to Care including Wrightington Wigan and Leigh Foundation Trust, Wigan Clinical Commissioning Group, all 63 GP practices from across Wigan, Bridgewater and 5 Boroughs Partnership.

The programme securely connects different medical and care computer systems together. This means professionals can see accurate and up-to-date information which helps them deliver appropriate care and prevents patients having to re-tell the same information every time they see a different professional.

Integrated Community Services in Wigan

The Wigan Integrated Service (ICS) launched in October and is bringing together NHS staff based in the community with local council health and adult social care staff to provide support to patients in their place of residence. It will make it easier to coordinate care and services for patients, treating and supporting them at home or in community clinics, keeping them well and reducing the need for hospital care.

Bridgewater is working with Wigan Borough Clinical Commissioning Group, Wrightington, Wigan and Leigh Hospitals NHS Foundation Trust, Wigan Council and 5 Boroughs Partnership NHS Foundation Trust to deliver the new look service.

Children and Young People's services in Oldham awarded Unicef Baby Friendly Award

Right Start Oldham received international recognition from UNICEF (United Nations Children's Fund) by receiving the Baby Friendly Award for their work to increase breastfeeding rates and improve care for mothers.

Right Start Oldham includes services such as school nursing, health visiting, oral health, Family Nurse Partnership to support young mothers and services in the borough's 16 children's centres. Right Start services are provided by Bridgewater in partnership with Oldham Council.

The Baby Friendly Initiative, set up by UNICEF and the World Health Organisation, is a global programme which provides a practical and effective way for health services to improve the

care provided for all mothers and babies. In the UK, the initiative works with UK public services to protect, promote, and support breastfeeding and to strengthen mother-baby and family relationships. Support for these relationships is important for all babies, not only those who are breastfed. The award is given to health services after an assessment by a UNICEF team has shown that recognised best practice standards are in place.

Oldham Right Start and School Nursing Service

The Trust secured the Oldham Right Start and School Nursing contracts following a successful tender and the respective services transferred on 1st April 2016. The staff TUPE arrangements brought to Bridgewater a range of staff who had previously been employed by four predecessor organisations; Oldham Borough Council, Pennine Care NHS Foundation Trust, Action For Children and The Children's Society.

The new contract requires the development and implementation of an innovative, integrated, multi skilled 0 – 5 health and education "Right Start" service model. The transformational element of the new service comes in the integration of a number of key functions; namely health visiting and children's centres; to create a single service to achieve agreed and improved information sharing within the integrated model thus reducing duplication of services.

The staffing structure has been reviewed in line with the service model presented to Oldham commissioners at the time of bidding for the service and a redesign / restructure programme will begin in 2017.

Warrington Enhanced Care Home Support Service

The Enhanced Care Home Support Service has been redesigned to reflect an educational, primary care GP and pharmacy delivery model.

The aim is to develop closer working relationships with care homes across a multi-disciplinary care team assuring improved care and support for staff and residents in care homes; inclusive of identifying a need for multi-disciplinary team meetings.
Bridgewater is the key provider and works alongside Warrington Health Plus for Pharmacy provision.

The model includes proactive weekly visits to care homes by named GPs, nurses and pharmacist. Patients have a full assessment with care plans in place to ensure their needs can be met within the home; the home staff feel supported to care for the individual.

There is an emphasis on end of life patients to ensure the individual and their families are included in discussions relating to advanced care planning.

Homes continue to be supported for urgent in day requests for visits and advice via the care home support line, with an advanced nurse practitioner rota in place for rapid response care the same day. The aim is to improve care and prevent unnecessary admissions to hospital for frail elderly individuals.

Youth Offending Service (SLT) Warrington

A pilot project has been running in Warrington since February 2016 identifying and supporting young people in the Youth Justice Service (YJS) with Speech Language Communication Needs (SLCN). 75% of young people who have been assessed to date had some SLCN. This is consistent with national research that shows that 65 -80% of young people in Youth Justice Services have unidentified speech language and communication needs (SLCN); their communication needs are unrecognised even though behaviour difficulties are clearly recorded.

Many young people have found it positive to work with the speech and language therapist alongside their YJS workers who they know and trust. Many have been prepared to talk about their difficulties and work with strategies that they can use themselves and also enable them to explain to people how to help them. One young person when reviewed recently had greater confidence in using his strategies. This has coincided with his successful work in college and his YJS work finishing early due to his good progress. Another young person has had his strategies incorporated in his plan at his care placement. People who work with him at home report that they can now more effectively manage his outbursts. He is in the process of moving from school to college and he is feeling positive about his new challenges.

There have been a number of recognised impacts of this service to date:

- Young people often appreciate the opportunity to recognise and discuss SLCN difficulties. For these young people, simple SLCN strategies are explained for them to influence their own environment in a positive way.
- YJS staff have reported that SLCN adaptations help young people understand YJS work more clearly and gain more from it. The staff will often discuss strategies and apply them to other cases.
- In learning / training placements, recognition of difficulties can lead to a young person being supported in a different and more effective way. This could have a positive impact on their educational and therefore their life chances.
- Families / carers have reported that knowing how to help their young person with SLCN has made home life easier and more positive.

Children and Young People's Services in Warrington

The new integrated 0-19 children and young people's service in Warrington was launched in October 2016. The service, delivered in partnership with Warrington Borough Council, saw staff from current services such as health visiting, school nursing, family nurse partnership,

oral health improvement, breastfeeding, immunisation and National Child Measurement Programme working more closely together.

Families experience a number of benefits from the new 0-19 service:

- One single email address to access advice and arrange appointments.
- Health visiting advice and information available to families until 8pm – this is via a specialist telephone line, later drop-in baby clinic sessions at Bath Street Health and Wellbeing Centre and some evening scheduled appointments.
- A more consistent and flexible service by healthcare staff working more closely together from different services thus families experience less disruption when transferring from one service to another.
- Healthcare staff from different disciplines have better opportunities to share best practice to improve their knowledge and learning.
- The use of new innovative technologies e.g. a new award-winning school readiness app, developed by Chester University in partnership with Bridgewater, available for local families with pre-school children.
- Better partnership working with schools, children's centres and nurseries to produce tailored health action plans that specifically meet the needs of their pupils and service users.
- Working with nurseries and parents to deliver the children's two year review in a nursery environment if preferred by the parent or carer.
- More specialist support for mothers who are breastfeeding and for families weaning their babies.

Halton Midwives promote new Baby Box Pilot

Cheshire and Merseyside Women's & Children's Services Partnership, 'Improving Me', is the first baby box programme to launch in the North of the UK, and the first to roll out to new mums across multiple boroughs and NHS Clinical Commissioning Groups.

The baby box initiative was initially rolled out in Halton with information and support on baby boxes being provided to local families by Halton's Midwifery Service which is part of Bridgewater. Other areas will have their launch in the first six months of 2017.

The partnership will be issuing 30,000 baby boxes across the region to women in pregnancy over the course of the initial pilot. The baby boxes will encourage early engagement with maternity services and access to care for all pregnant women. It will form part of their antenatal pathway and be supported by local midwifery teams. Women who partake in the pilot will be enrolled in the 'Baby Box University' and will have access to hints and tips for the health and care of new babies including information on immunisations for the neonate and infant.

The baby box tradition, which originates from Finland, has been associated with supporting the reduction in the infant mortality rate in the country from 65 infant deaths per 1,000 births in 1938 to 2.26 per 1,000 births in 2015. The UK has some of highest rates of infant mortality in Europe, ranking 22nd out of the 50 European countries with 4.19 deaths per 1,000 births.

The initiative was launched at an event at Halton Stadium on Friday 7th October for health care professionals, commissioners and allied staff. The Midwifery Team Leader discussed baby boxes and handed out the first batch of boxes to local families.

Service Launched to Improve Speech, Language and Literacy Development in Schools in St Helens

St Helens Council and Bridgewater launched a new service that offers high quality reading resources to support speech, language and literacy development in schools across the borough.

Books and Language Unite St Helens (BLUSH) is a partnership project between St Helens Schools Library Service, St Helens libraries, Bridgewater and St Helens paediatric speech and language team with the aim of developing language skills through reading.

Special educational needs co-ordinators and other members of teaching staff who have received universal training on speech, language and communication from the Speech and Language Team can now access special BLUSH boxes from the Schools Library Service based at the Park Road Centre.

Each BLUSH box contains questions that vary in difficulty so they can be used to help children of all abilities in developing their understanding of language. They contain examples of the best books that have been written to introduce children and adults to the wonderful world of reading – whilst also improving their speech and language skills.

The aim of the training delivered in primary schools is to make a real difference to all local children, including those with speech, language and communications difficulties, enabling them to join in successfully with all aspects of home, school and community life.

Schools Library Service members can request BLUSH boxes free of charge.

NHS Improvement (NHSI) Compliance

NHSI (previously MONITOR) expects NHS Foundation Trusts to establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services. MONITOR incorporated performance against a number of

these standards in their assessment of the overall governance of Bridgewater going forward as a Foundation Trust.

Performance against the relevant indicators and performance thresholds is set out on next page.

Single Oversight Framework (SOF) Indicators	Target	Quarter 1 2016/17	Quarter 2 2016/17	Quarter 3 2016/17	Quarter 4 2016/17	Average Over 4 Quarters	
Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted	95%	99.32%	93.26%	97.79%	98.86%	97.31%	
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway	92%	98.85%	98.14%	98.80%	99.49%	98.82%	A
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	99.62%	99.20%	99.00%	98.21%	99.01%	
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer	85%	100.00%	96.77%	100.00%	100.00%	99.19%	A
All cancers: 31-day wait for second or subsequent treatment, : comprising: Surgery	94%	100.00%	100.00%	68.70%	100.00%	91.68%	
All cancers: 31-day wait from diagnosis to first treatment	96%	96.20%	100.00%	95.50%	100.00%	97.93%	
Cancer: two week wait from referral to date first seen, comprising: all urgent referrals (cancer suspected)	93%	94.50%	96.18%	95.20%	96.89%	95.69%	
Clostridium (C.) difficile	0	0	0	0	0	0	
MRSA	0	0	0	1	0	1	
Diagnostics six week waiters (% under six Weeks)	99%	98.49%	92.26%	99.43%	99.47%	94.91%	
Improving access to psychological therapies: Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	57.82%	61.49%	60.92%	59.09%	59.83%	
Improving access to psychological therapies: % patients beginning treatment within 6 weeks of referral	75%	100.00%	100.00%	100.00%	100.00%	100.00%	
Improving access to psychological therapies: % patients beginning treatment within 18 weeks of referral	95%	100.00%	100.00%	100.00%	100.00%	100.00%	
Mental health data completeness: identifiers	97%	97.31%	100.00%	99.88%	99.87%	99.26%	
Mental health data completeness: outcomes for patients on CPA	50%	-	62.56%	71.58%	70.90%	68.35%	
Data completeness: community services, comprising: Referral to treatment information	50%	99.67%	99.81%	99.78%	100.00%	99.82%	
Data completeness: community services, comprising: Referral information	50%	84.71%	85.80%	88.52%	90.44%	87.37%	
Data completeness: community services, comprising: Treatment activity information	50%	80.17%	92.48%	89.84%	93.29%	88.94%	

Referral to Treatment time is the length of time between a patient's referral to one of our services to the start of their treatment.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

This indicator is defined as the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

Numerator: The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks.

Denominator: The total number of patients on an incomplete pathway at the end of the reporting period.

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

This indicator is defined as the percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer.

Data definition: All cancer two-month urgent referral to treatment wait.

Numerator: Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers.

Denominator: Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers.

The NHS Constitution gives patients the right to:

- start your consultant-led treatment within a maximum of 18 weeks from referral for non-urgent conditions
- be seen by a cancer specialist within a maximum of two weeks from GP referral for urgent referrals where cancer is suspected
- start your AHP led treatment within a maximum of 18 weeks from referral for non-urgent conditions.

The Trust also aspires to meeting the 18 week pledge for all other services.
The Trust is required to report on the length of time between referral to a Consultant-Led service and the start of treatment being received.

The Trust achieved all its monthly monitored national targets for Consultant-led RTT waiting times during 2016/17.

Waiting Times Consultant Led (Incomplete Pathway)

Consultant-led services are those where a consultant retains overall responsibility for the clinical care of the patient.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Bridgewater	99.61%	99.20%	97.74%	99.80%	95.78%	98.85%	98.38%	98.47%	99.54%	99.13%	99.54%	99.81%

At the end of 2016/17 the Trust had a total of 1,055 patients waiting for consultant led services.

Waiting Times All Services

The Trust measures the time that has elapsed between receipt of referrals to the start of treatment and applies the national target of 18 weeks to all its services. Below are patient waiting times reported at the end of each month for all Bridgewater services (2016/17).

Waiting Times	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
<11 Weeks	9815	9763	9722	10044	9827	9267	9000	9086	8865	8719	9222	10190
11-17 Weeks	748	1057	991	1047	1075	1116	1114	946	1391	1186	1086	839
> 18 Weeks	68	61	92	102	162	142	176	167	179	161	132	71

At the end of 2016/17 the Trust had a total of 11100 patients waiting for all services. Of these 10190 (91.80%) were waiting under 11 weeks.

Cancer Services

The Trust delivers community based cancer services to patients living in the Warrington area which is commissioned by Warrington CCG. The table below demonstrates the Trust's performance against the national cancer targets throughout 2016/17:

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
All cancers: 31-day wait for second or subsequent treatment	100.00%	N/A	100.00%	100.00%	N/A	N/A	0.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All cancers: 62-day wait for first treatment	100.00%	100.00%	100.00%	100.00%	100.00%	94.12%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
All Cancers: 31-day wait from diagnosis to first treatment	100.00%	92.31%	100.00%	100.00%	100.00%	100.00%	92.86%	100.00%	93.75%	87.50%	100.00%	100.00%
Cancer: 2 week wait from referral to date first seen	97.30%	94.16%	92.59%	90.98%	98.86%	98.70%	93.20%	95.68%	97.25%	97.32%	95.65%	97.35%

Equality and Diversity and Inclusion

As a Trust we are committed to promoting human rights, equality, diversity and inclusion for the communities we serve and the staff we employ. As a service provider we seek to provide care that meets individual needs, supports cultural differences and is accessible to all. As an employer we want to ensure there is a positive and inclusive culture within the Trust, with our staff working in an environment that is free from discrimination, bullying and harassment.

Board level responsibility for equality, diversity and inclusion sits with the Director of People and Organisational Development/Deputy Chief Executive, whilst day to day equality work and support is provided by the Equality and Human Rights Officer.

The following are just some of the ways we work to ensure that equality, diversity and inclusion, and compliance with relevant legislation and guidance are embedded in the Trust:

- The annual publication of our Public Sector Equality Duty Annual Report.
- Assessment and grading of equality performance using the EDS2 toolkit.
- The production of specific and measurable equality objectives.
- The availability of borough specific health inequalities documents, providing a profile of health inequalities and barriers to access for protected characteristic and other vulnerable health groups.
- The ongoing embedding of the Accessible Information Standard in the Trust.
- Browsealoud availability on the Trust website to support patients whose first language isn't English or who have particular needs related to a disability. The software can translate webpages and documents into community languages, has

screen reading technology, or can change such things as font size and background to support access.

- The development and review of policies and procedures that address equality, diversity and inclusion for both staff and patients.
- The equality analysis of all Trust services.
- The annual publication of the NHS Workforce Race Equality Standard data.

A highlight for 2016 was the announcement that the Equality and Diversity Team were winners in the Greater Manchester Clinical Research award for Best Community Research Project for their work on the Extending Working Lives project of the University of Bath and the Medical Research Council. This research project sought staff views on the impact of pension reforms and working longer in the NHS. As the only community provider the 130 staff who took part provided a valuable insight into the potential impacts on staff working in community settings. Trust data will be used for workforce planning for the future.

There are a number of planned actions for 2017, these include:

- Regional work on EDS2, detailed further within the 2017 Equality Objectives.
- Completion of a new Equal Opportunities Policy for the Trust that will replace the existing Equality Statement.
- Implementation of a new Equality Impact Assessment Policy and Toolkit.
- Assessment and resubmission to the Mindful Employer Charter.
- Work on the Disability Confident Campaign.
- Completion of guidance and policy to support transgender staff and patients.
- Submission to the 2017 Navajo Charter.
- Work on staff wellbeing initiatives, such as the menopause, dementia and carers.
- Continuing work on the contractual reasonable adjustments project.
- Work on the new Gender Pay Gap reporting.
- Work on the new Workforce Disability Equality Standard.

Further information on our planned work around equality, diversity and inclusion can be found in our Health Inequalities and Inclusion Action Plan which can be viewed on our webpages along with our published reports and contact details for the team.

Stakeholder Involvement in the Development of our Quality Report

Opportunity to Shape the Content of our Quality Account

Prior to our quality report being drafted our Chief Nurse wrote to our stakeholders requesting their input into the content of the report. A number of suggestions were received regarding content and our 2016/17 quality improvement priorities, which have been taken into account during the development of the report.

Stakeholder Feedback

We sent out our draft Quality Report to our stakeholders inviting them to comment on whether or not they considered the document to be accurate in relation to the services provided.

All of the responses have been included in our report – please see appendix B

Appendix A – Workforce Information

Our key priorities for 2016 were to:

- improve on the national NHS Staff Survey results
- improve the national NHS Staff Survey 'Engagement' score
- improve the national NHS Staff Survey score for Staff recommending the Trust as a place to work and receive treatment
- increase the Personal Development Review rate (Staff appraisal)
- reduce sickness absence rates against a Trust target of 3.78%
- achieve the Trust target of a rolling 8% for staff turnover.

Staff Engagement

The Trust promotes effective employee engagement to create a motivated and valued workforce which ultimately leads to better patient care and service experience. Engagement, consultation and ensuring effective communications with our staff is of paramount importance. During the past 12 months we have continued to improve our methods of communication, involvement and engagement with staff to enable them to understand the aims and objectives of the Trust, its mission, vision and values.

The key performance indicators have helped the Trust to measure, and will continue to help measure, the quality of staff experience. Data relating to workforce indicators are reported to the Trust Board as are the annual national NHS staff survey results.

We enjoy effective partnership working with our trade unions and staff-side colleagues and believe this is critical to our success.

We have various information and communication channels, engagement systems, programmes and initiatives which include, but are not limited to:

- A monthly Team Brief cascade led by the Chief Executive and Executive Team. The Brief is cascaded by managers across the whole organisation within seven days. March 2017, saw the development of the Team Brief by video
- Regular 'Open Space' events which give all staff the opportunity to bring forward ideas or suggestions. The ones agreed by the group to be the most viable are worked into a proposal for consideration for implementation
- A weekly Trust Bulletin which provides staff with information as to what is happening within the Trust, patient stories, the events that they can attend, seminars, workshops and forums they can engage in. Staff are able to contribute to the content of the Bulletin, put questions to the Trust's Communications Team and partake in research programmes and promote the good work of their services as per its regular 'Spotlight on Services' feature

- A “Star of the Month Award” whereby staff can nominate colleagues who have gone over and above their role, living up to the Trust’s values and demonstrating ‘star’ qualities. Awards are presented by the Area Directors and Heads of Departments and publicised in the Bridgewater Bulletin, Trust Intranet and website
- Trust wide Staff Awards, featuring six award categories:
    - Clinical Employee of the Year
    - Non-Clinical Employee of the Year
    - Team of the Year
    - Outstanding Contribution to Innovation
    - Patient Choice Award – nominated by our Patients/Members
    - Chairman’s Award for Lifetime Achievement
- The Chief Executive’s Blog is featured in the Trust Bulletin and also accessible to staff via the Trust’s intranet
- The Chief Nurse and Finance Director have Blogs featured on the Trust’s intranet site, the Hub
- The Trust intranet keeps staff updated with current information on the organisation; what is happening within the Trust, its services, organisational change, developments, initiatives, innovation and improvements
- Quality Visits enable staff to meet members of the executive team to discuss the quality of services they delivery and listen to their views, ideas and what it is like to work for the Trust
- Professional Forums, which are made up of clinical staff, include presentations and workshops on national, regional and local issues and initiatives, best practice and networking opportunities
- The Productive Community Services Programme enables staff to share their experiences of service improvements and developments. Staff have and are adjusting to new ways of working. Staff who have undergone modules have reported much improved working environments, increased face-to-face contact time with patients and less time spent on administration tasks due to system and process improvements, enabling more time to deliver patient care.


Staff are actively encouraged to follow the Trust’s social media accounts on Twitter and Facebook.

Listening into Action (LiA) has an overarching theme of listening to staff concerns and supporting them to act as quickly as possible to make changes that create a great place to work where staff feel empowered and proud. Although work streams addressed operational issues and concerns, they are underpinned by a strong commitment

to staff empowerment and enrichment. The Trust will use its (LiA) programme to address some of the themes emerging from the NHS Staff Survey.

NHS Staff Survey 2016 - Working with staff to understand key messages from the staff survey

In 2016, all staff were surveyed by paper. This was a change in approach from previous years where a random selection of 850 staff were surveyed. Our response rate improved as follows:

2015		**2016**		**Trust Improvement/ Deterioration**
Trust	National Average *	Trust	National Average*	
28%	48%	46%	51%	18% improvement

The Trust takes part in the national annual NHS staff survey. As well as providing us with feedback on how we are doing and how staff are feeling in relation to 32 'Key Findings', we are provided with a national 'staff engagement' score. Our 2016 score very slightly deteriorated by 0.02 in comparison to 2015 from 3.75 to 3.73. The scoring system is a scale of 1 to 5 with 1 being 'strongly disagree' and 5 'strongly agree'. The national average score for Community Trusts was 3.78.

The overall indicator of staff engagement is calculated using the following 'Key Findings' questions:

- KF1: Staff recommendation of the Trust as a place to work or receive treatment
- KF4: Staff motivation at work
- KF7: Staff ability to contribute towards improvement in work

To ensure that we continue to listen to our staff and acknowledge the important feedback we get from our survey, we develop action plans to inform us of our key priorities and areas for further developments and continuous improvements. The action plan is, and will continue to be, managed through formal management meetings where performance reviews take place. Action plans and progress against the same are shared with our staff-side colleagues at our partnership working groups.

As part of our response to the staff survey to enable staff to see how we are responding to their feedback, we have used our Listening in Action groups to explore staff values, attitudes

and behaviours to enhance care delivery and the patient's experience. The feedback has informed the Trust's Staff Engagement Strategy which was launched in March 2017.

We have a quarterly staff friends and family test which is focussed on areas of the national staff survey, enabling us to monitor our progress throughout the year.

The staff survey results provide us with our top five and bottom five ranking scores:

Top 5 ranking scores	**2015**		**2016**		**Trust Improvement/ Deterioration**
	Trust	National Average	Trust	National Average	
*KF16: Percentage of staff working extra hours	72%	74%	67%	71%	5% improvement
*KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	6%	7%	6%	7%	Same
*KF28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	19%	21%	18%	20%	1% improvement
**KF2: Staff satisfaction with the quality of work and care they are able to deliver	3.85	3.86	3.89	3.85	0.04% improvement
***KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	83%	90%	90%	90%	7% improvement

* the lower the score the better

**score out of 5 - the higher the score the better

***the higher the score the better

Bottom 5 ranking scores	**2015**		**2016**		**Trust Improvement/ Deterioration**
	Trust	National Average	Trust	National Average	
***KF6: Percentage of staff reporting good communication between senior management and staff	22%	30%	24%	32%	2% improvement
***KF24: Percentage of staff/colleagues reporting most recent	62%	61%	58%	72%	4% deterioration

Bottom 5 ranking scores	2015		2016		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
experience of violence					
*KF18: Percentage of staff attending work in the last 3 months despite feeling unwell because they felt pressure from their manager, colleagues or themselves	65%	58%	70%	56%	5% deterioration
**KF19: Organisation and management interest in and action on health and wellbeing	3.52	3.81	3.57	3.69	0.05% improvement
**KF31: Staff confidence and security in reporting unsafe clinical practice	3.77	3.76	3.65	3.76	0.12% deterioration

* the lower the score the better

**score out of 5 - the higher the score the better

***the higher the score the better

Local improvement plans are required to consider the following results relating to the percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months and the percentage believing that the Trust provides equal opportunities for career progression or promotion, for the Workforce Race Equality Standard are as follows:

NHS Staff Survey	2015	2016	Median Community Trust	Best Community Trust Score
KF26: percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months *(The lower the score the better)*	23%	23%	20%	16%
KF21: percentage of staff believing that the trust provides equal opportunities for career progression or promotion *(The higher the score the better)*	83%	90%	90%	92%

KF26 has remained the same and is slightly above the national average for Community Trust response rates. KF21 is where we have seen the most improvement since the 2015 Survey.

Improving on the staff survey results will remain a key priority through our action plans, focus groups, Corporate Partnership Forum and Listening into Action Programme.

Staff Health & Wellbeing

We continue in our commitment to reduce sickness absence through effective management and support from occupational health and the Trust's human resources team. A healthy motivated workforce is integral to achieving better care for our patients. We have an occupational health service which provides staff with:

- Telephone and face to face counselling services
- Physiotherapy services
- Occupational health referral and assessment services, including speedy referrals for mental health and muscular-skeletal disorders

Our occupational health service provides us with information that helps us identify areas of staff health and wellbeing that may require more attention, such as issues of personal and workplace stress. The introduction of on-line occupational health referrals has enabled more timely referrals and feedback on medical assessments/opinions.

The Trust recognises that any adverse impact on staff that affects their ability to function at their best in the workplace needs active steps to provide support and take a preventative stance where possible. The Trust will be recruiting a member of staff to support the managing and handing of staff health and wellbeing.

The Trust's sickness absence target is 3.78%. The absence rate at the end of March 2017 was 5.37% in comparison to 5.02% at the end of March 2016. Whilst this is above the Trust target proactive work is being undertaken to manage sickness absence within the Trust.

Management are provided with monthly absence reports which enable them to monitor absence in line with the Trust's policies and procedures. Absence rates are monitored by the Trust Board.

Personal Development Reviews (PDRs)

We continue to provide opportunities for our staff to develop via a 'values' driven personal development review to ensure they can continue to meet the needs of our aims and objectives and patients.

The Trust's focus on PDRs has been captured within the 2016 NHS Staff Survey in which 87% of respondents confirmed that they had been appraised in the last 12 months. The national average for Community Trusts was 89%.

Directorate	Percentage of Staff Compliance
Adult Services	90.53%

Children's Services	93.29%
Dental Services	95.54%
Corporate Service	26.52%
BRIDGEWATER	82.81%

A full review of our PDR process has been undertaken with a new system to be launched during 2017. Managers now complete and return monthly compliance reports which enable senior managers to review PDR take up, compliance and non-compliance by way of individual staff members within their Teams.

Staff Turnover

The rolling staff turnover for the Trust as at 31 March 2017 was 11.80% (this includes only voluntary turnover). This is above the Trust target of 8%. However, during a time of organisational change and continuing cost improvement programmes, this is not necessarily unexpected or a cause for concern. There have also been groups of staff TUPE transferred in to and out of the organisation during the last year which impacts significantly on the staff turnover rates. Work is ongoing around staff engagement and any particular issues should be identified during this stream of work.

Workforce Planning – Staff in the right place at the right time with the right skills

The Trust is committed to deliver a robust, integrated workforce plan. As a community based organisation our workforce is primary to community care which is reflected in the plan. The 2016/17 plan was developed with input from each of our clinical services. The Clinical Services Strategies set out the intentions for the delivery and development of services over the next five years. They include what we do, why and how to ensure that our services are in the strongest position to deliver high quality care and promote health and wellbeing in our communities.

The composition of the workforce has remained relatively stable over recent years but it will need to change to reflect and respond to national and local changes. This will impact on the productivity levels and the ways of working. Implementing new roles, new ways of working and skill mix changes will be essential to meet costs and increase outputs. New ways of working are being developed as part of redesign and in conjunction with new technologies and IT strategies i.e. patient systems and mobile working.

This includes the implementation of the Trust's mobile electronic patient records system, which is now underway and expected to increase productivity by around 10% for each service on the roll-out schedule.

In line with the competitive commercial environment, one of the Trust's key strategic priorities is retaining existing business and development of new business. This will be regularly reviewed and will be reflected in future workforce plans.

As part of its commitment to improving quality and efficiency, the Trust has undertaken capacity and demand modelling with key services e.g. district nursing, school nursing and health visiting. A clinically led approach, which was informed by patients' needs and supported by the service improvement team, has enabled staff to redesign the workforce profile. This has resulted in a greater congruence between skill mix and case mix.

As part of the planning process our workforce profile factors in the Cost Improvement Programmes (CIP) - The Trust's activity remains fairly constant and the emphasis is upon increasing productivity, via skill mix and service redesign to support the CIP programme and ensure maximum service efficiency, whilst maintaining quality. CIP plans have been reviewed through the Trust's Quality Assurance Process and key workforce indicators are reported on a monthly basis.

Work is progressing with our local CCG's on the response to the Five Year Forward Plan and supporting relationships with patients and the communities. The workforce plan focuses on new models of care with dementia, mental health, cancer/palliative care and integrated working models. The priority for 2016/17 is the integrated care models and the relationships between primary and secondary care and 'out of hospital' care. Our future plans will include the development of the public health agenda and the greater support for community organisations and also integration with social care.

Work is taking place to align workforce plans to boroughs. This will incorporate integrated models of care based on population centric workforce modelling. Getting the right balance requires a robust understanding of the nature of the workforce pressures, locally and nationally and what can be done to address them in the short and longer term.

The Trust has a Quality Impact Assessment (QIA) process for any workforce plans and proposed service changes which have cost savings/efficiencies attached to them. This comprises of a panel that review and approve the proposals. The QIA panel process was recently reviewed by our Auditors and received 'significant assurance'.

As a Trust we are aligned to two Local Education and Training Boards to meet our geographical needs. As an organisation we are committed to offering high quality and diverse placements to both pre and post-registration health care professionals and to be the placement provider of choice. We also aim to continue to develop a learning environment that not only consistently delivers the inter-professional learning agenda and the Placement Charter but that also provides a rich learning experience for all staff that we employ or host

on placement. There is a robust education governance structure in place with clearly defined work-streams, accountabilities and reporting arrangements.

Recruitment

When recruiting, we consider the post requirements, along with the skills mix required. This may involve role redesign or the development of new roles.

We recruit in line with the national 'NHS Safer Recruitment' process.

The recruitment process has recently been reviewed to further streamline systems and process and where possible, speed up the recruitment, selection and appointment process.

Regionally, we are engaged in a 'streamlining' project that will give those who work within the NHS greater flexibility to move around the NHS system from one employer to another. The regions engaged in the process are Greater Manchester, Cheshire & Merseyside and Cumbria & Lancashire.

Responsible Officer (RO) Compliance

Medical revalidation is a legal requirement which strengthens the way that doctors are regulated, with the aim of improving the quality and safety of patient care and increasing public trust and confidence in the medical system.

Bridgewater is a designated body in accordance with the Medical Profession (Responsible Officer) Regulations 2013 and, through the RO function, has a statutory duty to ensure that the doctors working at Bridgewater are up to date and fit to practice. This includes:

- monitoring the frequency and quality of medical appraisals in their organisation
- checking there are effective systems in place for monitoring the conduct and performance of their doctors
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors
- ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

Through utilising the PREM IT electronic appraisal system, Bridgewater maintains an accurate record of all licensed medical practitioners with a prescribed connection to the organisation as their designated body for revalidation.

Through utilising the PREM IT electronic appraisal system, Bridgewater maintains an accurate record of all licensed medical practitioners with a prescribed connection to the organisation, as their designated body for revalidation. 91% (national target - greater than

90%) of our doctors have received an appraisal in the last 12 months. The remaining 9% incomplete appraisals are approved postponements by the RO, in accordance to our Medical Appraisal Policy.

The Annual RO report for 2015/16 was accepted by the Board in September 2016 and our Statement of Compliance submitted to NHS England within the agreed timescales.

NHS England confirmed in April 2016 that the Trust, as a designated Body (DB) has met the criteria for being exempt from the requirement to provide quarterly returns nationally and are only required to report at a regional level.

Overall criteria met as follows:

- The DB has achieved greater than 90% appraisal uptake in the previous year as stated in the 2014/15 Annual Organisational Audit (AOA)
- The DB has less than 1% non-managed incomplete or missed appraisal
- The DB engages with the RO and appraisal networks
- No concerns have been evidenced from an independent verification visit or any other source.

Education & Professional Development

The primary aim of the Education and Professional Development (EPD) Service is to support all health care staff within Bridgewater to have up to date, evidence based knowledge, skills and abilities in order to ensure that they can provide safe, effective and compassionate care.

Mandatory Training

The Trust recognises that statutory and mandatory training is of vital importance to adequately protect patients, staff, and members of the public and to support the quality of services and clinical effectiveness.

The EPD Service report mandatory training compliance to the Board on a monthly basis, this includes the identification of any issues and plans in place or recommendations to address them.

Compliance for all mandatory training is the responsibility of individual staff and is supported and prioritised by their Line Managers

The Education & Professional Development Service assist staff and managers across the Trust to target non-compliance on a monthly basis by informing the:

- individual staff member by email with dates of face-to-face sessions where applicable and the requirement for them to book on as a matter of priority
- clinical managers of their mandatory training compliance figures.

Work is currently being undertaken to move over from external provision of eLearning onto the National Learning Management System (NLMS); this has been delayed due to some IT issues which have now been resolved. This will ensure that the Electronic Staff Record (ESR) is updated immediately on completion of any modules and will improve the quality and accuracy of the compliance data. This will also mean that staff and managers will be able to see compliance for all mandatory training. In addition we are continuing to work with the Reporting Team to get all mandatory training compliance data, per cost centre/team, available on pivot tables and Qlikview.

Compliance with mandatory training across the Trust remains a challenge and a plan has been put into place to improve this which has taken into consideration our wide geographical footprint and the issues for staff and services. This has included allocating staff dedicated time away from their workplace to complete the required eLearning.

Continuing Professional Development

Continuing professional development (CPD) is fundamental to the advancement of all staff and is the mechanism through which high quality care is identified and maintained (DH 2014, DH 2015). The EPD service has continued to support all staff to further develop their knowledge, skills, practical experience and competencies. This is achieved by completion of an annual Training Needs Analysis which is based on both individual learning and development needs, identified through Personal Development Review, and the Commissioned Service delivery. The TNA for 2017/18 has been reviewed and now encompasses all aspects of education and professional development with clear alignment to the quality agenda priorities of patient safety, patient experience and clinical effectiveness. Essential training for service delivery and forecast planning is the key focus. The TNA document will be updated on a four monthly basis to ensure it is current. Any application for funding will be considered in relation to that services TNA and care delivery including priority areas. This will ensure that staff have the right skills to deliver a high quality service to meet the identified needs of the population they serve.

During 2016/17 training has been provided on a variety of topics including:

- Clinical skills for all Services
- Coaching and Mentorship
- Leadership and management

In addition we continue to support and fund staff to attend external learning and development opportunities and to access academic modules on a wide range of subjects for example:

- Advanced Clinical Skills
- Apprenticeship frameworks, vocational qualifications and cadet programmes
- Clinical assessment and diagnostics
- Non-medical Prescribing (NMP)
- Prevention and early intervention
- Research and development

In 2016/17 we have delivered in-house NMP and educator courses to make best use of available resources. As we move forwards into 2017/18 we already have plans in place to deliver another in-house V150 course and are in negotiation with local universities about non-credit bearing Multi-Professional Support of Learning and Assessment in Practice (MSLAP) to be run within the Trust.

Talent for Care and Work Based Development Opportunities

During 2016/17 we provided a range of work experience opportunities which included a joint project with Edge Hill University on the pre-degree Year of Care. We have expanded our offer and are engaging with local schools, colleges and universities across the geographical footprint. We have recruited Health Ambassadors and are actively engaged with Greater Manchester and Cheshire Career Hubs and apprenticeship groups.

All staff at Bands 1- 4 within the Trust have the eligibility and are actively encouraged to access vocational and occupational development qualifications and frameworks. These can be full Apprenticeship Frameworks or a range of shorter programmes that can be accessed for specialised areas of learning.

In April 2017 the way the government funds apprenticeships in England is changing. As an employer we will be required to contribute to a new apprenticeship levy, and there will be changes to the funding for apprenticeship training. The EPD service have established a Trust Project Group with all relevant partners and are engaging with Greater Manchester and Cheshire & Mersey Strategy Project Groups to drive this agenda forwards.

Since April 2015 we have been issuing the Care Certificate Workbook to new staff at Bands 1- 4, commencing in clinical support roles for example: Healthcare Assistants, Assistant Practitioners and Health Support Workers. We also offer this as a development opportunity for any other eligible staff.

Trainee Nursing Associates

The Trust has been successful in two partnership bids to support the development of the new nurse associate role. We are employing five trainee associate nurses who will be attending Edge Hill University and be providing community based spoke placements for trainee nurse associates from other local NHS Trusts working alongside the University of Chester.

The nursing associate role is part of developing a new contemporary workforce who will work under the direction of a registered nurse mentor with support from the EPD service to transform the future nursing and care workforce. They will learn on the job whilst attending university to gain a foundation degree.

The nurse associates role will bridge the gap between healthcare support workers, and registered nurses to deliver hands on care, ensuring patients continue to get the compassionate care they deserve. This will allow registered nurses to spend more time using their specialist knowledge and training to focus on clinical duties and take more of a lead in decisions about patient care.

Pre-Registration and Student Placements

A dedicated team of practice education facilitators work in partnership with our clinical staff, services and local universities to ensure the maintenance of high quality educational placements and positive learning experiences for all pre-registration students. During 2016/17 we continued to support placements for 1st year undergraduate medical students from the University of Central Lancashire and we are due to commence a pilot with 5th year students from Lancaster University in May 2017.

The team also supports practice education through the ongoing development and maintenance of our qualified mentors and educators. The Trust is able to offer students the opportunity to undertake placements in a diverse range of clinical services and in integrated health and social care settings. This prepares our future practitioners to respond to the needs of our current and future population as health and social care continues to transform and develop.

Forward Planning

In 2017/18 we plan to:

- Further develop our mandatory training offer as we move over to the National Learning Management System
- Continue supporting managers across the Trust with mandatory training compliance and reporting any identified issues to Board

- Review the TNA on a four monthly basis to ensure that the EPD service is responsive to any identified training needs on an on-going basis
- Continue the delivery of in-house NMP and educator modules and further develop this offer with MSLAP
- To support delivery of the national apprenticeship agenda
- Further develop our education strategy and action plan

In addition we will further affirm our commitment to the development of our future workforce through the talent for care widening participation agenda. This will include providing opportunities for local people to access:

- Work experience
- Apprenticeships
- Pre-employment programmes

Education and Professional Development Governance

We have a newly established EPD Governance Steering Group which aims to co-ordinate the provision of education and professional development within the Trust involving internal stakeholders specifically to:

- influence decisions about education and training in relevant subject areas
- share good practice and promote continuous improvement via education & training within the Trust
- support infrastructure development/engagement
- support professional revalidation/re-registration and continuing professional development
- provide a strategic role in the effective sharing of learning.

The aligned education strategy will ensure that the Trust is focused on strengthening our workforce to meet the challenges of the next five years and beyond, able to adapt to change and transfer skills into new and different roles, as required to meet our strategic aims.

This strategy is crucial to enable the organisation and its staff to work across sectors as detailed in the Five Year Forward Review and supported by an action plan (to be developed). It delivers the key Learning & Development aim of Bridgewater's Human Resource Strategy:

- To maintain a commitment to investing in the recruitment and development of a highly skilled and motivated workforce, ensuring value for money for all education, learning and development programmes

- To commission effective education and training programmes that support staff in acquiring the necessary competences required for their job roles
- To meet the education and training needs of a diverse and increasingly complex workforce, with new structures, roles and ways of working

Appendix B – Stakeholder Feedback

The Trust is required to include verbatim any stakeholder written statements about their views on our Quality Report.

The following changes were made to the report following feedback from our stakeholders:

- Halton CCG requested that the patient safety incidents be reported as a percentage of contacts.
- Halton CCG requested a minor amendment to the narrative regarding the Halton Midwives promote new Baby Box Pilot.
- When the Quality Report was presented to a meeting at Warrington CCG they commented that the Trust had not reflected on what they felt was their biggest strategic risk and they also felt that there was not enough information on workforce and staff development.
- Wigan CCG noted that the NHS Trust Annual Survey results had slightly deteriorated in the 'overall staff engagement score'. The CCG were keen to understand how the Trust would work with their staff to understand and address the key messages from the survey.

NHS
Wigan Borough
Clinical Commissioning Group

Wigan Borough Clinical Commissioning Group Response to Bridgewater Community Healthcare NHS Foundation Trust Quality Account 2016 / 17

Wigan Borough Clinical Commissioning Group (*the CCG*) welcomes the opportunity to comment on Annual Quality Account for Bridgewater Community Healthcare NHS Foundation Trust.

In June 2016, the Care Quality Commission (CQC) carried out their comprehensive inspection of the Trust. The overall rating for the Trust following this inspection is '*Requires Improvement*'. The Trusts CQC's Quality Report published on 6 February 2017 identified a number of areas were improvement had been made post the last inspection in 2014; however the report also highlighted areas where the Trust is now required to make improvements.

The CCG recognises the progress that the Trust has made in respect of their 2016 / 17 quality priorities. The last year has seen the appointment of a number of new members within the Senior Nursing Leadership Team. In addition there have been key appointments to strengthen the Medicines Management Team and provide strategic leadership. The CCG supports the Trusts view that these roles will make an invaluable contribution to improving their internal Governance arrangements and importantly in shaping and enhancing services provided by the Trust.

Notable successes have included; the Share to Care Digital Programme enabling information sharing across a number of organisations. The MIAA audit carried out during 2016 to demonstrate learning from Serious Incidents provided significant assurance; and the Trust is continuing to drive improvements in the reporting of patient safety incidents to the National Reporting and Learning Service. In addition the work that has been done on Safer Caseloads in the District Nursing Service has included working with National experts in the development of a case load monitoring tool. The CCG supports the Trusts commitment to continue this work in 2017 / 18.

In year the CCG has highlighted and discussed with the Trust their NHS Annual Staff Survey results having noted the slight deterioration in the 'overall staff engagement score'. The CCG were keen to understand how the Trust would work with their staff to understand and address the key messages from this survey.

The quality priorities for 2017 / 18 are inclusive of developing the mandatory training offer and a shift to the National Learning Management System to assist with mandatory training compliance. The aligned Education Strategy will assist to ensure a Trust focus on strengthening the workforce to meet the future challenges. This will assist to shape and support the work-streams that will drive improvements in the quality and safety of Trust services.

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Wigan Borough
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The CCG has and will continue to support the delivery of safe, effective and caring healthcare through the agreed Commissioning for Quality and Innovation (CQUIN) Schemes for 2017 / 18 to incentivise quality improvements in the nationally directed areas.

The CCG will work with the Trust during the coming year to build on the progress made and to provide further support to the initiatives that will improve the quality of care and outcomes for the resident population of the Wigan Borough.

Dr Tim Dalton, Chairman, Wigan Borough Clinical Commissioning Group
9 May 2017

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HALTON
BOROUGH COUNCIL

Colin Scales Chief Executive Bridgewater Community Healthcare NHS Trust Bevan House Smithy Brook Road Pemberton Wigan, WN3 6PR	Our Ref	EST
	If you telephone please ask for	Emma Sutton-Thompson
	Your ref	
	Date	12th May 2017
	E-mail address	Emma.Sutton-Thompson@halton.gov.uk

Dear Colin,

Quality Accounts 2016 - 2017

Further to receiving a copy of your draft Quality Accounts and the Joint Quality Accounts event held in Halton on 26th April that your colleagues Esther Kirby and Bernadette Connell attended to present a summary of your Quality Accounts, I am writing with the Health Policy and Performance Board comments. The Health Policy and Performance Board particularly noted the following key areas:

Under Priorities for Improvement for 2016/17, the Board are pleased to note the progress made against these, in particular the continuation of the Sign Up to Safety programme which included the following areas this year;

- Medication Safety - The trust has continued to reduce internal Trust drug errors and maintain its record for medicines related never events with none occurring. The development and implementation of electronic patient records and software systems is on-going to help reduce the number of medication errors.

- The Board were pleased to note that there was a decrease in the number of pressure ulcers which developed whilst patients were in their care (down to 39% from 42% in 2015/16). However grade 3 & 4 ulcers have increased and the Board noted that the Trust have created a 'Harm Free Working Group' to ensure that the right wound care product is in use as well as pressure relieving equipment. The group also provides opportunities to identify ways in which practice can be improved.

An action plan has been approved following an inspection of the Trust by CQC and the Board were pleased to note that the Trust were rated as 'good' in 27 of the 40 service ratings received with one area as outstanding (Outpatients – Caring). The formal reported stated that the Trust was safe, effective, responsive and well led.

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In terms of organisational wide quality control there were 2 cases of Clostridium Difficile in 2016/17 compared to 0 in 2015/16 which were due to antibiotic prescribing issues and training has been undertaken to address. There were 0 cases of MRSA.

There was an increase in the number of incidents reported across the trust (4676 compared to 3986 in 2015/16) due to an improvement in the reporting of incidents. The Board were interested to know if they are higher in Halton compared to other areas and would like to see the number of incidents reported in Halton by percentage.

The Board are pleased to note the following Improvement Priorities for 2017 – 2018:

- Falls Safe Programme – the Trust are implementing the Fall Safe programme which will be mainly focused on their inpatient facilities. The Board were interested to know if nutrition had an impact on the likelihood of a fall.
- The Board enquired if staff in the Urgent Care Centre have received guidance and information regarding the increase in Sepsis. The Trust are supporting the national drive to improve the management of sepsis in the NHS and have developed guidance for staff which will be audited to monitor take up and understanding.
- A focus on better coordination of end of life care across the boroughs as required by the CQC has resulted in the appointment of an Assistant Director of End of Life care and the launch of an EoL strategy.

The Board would like to thank Bridgewater Community Healthcare NHS Trust for the opportunity to comment on these Quality Accounts.

Yours sincerely,

Councillor Joan Lowe
Chair, Health Policy and Performance Board

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12th May 2017

Colin Scales
Chief Executive
Bridgewater Community Healthcare NHS Trust
Bevan House
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Pemberton
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Dear Colin,

Quality Accounts 2016 - 2017

I am writing to express my thanks for the submission of Bridgewater Community Healthcare NHS Trust Quality Report for 2016-2017 and for the presentation given by Esther Kirby and Bernadette Connell to local stakeholders on 26th April 2017. This letter provides the response from NHS Halton Clinical Commissioning Group to the Quality Report 2016-2017.

NHS Halton CCG understands the pressures and challenges for the Trust and the local health economy in the last year and would like to congratulate and thank the Trust for the level of partnership working and support in this year in relation to the One Halton Programme and Multidisciplinary team developments.

We also note the Trust had a full CQC inspection in which the overall rating was requires improvement, however, the care provided is rated highly across services and that patients reported they are satisfied with the care provided. The Quality Report acknowledged that an action plan was now in place which has been approved by the CQC and changes have taken place that have further improved and strengthened your services over the last year, including strengthening in key areas with senior nursing leadership roles focusing on safeguarding, governance and end of life care, reducing variation and providing the leadership to support staff. The action plan will be monitored via NHS Halton CCG Clinical Quality and Performance Group.

NHS Halton CCG noted service improvement initiatives in 2016-2017:

- The Trusts Medicines Management Team have worked collaboratively with NHS Halton CCG Medicines Management Team on Medication Safety issues and the trust has continued to reduce internal Trust drug errors and maintain its record for medicines related never events with none occurring.
- We look forward to seeing further improvement in medicines management with the development and implementation of the electronic patient records and software systems.
- We were pleased to note that there has been a decrease in the number of pressure ulcers which developed whilst patients are in your care (down to 39% from 42% in 2015/16). However the reporting of grade 3 & 4 pressure ulcers have increased and the CCG noted a Harm Free Group has been established, with initial focus on pressure ulcer quality work

streams. Pressure ulcer improvement plans have been developed, with a focus on accuracy of reporting and learning from root cause analysis.

- Health Care Acquired Infection surveillance recorded 2 cases of Clostridium Difficile in 2016/17 compared to 0 in 2015/16 which were due to antibiotic prescribing issues and training has been undertaken to address.
- There were 0 cases of Methicillin-resistant Staphylococcus aureus (MRSA)
- The organisation commissioned defensible record keeping training and a number of managers attended the session in order to gain the knowledge and skills to provide cascaded training sessions across the organisation. There is now a group of record keeping trainers identified and a rolling programme of training in place.
- An improvement in the handling, system process and learning from serious incidents has been demonstrated.

We note the Trust has 3 identified priorities for 2017-2018:

1. **Falls Safe** - Implementing the Fall Safe programme - mainly focused in inpatient facilities
2. **Sepsis** - Supporting the national drive to improve the management of sepsis in the NHS and Auditing the Trusts guidance for staff regarding implementation and understanding.
3. **End of Life Care** - Improving coordination of end of life care across our boroughs as required by the CQC and Implementing the End of Life Strategy that has been launched in 2016-2017.

NHS Halton CCG recognises the challenges for providers in the coming year but we look forward to working with the Trust during 2017-2018 to deliver continued improvement in service quality, safety and patient experience and also on the partnership work as we move forward with our One Halton model of service delivery.

NHS Halton CCG would like to congratulate the trust on the hard work of its staff and their commitment to the care of the people of Halton thanking local staff and managers for their on-going commitment locally and for the opportunity to comment on the draft Quality Account for 2016/2017.

Yours sincerely,

Michelle Creed.

Michelle Creed
Chief Nurse

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24th May 2017

Dear Sharan,

Re: Healthwatch Warrington's Response to Bridgewater Community Healthcare NHS Foundation Trust's Draft Quality Account Document 2016 - 2017 (May 2017)

Healthwatch Warrington is pleased to have the opportunity to review Bridgewater Community Healthcare Foundation Trust's 2016 - 2017 Quality Account (QA) and reflect on the information presented within the document.

As a consumer champion for health and social care, we recognise the fundamental impact that values and a person-centred approach have in shaping the quality and safety of service delivery, as well as patient experience. Though the Trust's QA comprises a vast array of medical data and evidence, the document and narrative feel clinical-led. It is unfortunate that the Trust QA does not centre from the beginning on a person-centred focus, for example, using the Trust's values/mission statements, though we appreciate there is mention of the work undertaken to involve and include patients, relatives and carers in care and there is documented feedback later in the QA of patient experience, learning and patient stories, as well as involvement being clear in the governing principles of the End of Life care strategy. As a Healthwatch, we often find that a values-based approach sets a tone for a QA, and indeed a services' approach, and is well received by the public.

Though the QA discusses the Trust's CQC rating as 'Requires Improvement' where there are areas to be addressed and improved upon. The Chief Executive responding to the CQC's findings cited the "Compassion and dedication" of staff and "Commitment and desire to do the very best", which is very positive. The Chief Executive's introduction and the rest of the QA also refers throughout to staff development, training, and good practice, which is to be commended.

It it must be said that most of the feedback that Healthwatch Warrington receives through our online public Feedback Centre (www.healthwatchwarrington.co.uk) is largely positive. Our Feedback Centre allows reviewers to rate health and social care services accessed by Warrington residents out of 5 stars (1 being the lowest, 5 being the highest rating). The feedback centre also allows providers to have their say and respond directly to reviewers (who can choose to leave feedback anonymously).

Overall, the Trust is rated positively, with a rating of 5/5 stars based on 5 reviews submitted over the 2016/17 period. Cleanliness and treatment explanation are both highly rated with

5/5 stars each. Quality of care, in particular treatment explanation and staff attitude are positive aspects of patient experience, with a rating of 4.5/5 stars each. Waiting times are also rated at 4.5/5 stars. Staff attitude is also rated very highly, with just over 4.5/5 stars. Themes mapping indicates that treatment and care, experience and quality is rated as 100% positive, and continuity and integration of care is also 100% positive. These ratings indicate that there are positive experiences of care at the Trust, but it is also important to highlight that this is based on a small number of responses (5); the Trust could achieve a much more representative overview of the services by increasing patient awareness and engagement with the Healthwatch Warrington Feedback Centre.

The report clearly states the three key priorities of the Trust during 16/17; improving quality of record keeping, reduction of medication errors and reducing harm from pressure ulcers. Work is ongoing on priorities from 15/16, including: Sign up to Safety, Improving the handling of SUIs, NHS Safety Thermometer improvements in care, and improvement of Vision and Strategy in Newton Hospital (St Helens). The Trust also acknowledges that it has not met the priority from 2014/15 around innovative care treatment and approaches of children's atopic eczema. Though these aims have not yet been met, the Trust's willingness to acknowledge and to continue to work on these areas is a positive step as it recognises the ongoing need for quality improvements around these areas and has actions plans in place to do so.

In 2016/17 the Trust aimed to enhance record keeping by undertaking 'defensible record keeping training' with managers (to provide cascaded training sessions), with Band 5 and Band 6 and above staff through standardised training, encompassing practice, record keeping audit and action plans. This training is now deemed 'essential training for all clinical staff who would document, review or audit records as part of their role'. Record Keeping compliance at the end of March 2017 is relatively low, at 24.07% - the Trust aims to increase this level of compliance substantially moving forward.

In 2016/17 medication errors have become an ongoing issue - there has been a notable increase in the number of reported medicines incidents, with over 400 incidents reported throughout the year, comprising 8.8% of incidents for the year. They are in the top three of reported incidents, which the Trust suggests is partly due to lack of a dedicated Medication Safety Officer. The Trust indicates that this increase is also due to more visibility of the medicines management team, as well as improved relationships, and that approximately 1/3 of these incidents are third party issues (most frequently omitted doses due to lack of information when patients are referred and processes where patient visits are missed because staff were not aware patients had been discharged from hospital or patient information was not transferred). The QA acknowledges that development and implementation of electronic patient records and software systems is on-going to address these potentially avoidable errors. The QA does not state that a Medication Safety Officer has now been/will be appointed - it seems that alongside the quality monitoring and technology developments this could be a positive step towards achieving this priority.

The Trust states a Harm Free Group has been established, with initial focus on pressure ulcer quality work streams to reduce pressure ulcers across services, including; accurate reporting/recording, implementation of effective systems/processes to investigate ulcer incidences, and developing a learning framework, especially for those pressure ulcers defined as Grade 3 and 4. The Trust QA states that the 'Care Indicator Tool for Pressure Ulcers' has indicated quarterly improvements and weekly Patient Safety meetings review

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and monitor pressure ulcers. The QA also highlights monitoring of ulcers through photographs, noting an improvement in the number of photographs attached electronically to incidents (so tissue viability nurses can provide early advice remotely). This looks to be a positive way to access preventative advice remotely, especially for those staff who are administering care in patients' homes, for example, District Nurses. The QA also refers to care bundles (sets of interventions when used together, improve patient outcomes) developed in collaboration with Halton CCG to define and measure against standards, implement changes and evaluate improvements. The bundles focus around areas such as high risk patient care, intravenous therapy, heart failure, COPD, continence, and issues such as skin wound care, pressure ulcers, and foot ulcers. As the QAs across the region have shown, pressure ulcers continue to be an area for improvement for most acute trusts - perhaps there is learning to be done from those Trusts who are actively succeeding in addressing this.
The Trusts' future priorities for 2017/18 are clear and concise; to implement a Falls Safe Programme, to improve management of sepsis, and improve End of Life Care.

The Trust's QA states that the recording of incidence of falls in inpatient units (for example, Padgate House, Intermediate Care facility, Warrington) to monitoring and improve patient safety, reduce harm and compare improvement over time. However, the QA states that this data 'cannot be used to compare us with other hospitals, as their staff may report falls in different ways, and their patients may be more or less vulnerable to falling than our patients'. Total falls rates at the Trust show a 13% reduction in falls across all inpatient unites, comprising a 15% reduction in falls at Padgate House, a 12% decrease in falls at Newton Hospital and a 7% increase in the Maple Unit (equating to one additional patient fall). This reduction is linked to a FallsSafe care bundle to support risk assessments and management of falls. The QA states the initiative 'involved educating, inspiring and supporting registered nurses and therapy staff to lead their local MDTs in reliably delivering assessments and interventions'. This collaborative and targeted approach is a positive example of team working and staff education, which will hopefully continue to deliver improvements moving forwards. This can be evaluated in the next QA.

The Trust acknowledges wider determinants for sepsis action e.g. a national NHS drive to improve the management of sepsis in 2016. Sepsis management issues were focussed around delayed identification in patient treatment, needs for clinical staff training in management of sepsis and undertaking a clinical audit to ensure standards compliance. The Trust states it has developed guidance in the management of sepsis, but it is worth noting that there are also examples of positive, Trust-wide practice in other Trusts. Warrington and Halton Hospital's NHS Foundation Trust use of a Sepsis Six pathway to ensure a clear and consistent approach to identifying and monitoring sepsis/early diagnosis.

The QA states that the CQC identified a requirement to coordinate End of Life Care across the boroughs within the Trust, as there was a lack of a co-ordinated approach and Trust-wide strategy. The QA states that the End of Life (EOL) strategy was launched throughout the Trust, led by the Associate Director of EOL service (appointed in November 2016), setting out commitments, information and tools to support end of life care, placing 'quality at the heart of everything we do'. The QA states the Strategy also provides 'information on how [staff] training, education and support will be provided', with ongoing support and development from Quality and Safety sub groups and Trust Clinical Governance Sub Committee. The drive for the EOL strategy states that there is an enhanced awareness of

Trust-wide ownership of the initiative: 'end of life care becomes not only everybody's business but also everyone's responsibility'. The 6 key principles centre on individualised care, patient priorities, value-based care, openness and honesty, skilled staff, monitoring and systems. This priority strongly evidences a patient-led focus, surrounded by a caring culture and monitoring process. This is likely due to the work implemented by the newly appointed Associate Director of EOL and is not just noteworthy but is to be commended as a positive way forward that will be reflected upon in the 2017/18 QA.

The QA states that in Warrington, the EOL percentage of patients being cared for in their Preferred Place of Care (PPC) has declined since the previous year, falling by 2% from 97% to 95%. There is no information as to why this change may have occurred. However, Warrington continues to have the highest level of patients in their PPC, potentially positive practice to share more widely.

The Trust states that it 'aims to learn from complaints as part of improving patients' experience'. Throughout 2016/17, 15 complaints were received about Warrington services, from a total of 94 (an increase of 8 complaints on the previous year). The highest complaints across the Trust were around aspects of clinical treatment, which comprised 62% of all complaints across all services. This is evidently a high area of priority for Trust improvements - it would be positive to have seen more of a Trust response to this area of need in the QA, or more detail given to identify the areas of need within these complaints.

Healthwatch Warrington's advocacy support work for patients/families/carers with experience of the Trust has shown us that there are some issues that they face - lack of timely intervention in care e.g. in the case of District Nurse visits where appointments are sometimes missed/don't occur. Patients, families and carers also shared that communications can be limited/disjointed, especially during staff changes during District Nursing, and that information is sometimes not always clearly communicated between staff. It must be highlighted that this has given Healthwatch cause to contact or work with the Complaints Manager at the Trust, who in our experience is quick to act and supportive of resolutions that are in the interest of the patient. The QA addresses their registered complaints within the DN service highlighting difficulties in accessing the service following discharge from hospital and incomplete records of staff/patient engagement. The Trust acknowledged all teams have changed how telephone messages are recorded for documenting patient care and needs, message books in all teams now have the same layout to capture essential information as well as the importance of encouraging and advising patients to contact the service if unable to book treatment room and the need for conversations with patients to be documented. This indicates a commitment to a learning culture, and highlights the Trust's aim to work with complainants to achieve outcomes. Furthermore, the QA states that 99% of patients indicated a 'good overall experience' of the service. A total of over 39,000 people responded to the Friends and Family Test, with overall 95.2% indicating that 'they would recommend Bridgewater services'. Of the total, 3214 responses related to Warrington services, with a recommendation rate of 96.8%, and a 'would not recommend' rate of 0.9%. In terms of feedback, the Trust could also engage and be more proactive at responding to feedback on the online Healthwatch Warrington Feedback Centre, which acts as a rich source of qualitative feedback from those using Bridgewater services.

PALS data shared within the QA states that the service telephone number received 1958 contacts during 16/17, of which Warrington was the second highest area for contact, representing 427 contacts. The PALs data states that 'around 54% of the contacts were

requests for advice and information, including signposting to other organisations', indicating 46% of calls were related directly to services. The QA states that '29% of the contacts resulted in the department liaising between the enquirer and the service to resolve issues and concerns' while '11 of the 1958 contacts went on to become formal complaints' indicating that this earlier stage of resolution has helped patients overall to resolve issues in care and not lead to further problems, or the need for a formal complaint.

As a Healthwatch, we are also aware that cultivating positive staff attitudes and taking on board their ideas are essential ingredients for good care outcomes. Though the QA talks at length about staff development, training and investment, the document recounts that the level of staff satisfaction with the Trust is moderate 3.61 (of a rating of 5), a reduction of 0.02% since the previous year. In the NHS Annual Staff survey slight increases in staff experience are noted, with a 6% improvement in 'does your organisation take positive action on health and well-being?' and a 6% improvement in stress management (as 'during the last 12 months have you felt unwell as a result of work related stress?'). This is relatively positive but could be improved by moving towards a rating of 5. Again, perhaps there is potential to learn from other Trusts that have high levels of staff satisfaction.

Throughout the Trust QA, it was helpful to see that the data relating to specific geographic areas was separated - as such, each relevant area's residents/patients/ Healthwatch/other bodies can clearly see what services and issues are relevant to them in each part of the Trust's activity. This is a clear and defined approach to service review that will be useful to see continued in the future and is an approach to encourage within the QAs of other Trusts.

In the year ahead, we look forward to supporting the Trust's positive work, especially around End of Life Care, as well as developing the Trust's engagement by encouraging wider public participation and feedback of the service in our Feedback Centre and strengthening the voice of patients in other ways.

We look forward to hearing from you and being involved in future developments.

Kind regards,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

Healthwatch Warrington
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Registered Charity Number 1172704

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Please Ask For: John Wharton

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Date: 10th February 2017

Esther Kirby
Executive Nurse
Bridgewater Community Healthcare NHS Trust
Bevan House,
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Smithy Brook Road,
Pemberton,
Wigan.
WN3 6PR.

Dear Esther

Quality Accounts 2016 - 2017

In accordance with the national guidance around provider Quality Accounts and on behalf of NHS Warrington Clinical Commissioning Group, I hereby supply the organisation's official response.

Many thanks for submitting your quality account to us and attending the presentation. As you will be aware on the day the CCG had requested local views of the account which was supplied by representation from NHS England, Local Patient Participation Groups (PPGs) and Warrington Healthwatch, along with GP Commissioners from the organisation. The group were aware of your recent Care Quality Commission (CQC) inspection and the overall rating of requiring improvement. However, the CCG was unable to assure the group members of your action plan from both the CQC report or the NHS England quality risk profile plan as we are still awaiting receipt of both plans.

NHS Warrington CCG is aware of the pressures and challenges that the Trust regularly faces and welcomed the work that the organisation is doing to improve the systems and processes to ensure that they are meeting the standards of care commissioned for the local population of Warrington. However, the group did have some concerns over the lack of assurances that the report offered around the reporting of incidents and how the organisation demonstrates learning from these incidents to their staff at the interface of care.

A further concern raised from the report involved the complaints process of the organisation and the trust was asked if meetings are offered to patients who complain. Confirmation from the trust established that meetings do take place usually before a letter is shared so that they can talk through their response. There were concerns raised in the account around the Safeguarding section which raised concerns regarding the attendance for the PREVENT

training, which at 66.23% is low, with further concerns regarding compliance with level 3 Safeguarding Children which could be improved upon .

It is unclear from the report whether the 2016/17 priorities have been met. I note that training in defensible record keeping has taken place but it is unclear if this is having any impact on record keeping. You are reporting an increase in medication errors against a priority to reduce medication errors. It may have been helpful to have identified within the report if there had been a reduction in harm associated with these incidents. The final priority to reduce harm from pressure ulcers appears not to have been met, as within the body of the report you state that there has been a slight increase in the number of grade 3 & 4 pressure ulcers, although I acknowledge the work that you have put into place and I am pleased to see the Trust is collaborating with NHS Improvement with the "Stop the Pressure" programme of work.

I am also pleased to see that your priorities for the coming year include;

- Falls Safe - Implementing the Fall Safe programme - mainly focused in inpatient facilities

- Sepsis - Supporting the national drive to improve the management of sepsis in the NHS and Auditing the Trusts guidance for staff regarding implementation and understanding.

- End of Life Care - Improving coordination of end of life care across the boroughs and Implementing the End of Life Strategy that has now been launched.

Finally, there was a united agreement that whilst there are some positive aspects to the account the lack of a specific section focusing on each geographical area with a focused presentation on the service that Bridgewater provides for that commissioning organisation would be a significant improvement for future consideration.

In conclusion, NHS Warrington CCG would like to take this opportunity to thank the trust for all their hard work and the commitment to the care of the people of Warrington and thank staff and management for their daily commitment to patient care.

Yours sincerely

John Wharton
Chief Nurse & Quality Lead
Warrington Clinical Commissioning Group

Clinical Chief Officer : Dr Andrew Davies MB ChB

St Helens Clinical Commissioning Group

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St Helens Chamber
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9th June 2017

Esther Kirby – Chief Nurse
Bridgewater Community Healthcare NHS Trust

Dear Esther

Quality Accounts 2016-2017

Firstly, please accept my sincere apologies for the delay in providing this feedback, there had been a miscommunication here around who was preparing feedback.

On behalf of St Helens CCG I am writing to thank you for sharing the Trust's Draft Quality Account for comment.

We found your Draft Quality Account report to be appropriately informative, detailed and encouraging. It was positive to see good evidence of patient centred approaches at Newton Hospital and you have addressed the issues raised last year in relation to medicines management and incident reporting. You have identified your top 3 SUI's and have completed work around how you intend to address this. I was particularly impressed with the SLT and BLUSH projects which are excellent schemes.

We would have welcomed more discussion in the report regarding any improvements or challenges in relation to safeguarding also any progress on clinical supervision would have been useful.

Lastly, I look forward to continuing to work with yourself and the Trust to ensure we provide effective high quality care for local our local population.

Yours sincerely

Lisa Ellis
Chief Nurse

Working in partnership with St.Helens Council *and* St.Helens Chamber

Appendix C – School Aged Immunisation Programmes End of Academic Year 2015/16 (reported to NHSE in August 2016)

In the academic year 2015/16 Bridgewater was commissioned to deliver immunisations in:

- Halton
- St Helen
- Warrington
- Wigan
- Bolton (from December 2015)
- Oldham (from April)

Each borough has different commissioning acceptable and achievable targets (in brackets in the table below) which are set either by NHSE or the Boroughs Local Authority***.

Green – Met acceptable and achievable target
Amber – Met acceptable target only
Red – Did not meet acceptable target

Borough	HPV Dose 1 Year 8	HPV Dose 2 Year 8	Td/IPV (year 9/10)	MenACWY (year 9/10)	MenACWY catch up year 11
Bolton	93.08 (Both - 90%)	91.03 (Both - 90%)	82.68 (year 10) (Both - 95%)	84.28 (year 10) (Both - 95%)	86.33 (Both - 95%)
Oldham *	92.98 (Both 90%)	86.6 (Both 90%)	87.44 (year 9) (Both 90%)	86.8 (year 9) (Both 90%)	86.6 (Both 90%)
Warrington	88.24 (acceptable 88%, achievable 90%)	N/A **	89.04 (year 9) (acceptable 86%, achievable 90%)	88.5 (year 9) (acceptable 86%, achievable 90%)	81.9 (acceptable 86%, achievable 90%)
Halton	89.7 (acceptable 88%, achievable 90%)	N/A **	81.6 (year 9) (acceptable 86%, achievable 90%)	82.9 (year 9) (acceptable 86%, achievable 90%)	77.6 (acceptable 86%, achievable 90%)
St Helens	89.7 (acceptable 88%, achievable 90%)	N/A **	82.54 (year 9) (acceptable 86%, achievable 90%)	84.26 (year 9) (acceptable 86%, achievable 90%)	74.43 (acceptable 86%, achievable 90%)
Wigan	84.5 (no commissioning targets as no current signed specification)	N/A **	77.59 (year 10) (no commissioning targets as no current signed specification)	76.9 (year 10) (No commissioning targets as no current signed specification)	69.55 (No commissioning targets as no current signed specification)

HPV Year 9 (reportable on immform each year)

Borough	HPV Dose 1 Year 9	HPV Dose 2 Year 9
Bolton	94	93
Oldham *	89.4	88.2
Warrington	92.8	87.6
Halton	92.71	91.25
St Helens	93.41	89.15
Wigan	93.6	90.2

* Includes immunisations given at GP`s as Pennine Acute Hospitals NHS Trust performance team unable to breakdown immunisations delivered by 0-19 staff only. Oldham transferred from Pennine Acute Hospitals NHS Trust to Bridgewater in April 2016.

** To be delivered in the academic year 2016/17 (April 2017 onwards)

*** Commissioning targets set differently in each Borough. NHSE set commissioning targets for St Helens, Halton and Warrington. Local Authorities set targets in Bolton, Oldham and Wigan. There are currently no targets set for Wigan.

School aged Childhood Flu Vaccination Programme

Bridgewater was also commissioned to deliver the school aged childhood flu vaccination programme in the boroughs of Halton and Warrington in 2016/17.

Delivery of this programme was completed Oct 2016 – Dec 2016. Both boroughs were commissioned to deliver to an acceptable target of 40% of the population with an achievable target of 65%.

	Y1 cohort	Y1 school nurse uptake	Y1 Borough uptake (including GP data)	Y2 cohort	Y2 school nurse uptake	Y2 Borough uptake	Y3 cohort	Y3 school nurse uptake	Y3 Borough uptake
Warrington	2632	61.78%	63.87%	2543	60.31%	61.18%	2573	57.75%	59.19%
Halton	1519	50.76%	52.34%	1623	52.99%	54.22%	1480	51.89%	52.9%

Appendix D- Statement of directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 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 2016 to the date of this statement
    - papers relating to quality reported to the board over the period April 2016 to the date of this statement
    - feedback from commissioners dated May 2017
    - feedback from governors dated 26 May 2017
    - feedback from local Healthwatch organisations dated May 2017
    - feedback from Overview and Scrutiny Committee dated May 2017
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009; May 2017
    - the national patient survey – not applicable to community healthcare providers
    - the 2016 national staff survey 07 March 2017
    - the Head of Internal Audit's annual opinion over the trust's control environment dated March 2017
    - CQC Inspection report dated 06/02/17
- the Quality Report presents a balanced picture of the NHS foundation trust's 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 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

NB: sign and date in any colour ink except black

Chairman 26 May 2017

Chief Executive 26 May 2017

Appendix E Independent Auditors Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust to perform an independent assurance engagement in respect of Bridgewater Community Healthcare NHS Foundation Trust's Quality Report for the year ended 31 March 2017 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2017 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

Specified Indicators	***Specified indicators criteria*** (Monitor's Detailed Guidance)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Indicator – Page 183 Definition – Page 183
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.	Indicator – Page 183 Definition Page 183

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2016/17" issued by Monitor (operating as NHS Improvement) ("NHSI").

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 does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17"; 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 the following documents:

- Board minutes for the financial year from April 2016 up to 27 April 2017;
- Papers relating to quality report from the Quality and Safety Committee reported to the Board over the period April 2016 to 10 April 2017;
- Feedback from the Commissioners Halton CCG dated 12 May 2017 and Warrington CCG dated 10 February 2017;

- Feedback from Governors dated 26/05/2017;
- Feedback from Halton Borough Council dated 12 May 2017;
- Feedback from Local Healthwatch organisations; Healthwatch Warrington dated 24/05/2017;
- Feedback from Overview and Scrutiny Committee dated May 2017;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2017;
- The national and local patient survey which is not applicable to the Trust;
- The 2016 national staff survey dated 07/03/2017;
- Care Quality Commission inspection report, dated 06/02/2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment to 31 March 2017 dated 25/05/2017.

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.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour.
We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust as a body, to assist the Council of Governors in reporting Bridgewater Community Healthcare 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 2017, 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 Bridgewater Community Healthcare NHS Foundation Trust for our work or this report save 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 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;

- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less 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 which can result in materially different measurements and can impact 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 thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2016/17"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Bridgewater Community Healthcare NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2017:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2016/17";
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2016/17".

PricewaterhouseCoopers LLP
Manchester
M2 3PW
Date:

The maintenance and integrity of the Bridgewater Community Healthcare NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

5. Full Annual Accounts

Foreword to the accounts

These accounts, for the period ended 31 March 2017, have been prepared by Bridgewater Community Healthcare NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Colin Scales

Chief Executive Officer

26 May 2017

Statement of the chief executive's responsibilities as the accounting officer of Bridgewater Community Healthcare 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 Monitor.

Under the NHS Act 2006, Monitor has directed Bridgewater Community Healthcare NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bridgewater Community Healthcare 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 *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- observe the Accounts Direction issued by Monitor, 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* 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 Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.

Signed 

Chief Executive Date: 26 May 2017

Independent auditors' report to the Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, Bridgewater Community Healthcare NHS Foundation Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Trust's affairs as at 31 March 2017 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health Group Accounting Manual 2016/17.

What we have audited

The financial statements comprise the:

- Statement of Financial Position as at 31 March 2017;
- Statement of Comprehensive Income for the year then ended;
- Statement of Changes in Equity for the year then ended;
- Statement of Cash Flows for the year then ended; and
- Notes to the accounts, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Annual Report and Accounts 2016/17 (the "Annual Report"), rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements is the Department of Health Group Accounting Manual 2016/17.

Our audit approach

Context

The 2016/17 financial year audit is the first year that PricewaterhouseCoopers LLP has audited the Trust, which provides community-based services across the North West. We accessed the previous auditors' working papers to assess their work over the opening balances within the financial statements and to help inform us in the planning of our audit.

Overview

- Overall materiality: £3,276,000 which represents 2% of total revenue.
- We performed most of our audit of the financial information for the Trust at Bevan House which is where the Trust's finance function is based.
- In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements.

Management override of control and the risks of fraud in revenue and expenditure recognition;
Valuation of Property, Plant and Equipment; and
Financial sustainability and going concern.

The scope of our audit and our areas of focus

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") and, International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Area of focus	*How our audit addressed the area of focus*
Management override of control and the risks of fraud in revenue and expenditure recognition *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of income and expenditure and notes 3-5 for further information.* We focussed on this area because there is a risk that the Trust's results will be materially misstated due to: • the risks surrounding the future financial position and sustainability and position of the Trust; • the pressure the Trust is under to achieve the current Cost Improvement Programme ('CIP') plan; and • the inherent complexities in a number of contractual arrangements entered into by the Trust. As all Trusts are under pressure to achieve their control totals there is a risk that the Trust could adopt accounting policies, make accounting judgements or estimates or treat income and expenditure transactions in such a way as to lead to material misstatement in the reported surplus or deficit position and recognise additional Sustainability and Transformation Fund income. Given these incentives, we considered the risk of management manipulation in each of the key areas of focus, which are: • Recognition of revenue and expenditure; • The inherent complexities in a number of contractual arrangements entered into by the Trust, for example intra-NHS transactions; • Manipulation through non-standard journal transactions; • Items of income or expenditure whose value is dependent upon estimates, including the provision for bad debts; and • Unrecorded liabilities.	*Income and expenditure transactions:* For income and expenditure transactions close to the year-end we tested, on a sample basis that the transaction and the associated income and expenditure had been posted to the correct financial year end by tracing them to invoices or other documentary evidence. Our testing did not identify any balances which had been recorded in the incorrect period. For a sample of income contracts from NHS England and Clinical Commissioning Groups ("CCG"), we obtained and agreed the income received during the year to a signed contract with no exceptions noted. For a sample of income recognised in relation to over performance against contract (i.e. the 'the true up' income) we agreed to year end settlements with no exceptions noted. We have also examined confirmation of the Trust's Sustainability and Transformation Fund income and confirmed the receipt of cash. *Intra-NHS balances* We obtained the Trust's intra-NHS confirmations for debtor, creditor, income and expenditure balances, checked that management had investigated disputed amounts, and then discussed with them the results of their investigation and the resolution, which where possible, we agreed to correspondence with the counterparty. We then considered the impact, if any, these disputes would have on the value of income and expenditure recognised in 2016/17 and determined that there was no material impact. *Manual journals:* We tested a sample of manual journal transactions that had resulted in an adjustment to income or expenditure, focusing in particular on those recognised near the end of the year which credited the Statement of Comprehensive Income but did not debit NHS receivables, by tracing the journal entry to supporting documentation. Our testing confirmed that they were supported by appropriate documentation and that the related income and expenditure was recognised in the correct period. We also applied analytical review procedures to establish whether the volume and value of journals

Area of focus	*How our audit addressed the area of focus*
	posted in each month showed any unusual trends. No exceptions were noted from our analysis. *Estimates* We evaluated the provision for bad debts and the basis of its calculation by identifying old receivables, agreeing to cash receipt (where possible) or evidence to support their recoverability. We identified no issues from the testing. *Unrecorded liabilities:* We performed testing over the risk of unrecorded liabilities by agreeing a sample of payments made and invoices received after the year end to supporting documentation and checking that, where they related to 2016/17 expenditure, an accrual was recognised appropriately. From the testing we performed we did not identify any unrecorded liabilities as at the year-end date.
Valuation of Property, Plant and Equipment *See note 11 to the financial statements for the disclosures in relation to PPE.* We focussed on this area because Property, plant and equipment ("PPE") represents the largest balance in the Trust's statement of financial position and the Trust has undertaken an ambitious capital investment strategy over recent years which continued in 2016/17. The carrying value of PPE is £21.3m (2016: £21.1m). All PPE assets are measured initially at cost, with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and are required to be performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date. Based on management's decision, the Trust's external valuers have applied the Building Cost Information Service ("BCIS") indexation for the purpose of the valuation of land and buildings as at 31 March 2017. The PPE balance also includes £4.3m of assets which are intended to be loaned to patients, for example specialist wheelchairs, beds and other equipment items which patients require on an ongoing basis. These are held either in Trust community stores or in people's homes.	We used our valuations expertise to confirm that management's decision to apply the BCIS indexation and the indexation applied to the carrying value of Land and Buildings (including dwellings) was appropriate, particularly given the time period that had elapsed since the last full valuation at 31 March 2014 and the Trust's specific circumstances, including regional adjustments. We evaluated and challenged the assumptions and methodology in the valuation report produced by the Trust's external valuation experts and used our own valuations expertise in the health sector to: • check the valuer's qualifications and objectivity; • consider the suitability of the methodology adopted in valuing the assets; and • agree the movement in the BCIS indexation that has been adopted in the valuation to the average BCIS movements in the area. We also checked and found that the valuation of land and buildings per the valuation report had been accurately reflected in the financial statements and that the gains and impairments have been accurately reflected in the correct area within the Statement of Comprehensive Income and reserves. We found no issues from this testing. We also gained an understanding of management's processes and systems for recording and administering community equipment assets, physically verifying those held on Trust premises, and examining third party maintenance records to check the existence of assets held in the community. We found no issues from this testing.
Financial sustainability and going concern *The Trust's future business plans are highlighted in the Introduction to the Annual Report and Accounts. The Trust's finances for the year ended 31 March 2017 are discussed in detail in the Trust's Performance Report.* The Trust's overall financial position for the year end is a £1.9m surplus, though this includes £3.8m of Sustainability and Transformation Funding ("STF"). As such, the underlying result was a deficit of £1.9m. We examined the Trust's cash flow forecast for 2017/18	In considering the financial performance of the Trust we: • Understood the Trust's 2017/18 Annual Plan and cash flow forecasts, including their key assumptions, for example CIP requirements; • Confirmed the agreement of 2017/18 contracts with the Trust's significant commissioners, confirming those contracts were agreed and signed, given the importance of this informing our views around going concern; • Challenged the Trust's ability to achieve its CIP/

Area of focus	*How our audit addressed the area of focus*
and the subsequent period to May 2018 (inclusive). We noted throughout the period the Trust expects to maintain positive cash balances. There is a higher cost improvement requirement for 2017/18 of £7.0m compared with previous levels of £5.7m delivered in 2016/17. Individual saving schemes have been established for half of the total, with the remainder being allocated to departmental budgets. This means there is a degree of risk attaching to the Trust's ability to deliver the required CIP and revenue generation targets to deliver the planned deficit. We focussed on the Trust's annual plan for 2017/18 including the delivery against CIP targets and the consequences of the Trust's continued use of the going concern basis of preparation for the financial statements.	efficiencies target through consideration of historical delivery of CIP requirements; and • Assessed the sensitivity of the 2017/18 Annual Plan to underperformance in this area. • We discussed management's assertion of going concern with the Audit Committee who concurred with management. We found no issues from this testing.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Trust, the accounting processes and controls, the environment in which the Trust operates, and the fact that this is our first year auditing the Trust's Annual Report and Accounts.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements. We performed most of our audit work at Bevan House, which is where the finance function is based.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall materiality	£3,276,000
How we determined it	2% of revenue
Rationale for benchmark applied	We have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £163,000 as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other reporting

Opinions on other matters prescribed by the Code of Audit Practice

In our opinion:

- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the parts of the Remuneration and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2016/17.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

Between 31 May and 3 June 2016 the Trust was inspected by the Care Quality Commission ("CQC") who issued their report on 6 February 2017, which gave the Trust an overall 'requires improvement' rating. Of the five sub-categories in the CQC report, the Trust was rated as 'good' in relation to whether services are caring and responsive, and 'requires improvement' in relation to the safety, effectiveness, and well-led aspects of the inspection framework. These conclusions in the CQC report provide evidence that the Trust has not made informed decisions or deployed resources sustainably as defined by Auditor Guidance Note 3 ("AGN" 03).

As a result of these matters, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2017.

Other matters on which we report by exception

We are required to report to you if:

- information in the Annual Report is:
    - materially inconsistent with the information in the audited financial statements; or
    - apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or
    - otherwise misleading.
- the statement given by the directors in the Directors' Report on page 23, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Group and Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the Directors' Report section within the Annual Report on page 32, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2016/17 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor 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 issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.

We have no matters to report in relation to these responsibilities.

Respective responsibilities of the Directors and the Auditor

As explained more fully in the Statement of Accounting Officer's Responsibilities included within the Accountability Report the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the Department of Health Group Accounting Manual 2016/17.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Code of Audit Practice, and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you 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 work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

This report, including the opinions, has been prepared for and only for the Council of Governors of Bridgewater Community Healthcare NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice

Greg Wilson (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Manchester
May 2017

(a) The maintenance and integrity of the Bridgewater Community Healthcare NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Statement of Comprehensive Income for year ended 31 March 2017

	Note	**2017 £000**	2016 £000
Operating income from patient care activities	3	**157,974**	146,243
Other operating income	4	**6,164**	2,537
Total operating income from continuing activities		**164,138**	**148,780**
Operating expenses	5	**(161,694)**	(152,138)
Operating surplus/(deficit) from continuing operations		**2,444**	**(3,358)**
Finance income	9	**17**	19
PDC dividends payable		**(371)**	(505)
Net finance costs		**(354)**	**(486)**
Surplus/(deficit) for the year from continuing operations		**2,090**	**(3,844)**
Surplus/(deficit) for the year		**2,090**	**(3,844)**
Other Comprehensive Income			
Will not be reclassified to income and expenditure:			
Revaluations	11,12	**890**	300
Total comprehensive income for the year		**2,980**	**(3,544)**

Statement of Financial Position as at 31 March 2017

	NOTE	**30 March 2017** **£000**	31 March 2016 £000
Non-current assets:			
Intangible assets	10	1,924	2,185
Property, plant and equipment	11	21,251	21,065
Trade and other receivables	14	846	865
Total non-current assets		**24,021**	**24,115**
Current assets:			
Inventories	13	**44**	39
Trade and other receivables	14	**14,344**	8,780
Cash and cash equivalents	15	**4,357**	2,346
Total current assets		**18,745**	**11,165**
Current liabilities			
Trade and other payables	16	**(20,469)**	(15,974)
Provisions	17	**(65)**	(54)
Total current liabilities		**(20,534)**	**(16,028)**
Net current liabilities		**(1,789)**	**(4,863)**
Total assets less current liabilities		**22,232**	**19,252**
Total Assets Employed:		**22,232**	**19,252**
Financed by:			
Public Dividend Capital		**4,961**	4,961
Revaluation reserve		**6,004**	5,114
Retained earnings		**11,267**	9,177
Total Taxpayers' Equity:		**22,232**	**19,252**

The notes on pages 235 to 269 form part of this account

The annual accounts on pages 1 to 4 were approved on behalf of the Board on 24 May 2017 and signed on its behalf by:

Chief Executive:

Date: 26 May 2017

Statement of Changes in Equity for the year ended 31 March 2017

	Public Dividend Capital £000	Revaluation Reserve £000	Income and expenditure reserve £000	otal tax-payers' equity £000
Taxpayers' and others' equity at 1 April 2016 – brought forward	4,961	5,114	9,177	**19,252**
Surplus for the year	-	-	2,090	**2,090**
Revaluations	-	890	-	**890**
Taxpayers' and others' equity at 31 March 2017	**4,961**	**6,004**	**11,267**	**22,232**
Taxpayers' and others' equity at 1 April 2015 – brought forward	4,961	4,814	13,021	**22,796**
Deficit for the year	-	-	(3,844)	**(3,844)**
Revaluations	-	300	-	**300**
Taxpayers' and others' equity at 31 March 2016	**4,961**	**5,114**	**9,177**	**19,252**

Information on reserves

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 establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS foundation trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

Statement of Cash Flows for the year ended 31 March 2017

	NOTE	**2017** **£000**	2016 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**2,444**	(3,358)
Non-cash income and expense:			
Depreciation and Amortisation	5	**3,491**	2,473
(Increase)/decrease in receivables and other assets		**(5,545)**	1,033
Increase in Inventories		**(5)**	-
Increase in payables and other liabilities		**4,486**	394
Increase in provisions		**11**	20
Net cash generated from operating activities		**4,882**	**562**
Cash flows from investing activities			
Interest Received		**17**	19
Purchase of intangible assets		**(304)**	(475)
Purchase of property, plant, equipment and investment property		**(2,213)**	(3,116)
Net cash used in investing activities		**(2,500)**	**(3,572)**
Cash flows from financing activities			
PDC dividend paid		**(371)**	(505)
Net cash used in financing activities		**(371)**	**(505)**
Increase/(decrease) in cash and cash equivalents		**2,011**	**(3,515)**
Cash and cash equivalents at 1 April		**2,346**	5,861
Cash and cash equivalents at 31 March	15	**4,357**	**2,346**

Notes to the Accounts

Note 1 - Accounting policies and other information

Note 1.1 - Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, is responsible for issuing an accounts direction to NHS foundation trusts under the NHS Act 2006. NHS Improvement has directed that the annual accounts of NHS foundation trusts shall meet the accounting requirements of the *Department of Health Group Accounting Manual (DH GAM)* which shall be agreed with the Secretary of State. Consequently, the following annual accounts have been prepared in accordance with the *DH GAM 2016/17* issued by the Department of Health. The accounting policies contained in that manual follow IFRS and HM Treasury's Financial Reporting Manual (*FReM)* to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

The period covered by these annual accounts is the year ended 31 March 2017.

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.

Going concern

These accounts have been prepared on a going concern basis.

Note 1.2 - Income

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. The main source of income for the trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

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.

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 e.g. by an insurer. The Trust recognises the income when it

receives notification from 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.

Note 1.3 - Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments 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 annual accounts to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses 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.

Note 1.4 - 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.

Note 1.5 - Property, plant and equipment

Recognition

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;
- the cost of the item can be measured reliably;
- the item has cost more than £5,000;
- items to be issued in the community, with specific reference to Wheelchair and Home Loan Community services, where the individual item cost is at least £500;
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g., plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

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.

All assets are measured subsequently at valuation. Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the current value at the date of revaluation less any impairment.

For equipment within Wheelchairs and Home Loans on issue the Trust has adopted a depreciated historical cost basis as a proxy for current value in respect of these low/short life assets.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period.

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 determined 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.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DH 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 benefit 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 income 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.

De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset
    - an active programme has begun to find a buyer and complete the sale
    - the asset is being actively marketed at a reasonable price
    - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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 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.

Useful economic lives of property, plant and equipment

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	88
Plant and machinery	1	10
Information technology	1	5
Furniture and fittings	1	5
Wheelchairs/home loan equipment	1	5

Note 1.6 - Intangible assets

Recognition

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.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

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 asset and sell or use it;
- the trust has the ability to sell or use the 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 financial, technical and other resources are available to the trust to complete the development and sell or use the asset; and
- the trust can measure reliably the expenses attributable to the asset during development.

Software

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.

Measurement

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 depreciated replacement cost and the value in use where the asset is income generating. Revaluations 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 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or "fair value less costs to sell".

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful economic life of intangible assets

Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives is shown in the table below:

	Min life Years	**Max life Years**
Intangible assets – internally generated		
Information technology	1	5

Note 1.7 - 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.

Note 1.8 - Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonably approximation to fair value due to the high turnover of stocks.

Note 1.9 - Financial instruments and financial liabilities

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.

De-recognition

All financial assets are de-recognised when the 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 is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as "loans and receivables".

Financial liabilities are classified as "other financial liabilities".

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: cash and cash equivalents, NHS receivables, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions 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

All other financial liabilities are recognised initially 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. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices/independent appraisals/discounted cash flow analysis.

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 the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.10 - Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation 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 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.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11 - Provisions

The NHS foundation 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

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 30 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling

The NHS foundation 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 the NHS Litigation Authority 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 operating expenses when the liability arises.

Note 1.12 - 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 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 30, 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 a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.13 - 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 establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) 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, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (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.

Note 1.14 - Value added tax

Most of the activities of the NHS foundation 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.

Note 1.15 - Corporation tax

The Trust has determined that it is has no corporation tax liability as it does not operate any commercial activities that are not part of core health care delivery.

Note 1.16 - Foreign exchange

The functional and presentational currencies of the trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.17 - Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.18 - 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 that individual cases are handled. Losses and special

payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS foundation trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.19 - Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.20 – Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2016/17.

Note 1.21 – Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the annual accounts:

- assessment of the classification for estates rental charges, between operating and finance leases;
- non-consolidation of the Trust's element of the registered charity 5 Boroughs Partnership NHS Foundation Trust Charitable Fund (charity number 1061651). In making this judgement the Trust has made reference to the *DH GAM 2016/17*. The Trust's element of this fund is managed under a Service-level agreement with 5 Boroughs Partnership NHS Foundation Trust. Whilst the Trust is able to requisition expenditure from this fund within the constraints of the fund objective, corporate trusteeship of the fund remains with 5 Boroughs Partnership NHS Foundation Trust. Where a body acts as a corporate trustee, there is a presumption that the body possesses 'control' of the fund. Therefore there is no need for the Trust to consolidate.
- Full valuation of the Trust's estate was undertaken on 31 March 2014 by the District Valuer who is a qualified surveyor registered with Royal Institute of Chartered Surveyors. The impact of this valuation was reflected in the accounts as at 31 March 2014. Subsequently a desk top valuation of the Trust's estate was obtained on 31

March 2016 and 31 March 2017 and this has been the basis for the valuation as at 31 March 2016 and 31 March 2017 respectively.

- The Trust adopted a revised Property, plant and equipment accounting policy in the year ended 31 March 2015 to recognise Community Home Loan Equipment as Property, plant and equipment. For the year ended 31 March 2016 the Trust revised the capitalisation threshold from £250 to £500. The Trust is currently depreciating these assets over 5 years on a straight line basis.
- The Trust has taken a suitable and appropriate position regarding its balances with NHS Property Services.

Note 1.22 – Key sources of estimation uncertainty

There are no major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Note 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 2016/17. 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 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; and
- IFRIC 22 Foreign Currency Transactions and Advance Consideration – Application required for accounting periods beginning on or after 1 January 2018.

Note 2 Operating Segments

The Trust operates in a single segment, the provision of healthcare community services. There are therefore no reportable segments.

Income from transactions with the following organisations is in excess of 10% of total income:

	2017	2016
	£'000	£'000
CCGs and NHS England	**114,825**	116,707
Local authorities	**36,595**	22,746

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2017	2016
	£000	£000
Community services		
Community services income from CCGs and NHS England	**114,825**	116,707
Community services income from other commissioners	**43,149**	29,536
Total income from activities	**157,974**	**146,243**

Note 3.2 Income from patient care activities (by source)

	16/17	15/16
	£000	£000
CCGs and NHS England	**114,825**	116,707
Local authorities	**36,595**	22,746
Other NHS foundation trusts	**2,140**	1,337
NHS Trusts	**751**	1,610
NHS other	**1,437**	992
Non-NHS: injury scheme (was RTA)	**904**	650
Non-NHS: other	**1,322**	2,201
	157,974	**146,243**
Of which:		
Related to continuing operations	**157,974**	**145,243**
Related to discontinued operations	**-**	**-**

Revenue from patient care services includes income accrued for activity where data is not available at 31 March 2017. Wherever possible reference is made back to final data but estimates and assumptions are applied in order to ensure the completeness of income reported.

Injury cost recovery scheme is subject to a provision for impairment of receivables of 22.94% (2015/16: 21.99%) to reflect expected rates of collection.

Note 4 Other operating income

	2017	2016
	£000	£000
Education and training	**2,074**	2,537
Sustainability and Transformation Fund income	**4,090**	-
	6,164	**2,537**
Of which:		
Related to continuing operations	**6,164**	**2,537**
Related to discontinued operations	**-**	**-**

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2017	2016
	£000	£000
Income from services not designated as commissioner requested services	**157,974**	146,243
Total	**157,974**	**146,243**

Note 5 Operating expenses

	2017	2016
	£000	£000
Services from NHS foundation trusts	**5,835**	3,946
Services from NHS trusts	**575**	3,101
Services from CCGs and NHS England	**226**	530
Purchase of healthcare from non NHS bodies	**2,523**	1,652
Employee expenses - executive directors	**988**	1,248
Remuneration of non-executive directors	**137**	124
Employee expenses - staff	**109,482**	103,290
Supplies and services - clinical	**8,161**	9,434
Supplies and services - general	**1,132**	1,659
Establishment	**7,044**	2,302
Transport	**249**	2,150
Premises	**5,511**	3,594
Increase/(decrease) in provision for impairment of receivables	**31**	70
Increase/(decrease) in other provisions	**11**	-
Drug costs	**1,821**	2,273
Rentals under operating leases	**12,107**	8,266
Depreciation on property, plant and equipment	**2,926**	2,196
Amortisation on intangible assets	**565**	277
Audit fees payable to the external auditors		
- audit services - statutory audit	**68**	61
- other auditors' remuneration (external auditors only)	**-**	8
Clinical negligence	**256**	270
Legal fees	**-**	369
Consultancy costs	**1,001**	554
Internal audit costs	**131**	136
Training, courses and conferences	**373**	309
Patient travel	**3**	3
Redundancy	**-**	275
Hospitality	**-**	7
Insurance	**-**	16
Other services, e.g. external payroll	**-**	1,257
Other	**538**	2,761
	161,694	**152,138**
Of which:		
Related to continuing operations	**161,694**	**152,138**
Related to discontinued operations	**-**	**-**

Operating expenses includes expenditure accrued for which no invoice has been received by 31st March 2017. In some cases it is necessary to use estimates based on knowledge of goods and services received. Wherever possible reference is made back to the value of orders but estimates and assumptions are applied in order to ensure the completeness of expenditure reported. Due to the volume of transactions adjustments are not made to prior periods unless the difference between the estimate and the actual value is material.

For expenditure accruals, any variation in outcome compared to the estimates used are accounted for in the next period. These estimates and assumptions are consistent with the previous year.

Directors' remuneration is set out above and includes employer contributions to the NHS Pension Scheme. Detailed director remuneration disclosures and staff number disclosures are contained within the Remuneration and Staff Report.

Note 5.1 Other auditors' remuneration

	2017	2016
	£000	£000
Other auditors' remuneration paid to the external auditors:		
Audit-related assurance services	**-**	8
Total	**-**	**8**

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work carried out for the financial years 2016/17 is £1 million. This is consistent with the principal terms of the agreement with the auditors date 31 January 2017.

Note 6 Employee benefits

	2017	2016
	£000	£000
Salaries and wages	**85,082**	81,252
Social security costs	**7,621**	5,303
Employer's contributions to NHS pensions	**11,126**	10,574
Pension cost - other	**-**	4
Termination benefits	**-**	763
Temporary staff (external bank)	**919**	-
Temporary staff (including agency)	**6,164**	7,442
Total gross staff costs	**110,912**	**105,338**
Recoveries in respect of seconded staff	**-**	-
Total staff costs	**110,912**	**105,338**
Of which:		
Costs capitalised as part of assets	**442**	800

Note 6.1 Retirements due to ill health

During 2016/17 there was one early retirements from the trust agreed on the grounds of ill-health (two in the year ended 31 March 2016). The estimated additional pension liabilities of this ill-health retirement is £169k (2015/16: £67k).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7 Pension costs

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 annual accounts 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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017 is based on valuation data as 31 March 2016, updated to 31 March 2017 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 scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their 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 appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. 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.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

d) Future requirements

In 2017/18 employer contribution rates will remain consistent at 14.3% and the Trust estimates its contributions will be £11.1m.

Note 8 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where Bridgewater Community Healthcare NHS Foundation Trust is the lessee.

Bridgewater Community Healthcare NHS Foundation Trust has included within lease costs occupancy charges in relation to occupancy of premises owned and controlled by NHS Property Services Ltd and Community Health Partnerships. Whilst the Trust occupies properties from NHS Property Services Ltd and Community Health Partnerships under arrangements which the Trust considers to be operating leases, the Trust does not have agreed formal lease arrangements in place.

The minimum lease payments disclosed above therefore only include our expected costs for these properties.

	2017	2016
	£000	£000
Operating lease expense	**12,107**	8,266
Minimum lease payments	**12,107**	**8,266**
Total		

	31 March 2017	31 March 2016
	£'000	£'000
Future minimum lease payments due:		
- not later than one year;	**12,453**	7,083
- later than one year and not later than five years;	**1,709**	2,201
- later than five years.	**2,677**	3,559
Total	**16,839**	**12,843**

Note 9 Finance Income

	2017	2016
	£000	£000
Interest on bank accounts	**17**	19
Total	**17**	**19**

Finance income represents interest received on assets and investments in the period.

Note 10 Intangible assets

Note 10.1 Intangible assets – 2016/17

	Internally generated information technology £000
Gross cost at 1 April 2016 – brought forward	**2,838**
Additions	304
Gross cost at 31 March 2017 – carried forward	**3,142**
Amortisation at 1 April 2016 – brought forward	**653**
Provided during the year	565
Amortisation at 31 March 2017 – carried forward	**1,218**
Net book value at 31 March 2017	**1,924**
Net book value at 31 March 2016	2,185

Note 10.2 Intangible assets – 2015/16

	Internally generated information technology £000
Gross cost at 1 April 2015 – brought forward	**177**
Additions	475
Reclassifications	2,186
Gross cost at 31 March 2016 – carried forward	**2,838**
Amortisation at 1 April 2015 – brought forward	**69**
Provided during the year	277
Reclassifications	307
Amortisation at 31 March 2016 – carried forward	**653**
Net book value at 31 March 2016	**2,185**
Net book value at 31 March 2015	108

The reclassification relates to the Trust's clinical system infrastructure which was recognised as 'Property, Plant and Equipment' in 2014/15 but on review was considered to be more appropriately classified as 'Intangible Assets'. Therefore £2,186k of gross cost and £307k of accumulated depreciation was transferred from 'Property, Plant and Equipment' to 'Intangible Assets' during 2015/16.

11 Property, plant and equipment

Note 11.1 Property, plant and equipment – 2016/17

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2016 – brought forward	**2,424**	**9,237**	**6,901**	**6,721**	**658**	**25,941**
Additions	-	-	1,717	505	-	**2,222**
Revaluations	-	553	-	-	-	**553**
Valuation/gross cost at 31 March 2017	**2,424**	**9,790**	**8,618**	**7,226**	**658**	**28,716**
Accumulated depreciation at 1 April 2016 – brought forward	**-**	**53**	**1,892**	**2,699**	**233**	**4,877**
Provided during the year	-	337	1,306	1,214	69	**2,926**
Revaluations	-	(337)	-	-	-	**(337)**
Accumulated depreciation at 31 March 2017	**-**	**53**	**3,197**	**3,913**	**302**	**7,465**
Net book value at 31 March 2017	**2,424**	**9,737**	**5,421**	**3,313**	**356**	**21,251**
Net book value at 31 March 2016	2,424	9,184	5,010	4,022	425	21,065

Note 11.2 Property, plant and equipment – 2015/16

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 – brought forward	**2,424**	**9,766**	**5,484**	**8,059**	**658**	**26,391**

Additions	-	-	1,417	848	-	2,265
Reclassifications	-	(829)	-	(2,186)	-	(3,015)
Revaluations	-	300	-	-	-	300
Valuation/gross cost at 31 March 2016	**2,424**	**9,237**	**6,901**	**6,721**	**658**	**25,941**
Accumulated depreciation at 1 April 2015 – brought forward	**-**	**561**	**902**	**2,193**	**160**	**3,816**
Provided during the year	-	321	989	813	73	2,196
Reclassifications	-	(829)	-	(307)	-	(1,136)
Accumulated depreciation at 31 March 2016	**-**	**53**	**1,891**	**2,699**	**233**	**4,876**
Net book value at 31 March 2016	**2,424**	**9,184**	**5,010**	**4,022**	**425**	**21,065**
Net book value at 31 March 2015	2,424	9,205	4,582	5,866	498	22,575

The reclassification relates to the Trust's clinical system infrastructure which was recognised as 'Property, Plant and Equipment' in 2014/15 but on review was considered to be more appropriately classified as 'Intangible Assets'. Therefore £2,186k of gross cost and £307k of accumulated depreciation was transferred from 'Property, Plant and Equipment' to 'Intangible Assets' during 2015/16.

Note 11.3 Property, plant and equipment financing – 2016/17

	Land	**Buildings excluding dwellings**	**Plant & machinery**	**Information technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Owned	2,424	9,737	5,421	3,313	356	21,251
Net book value at 31 March 2017	**2,424**	**9,737**	**5,421**	**3,313**	**356**	**21,251**

Note 11.4 Property, plant and equipment financing – 2015/16

	Land	**Buildings excluding dwellings**	**Plant & machinery**	**Information technology**	**Furniture & fittings**	**Total**

	£000	£000	£000	£000	£000	£000
Owned	2,388	8,974	4,997	4,022	425	**20,806**
Government granted	36	210	-	-	-	**246**
Donated	-	-	13	-	-	**13**
Net book value at 31 March 2016	**2,424**	**9,184**	**5,010**	**4,022**	**425**	**21,065**

Note 12 Revaluations of property, plant and equipment

All of the Trusts owned Land & Buildings have been revalued at 31 March 2017. The revaluation was carried out independently by DVS - Property Services arm of the VOA (DipSurv MRICS RICS Registered Valuer), Crewe Valuation Office, 2nd Floor Wellington House, Delamere Street, Crewe, CW1 2LQ.

The revaluation was undertaken in accordance with International Financial Reporting Standards (IFRS) as interpreted and applied by the Annual Reporting Manual. The assumption has been made that the properties valued will continue to be held for the foreseeable future having regard to the prospect and viability of the continuance of occupation. The basis of valuation is Current Value which has been interpreted as market value for existing use.

For those properties where there is market-based evidence to support the use of 'Existing Use Value' (EUV) to arrive at Current Value the comparative method of valuation has been adopted.

For those properties where there is no market based evidence to support the use of EUV to arrive at Current Value, the Depreciated Replacement Cost (DRC) approach has been used.

Note 13 Inventories

	31 March 2017 £000	31 March 2016 £000
Drugs	**44**	39

Inventories recognised in expenses for the year were £427k (2015/16: £466k). Write down of inventories recognised as expenses for the year was £nil (2015/16: £nil).

Note 14 Trade receivables and other receivables

Note 14.1 Current and non-current trade receivables and other receivables

	31 March 2017 £000	31 March 2016 £000
Current		
Trade receivables due from NHS bodies	**8,084**	2,672
Other receivables due from related parties	**889**	-
Provision for impaired receivables	**(312)**	(300)
Prepayments (non-PFI)	**-**	759
Accrued income	**5,337**	1,198
VAT receivable	**346**	797
Other receivables	**-**	3,654
Total current trade and other receivables	**14,344**	**8,780**
Non-current		
Provision for impaired receivables	**(186)**	(167)
Other receivables	**1,032**	1,032
Total non-current trade and other receivables	**846**	**865**

Note 14.2 Provision for impairment of receivables

	31 March 2017 £000	31 March 2016 £000
At 1 April	**467**	397
Increase in provision	**31**	70
At 31 March	**498**	467

Note 14.3 Analysis of impaired receivables – 31 March 2017

	Trade and other receivables £000
Aging of impaired financial assets	
0-30 days	**14**
30-60 days	**10**
60-90 days	**14**
90-180 days	**43**
Over 180 days	**2,931**
Total	**3,012**

Aging of non-impaired financial assets past their due date	
0-30 days	**508**
30-60 days	**215**
60-90 days	**514**
90-180 days	**1,816**
Over 180 days	**702**
Total	**3,755**

Note 14.4 Analysis of impaired receivables – 31 March 2016

	Trade and other receivables £000
Aging of impaired assets	
0-30 days	69
30-60 days	69
60-90 days	69
90-180 days	299
Over 180 days	1,857
Total	**2,363**
Aging of non-impaired assets past their due date	
0-30 days	426
30-60 days	104
60-90 days	455
90-180 days	4
Over 180 days	243
Total	**1,232**

Note 15 Cash and cash equivalent movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	16/17 £000	15/16 £000
At 1 April	**2,346**	5,861
Net change in year	**2,011**	(3,515)
At 31 March	**4,357**	**2,346**
Broken down into:		
Cash at commercial banks and in hand	**30**	29
Cash with the Government Banking Service	**4,327**	2,317
Total cash and cash equivalents as in SoFP and SoCF	**4,357**	**2,346**

Note 16 Trade and other payables

	31 March 2017 £000	31 March 2016 £000
Current		
NHS trade payables	**8,051**	5,534
Amounts due to other related parties	**-**	308
Other trade payables	**4,019**	3,856
Capital payables	**9**	-
Social security costs	**1,944**	1,685
Other payables	**1,487**	-
Accruals	**4,959**	4,591
Total current trade and other payables	**20,469**	**15,974**

Note 17 Provisions

	Other legal claims £'000
At 1 April 2016	**54**
Arising during the year	71
Reversed unused	(60)
At 31 March 2017	**65**
Expected timing of cash flows:	
- not later than one year	**65**
Total	**65**

Legal claims provision relate to LTPS provisions as notified by the NHS Litigation Authority. The provision reflects the probability of the cases being settled as estimated by the NHS Litigation Authority.

Note 17.1 Clinical negligence liabilities

At 31 March 2017 £1,375k was included in the provisions of the NHSLA in respect of clinical negligence liabilities of Bridgewater Community Healthcare NHS Foundation Trust (2015/16: £1,533k).

Note 18 Contractual capital commitments

	31 March 2017 £000	31 March 2016 £000
Property, plant and equipment	**-**	54

Note 19 Financial Instruments

Note 19.1 Financial risk management

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 NHS England, Clinical Commissioning Groups and Local Authorities and the way NHS England, Clinical Commissioning Groups and Local Authorities 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 limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the department of health. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31st March 2017 are in receivables from customers, as disclosed in the trade and other receivables note."

Liquidity risk

The Trust's operating costs are incurred under contracts with other NHS bodies, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from internally generated resources. The Trust is not, therefore, exposed to significant liquidity risks.

Note 19.2 Financial assets

	Loans and receivables £000
Assets as per SoFP as at 31 March 2017	
Trade and other receivables excluding non-financial assets	**13,997**
Cash and cash equivalents at bank and in hand	**4,357**
Total at 31 March 2017	**18,354**
Assets as per SoFP as at 31 March 2016	
Trade and other receivables excluding non-financial assets	7,223
Cash and cash equivalents at bank and in hand	2,346
Total at 31 March 2016	**9,569**

Note 19.3 Financial liabilities

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2017	
Trade and other payables excluding non-financial liabilities	**13,566**
Total at 31 March 2017	**13,566**
Liabilities as per SoFP as at 31 March 2016	
Trade and other payables excluding non-financial liabilities	14,289
Total at 31 March 2016	**14,289**

Note 19.4 Maturity of financial liabilities

	31 March 2017 £000	31 March 2016 £000
In one year or less	13,566	14,289

Note 19.5 Fair values of financial assets at 31 March 2017

The fair value of financial assets is considered to be equivalent to the transaction value.

Note 19.6 Fair values of financial liabilities at 31 March 2017

The fair value of financial liabilities is considered to be equivalent to the transaction value.

Note 20 Losses and special payments

	2017		2016	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
		£000		£000
Losses				
Bad debts and claims abandoned	10	-	1	-
Total losses	**10**	**-**	**1**	**-**
Total losses and special payments	**10**	**-**	**1**	**-**

Note 21 Related parties

Related parties include but are not limited to:

- Department of Health ministers
- Board members of the NHS foundation trust
- The Department of Health
- Other NHS foundation trusts
- Other NHS trusts
- CCGs and NHS England
- Other health bodies
- Other Government departments
- Local authorities
- NHS charitable funds (where not consolidated)

During the reporting period none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Bridgewater Community Healthcare NHS Foundation Trust.

During the reporting period Bridgewater has had a significant number of material transactions (greater than £1 million) with these parties, the details of which are:

	Receivables		**Payables**	
	31 March 2017 £000	**31 March 2016 £000**	**31 March 2017 £000**	**31 March 2016 £000**
CCGs				
NHS Halton CCG	**1,085**	129	**5**	238
NHS St Helens CCG	**559**	237	**5**	1,046
NHS Warrington CCG	**790**	840	**-**	-
NHS Wigan Borough CCG	**473**	292	**-**	206
NHS England				
Cheshire and Merseyside	**-**	152	**-**	-
Lancashire and Greater Manchester	**-**	201	**-**	-
NHS Core	**2,927**	3	**67**	-
Greater Manchester Local Office	**135**	-	**-**	-
Lancashire Local Office	**56**	-	**-**	-
NHS Trusts				
St Helens and Knowsley NHS Trust	**438**	305	**399**	1,497
NHS Foundation Trusts				
Greater Manchester Mental	**-**	-	**180**	157

Health NHS Foundation Trust				
Warrington and Halton Hospitals NHS Foundation Trust	**590**	280	**360**	284
Wrightington, Wigan and Leigh NHS Foundation Trust	**194**	7	**1,246**	253
Other NHS Bodies				
NHS Pension Scheme	**-**	-	**1,487**	1,437
Health Education England	**14**	-	**38**	4
NHS Property Services	**2,622**	-	**4,182**	2,674
Community Health Partnerships	**250**	124	**2,117**	378
Total	**10,133**	2,570	**10,086**	8,174

	Income		**Expenditure**	
	2017	**2016**	**2017**	**2016**
	£000	**£000**	**£000**	**£000**
CCGs				
NHS Halton CCG	**19,161**	17,813	**2**	1
NHS St Helens CCG	**21,344**	20,815	**54**	-
NHS Warrington CCG	**21,520**	20,151	**-**	-
NHS Wigan Borough CCG	**36,858**	34,744	**-**	-
NHS England				
Cheshire and Merseyside	**3,353**	8,758	**-**	-
Lancashire and Greater Manchester	**-**	11,960	**-**	200
NHS Core	**4,090**	-	**28**	-
Greater Manchester Local Office	**4,241**	-	**10**	-
Lancashire Local Office	**6,174**	-	**-**	-
NHS Trusts				
St Helens and Knowsley NHS Trust	**481**	507	**2,514**	2,854
NHS Foundation Trusts				
Greater Manchester Mental Health NHS Foundation Trust	**53**	51	**1,764**	1,106
Warrington and Halton Hospitals NHS Foundation Trust	**614**	589	**1,440**	1,572
Wrightington, Wigan and Leigh NHS Foundation Trust	**186**	342	**2,134**	528
Other NHS Bodies				

NHS Pension Scheme	**-**	-	**11,126**	10,574
Health Education England	**2,663**	2,642	**25**	-
NHS Property Services	**266**	743	**2,402**	1,059
Community Health Partnerships	**259**	125	**8,780**	5,631
Total	**121,263**	119,240	**30,279**	23,525

In addition, the Trust has had a number of material transactions (greater than £1 million) with other government departments and other central and local government bodies. Most of these transactions have been with the following entities:

	Receivables		**Payables**	
	31 March 2017 £000	**31 March 2016 £000**	**31 March 2017 £000**	**31 March 2016 £000**
Local Authorities				
Halton Borough Council	**484**	392	**124**	102
St Helens Metropolitan Borough Council	**487**	978	**36**	42
Warrington Borough Council	**159**	869	**42**	170
Wigan Borough Council	**348**	715	**106**	24
Bolton Metropolitan Borough Council	**165**	490	**1**	12
Trafford Metropolitan Borough Council	**1**	-	**-**	1
Oldham Metropolitan Borough Council	**990**	-	**30**	-
	2,634	**3,444**	**339**	**351**

	Income		**Expenditure**	
	2017 £000	**2016 £000**	**2017 £000**	**2016 £000**
Local Authorities				
Halton Borough Council	**5,247**	3,738	**39**	14
St Helens Borough Council	**2,525**	4,766	**219**	-
Warrington Borough Council	**7,919**	6,072	**13**	39
Wigan Borough Council	**8,155**	5,273	**93**	28
Bolton Metropolitan Borough Council	**3,408**	1,088	**17**	-
Trafford Metropolitan Borough Council	**615**	1,337	**-**	-
Oldham Metropolitan Borough Council	**8,473**	-	**17**	-
	36,342	**22,274**	**398**	**81**

6. Key Contacts

Your views

We welcome your comments and feedback on our Annual Report and Accounts and Quality Account. Please contact 01942 482655 or email communications@bridgewater.nhs.uk if you:

- have any further questions or need help understanding any aspect of this document
- would like to view this document in another language or format such as Braille or audio
- would like us to send you a printed copy of this document or parts of this document

Giving feedback on our services

If you wish to tell us about your experience of our services please contact Patient Services:

Email: Patient.Services@bridgewater.nhs.uk
Telephone: 0800 587 0562

Membership

If you would like to have a say and help us to develop our services to meet local needs, then please consider becoming a member. Membership is open to anyone aged 14 years or over who lives in England. Please contact us to find out more:

Email: membership@bridgewater.nhs.uk

Telephone: 01942 482672

Want to know more about us? You can:

- find out more about us on our website: www.bridgewater.nhs.uk
- follow us on Twitter: www.twitter.com/Bridgewater_NHS
- "like" us on Facebook www.facebook.com/BridgewaterNHS
- contact our Headquarters:

Bevan House
17 Beecham Court
Smithy Brook Road
Wigan
WN3 6PR.
Telephone: 01942 482630 or
Email: enquiries@bridgewater.nhs.uk

Acknowledgements

Thank you to all the staff and teams who contributed to this document.

7. Appendices

Appendix 1 Board and Committee Attendance Register

Board and Committee Attendance Register - April 2016 to March 2017

Key - AP = Apologies
** Closed/Extraordinary Board session*
/ Two or three Board sessions in one month some closed*

		Apr*	May	Jun	Jul	Aug*	Sept	Oct**	Nov	Dec	Jan	Feb	Mar***	Total
Board Meetings (including both public and closed meetings)														
Harry Holden	Chairman	I	I		I	I	I	AP I	I	I		I	I I I	12/13
Karen Bliss	Non-Executive Director	I	AP		AP	I	I	I I	AP	I		I	I I I	10/13
Steve Cash	Non-Executive Director	I	I		I	I	AP	I I	I	I		I	I I I	12/13
Marian Carroll	Non-Executive Director	I	I		AP	I	I	I I	I	I		I	I AP I	11/13
Maggie Pearson	Non-Executive Director	I	I		AP	I	I	I I	AP	I		AP	I I I	10/13
Bob Saunders	Non-Executive Director	I	I		I	I	I	AP I	AP	I		I	I AP I	10/13
Sally Yeoman	Non-Executive Director/Senior Independent Director	I	I		I	I	I	I I	I	I		I	I I I	13/13
Dorothy Whitaker	Non-Executive Director/Vice Chair	I	I		I	I	I	I I	I	I		I	AP AP I	11/13
Christine Samosa	Director of People and Organisational Development/Deputy Chief Executive	I	I		I	AP	I	I I	I	I		I	I I I	12/13
Colin Scales	Chief Executive	I	I		I	I	I	I I	I	I		I	I I I	13/13
Esther Kirby	Chief Nurse and Director of Quality	I	I		I	I	I	AP I	I	I		I	AP I I	11/13
Gareth Davies	Director of Finance	I	I		I	I	I	I AP	I	I		I	I AP I	11/13
Mike Barker	Director of Strategic Development	I	I		I	I	I	I I	I	I		I	I I I	13/13
Karen Slade	Medical Director	I	I		I	I	I	I AP	I	I		I	I I I	12/13

		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Nominations and Remuneration Committee (Held on ad-hoc basis)														
Harry Holden	Chairman			I	I							I	I	4/4
Dorothy Whitaker	Non-Executive Director			I	I							I	I	4/4
Bob Saunders	Non-Executive Director			I	I							I	I	4/4
Karen Bliss	Non-Executive Director			I	AP							I	I	3/4
Steve Cash	Non-Executive Director			AP	I							I	I	3/4
Maggie Pearson	Non-Executive Director			I	AP							AP	I	2/4
Sally Yeoman	Non-Executive Director			I	AP							I	I	3/4
Marian Carroll	Non-Executive Director			I	I							I	I	4/4

** Extraordinary Audit Committee*		Apr	May*	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Audit Committee														
Karen Bliss	Non-Executive Director (Chair)	I	I			I			I		I		I	6/6
Steve Cash	Non-Executive Director	AP	I			AP			I		AP		AP	2/6
Bob Saunders	Non-Executive Director	I	I			I			AP		I		I	5/6
Dorothy Whitaker	Non-Executive Director	I	I			I			I		I		I	6/6
Maggie Pearson	Non-Executive Director	I	I			AP			I		I		I	5/6
Marian Carroll	Non-Executive Director	I	I			I			I		I		I	6/6

		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Quality and Safety Committee														
Bob Saunders (Chair)	Non-Executive Director	I	I	I	I	I	I	I	AP	I	I	I	I	11/12
Dorothy Whitaker	Non-Executive Director	I	I	AP	I	I	I	I	I (Chair)	I	I	I	I	11/12
Marian Carroll	Non-Executive Director	AP	I	AP	I	I	I	I	I	I	I	I	I	10/12
Sally Yeoman	Non-Executive Director	AP	I	I	AP	I	AP	I	I	AP	I	I	AP	7/12
Esther Kirby	Executive Nurse and Director of Quality	I	AP	I	AP	I	AP	AP	I	I	I	I	I	8/12
Karen Slade	Medical Director	I	I	I	I	I	I	I	I	I	I	AP	I	11/12

		Apr	May	June	July	Aug	Sept	Oct	Nov	Dec*	Jan	Feb	Mar	Total
Finance and Investment Committee														
Steve Cash (Chair until July 2016)	Non-Executive Director	I	I	AP	I	AP	AP	AP	I	I	I	AP	I	7/12
Karen Bliss (Chair from August 2016)	Non-Executive Director	I	I	I	AP	I	I	I	I	I	I	I	I	11/12
Maggie Pearson	Non-Executive Director	I	I	I	I	I	AP	I	I	I	AP	I	I	10/12
Sally Yeoman	Non-Executive Director	AP	I	I (Chair)	I	AP	I	AP	I	I	I	I	I	9/12
Christine Samosa	Director of People and Organisational Development	I	I	AP	I	AP	I	I	AP	AP	I	AP	I	7/12
Gareth Davies	Director of Finance	I	AP	I	I	I	I	I	I	AP	I	AP	I	9/12
Mike Barker	Director of Strategic Development (member of F&I from June 2016)			I	I	I	AP	AP	I	AP	I	I	I	9/12
Esther Kirby	Executive Nurse and Director of Quality (member of F&I from June 2016)			AP	AP	I	I	I	I	AP	I	AP	I	6/12

*informal meeting not quorate

AP - apologies, A - absent without apologies		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Council of Governors														
Harry Holden	Chairman	I		I			I		I			I		5/5
Dorothy Whitaker	Non-Executive Director/Vice Chair	I		I			I		I			I		5/5
Karen Bliss	Non-Executive Director	A		AP			A		I			I		2/5
Steve Cash	Non-Executive Director	A		AP			AP		I			I		2/5
Marian Carroll	Non-Executive Director	I		I			AP		I			A		3/5
Maggie Pearson	Non-Executive Director	I		I			AP		I			AP		3/5
Bob Saunders	Non-Executive Director	I		I			I		AP			I		4/5
Sally Yeoman	Non-Executive Director	A		I			I		I			I		4/5
Colin Scales	Chief Executive	I		AP			AP		I			AP		2/5
Chris Samosa	Director of People and Organisational Development	A		I			I		AP			I		3/5
Esther Kirby	Chief Nurse and Director of Quality	A		AP			I		AP			AP		1/5
Karen Slade	Medical Director	A		I			AP		A			A		1/5
Mike Barker	Director of Strategic Development	A		I			I		I			A		3/5
Gareth Davies	Director of Finance	A		I			AP		I			I		3/5
John Prince	Lead Governor and Public Governor - Wigan	I		I			I		AP			AP		3/5

		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Council of Governors (cont.)														
Irene Deakin	Public Governor - Community Dental (until 30/10/16)	A		A			A							0/5
Diane McCormick	Public Governor - Halton	I		I			I		I			I		5/5
Peter Appleby	Public Governor - St Helens (until 30/10/16)	AP		A			A							0/5
Rita Chapman	Public Governor - St Helens	I		AP			A		I			I		3/5
Derek Maylor	Public Governor - St Helens	AP		A			AP		I			I		2/5
Canon Geoff Almond	Public Governor - St Helens	I		I			AP		AP			I		3/5
Marlene Quinn	Public Governor - St Helens			A			A		A			A		0/5
Bill Harrison	Public Governor - St Helens (from 1/11/16)								I			I		2/5
G. Scott Baron	Public Governor - Warrington (until 30/10/16)	A		A			A							0/5
Jean Bullock	Public Governor - Warrington (resigned in 2016)	A		A										0/5
Paul Mendeika	Public Governor - Warrington	I		I			AP		I			I		4/5
Alan Guthrie	Public Governor - Warrington	I		A			AP		AP			AP		1/5
Gary Young	Public Governor - Wigan	AP		AP			I		I			I		3/5
William (Ken) Griffiths	Public Governor - Wigan	AP		A			I		I			I		3/5
Mick Taylor	Public Governor - Wigan (resigned May 2016)	A												0/5

Susan Francis	Public Governor - Wigan (from 1/11/16)								AP			I		1/5
Rebecca Reece	Public Governor - Wigan (from 1/11/16)								I			I		2/5

		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Council of Governors (cont.)														
Steven Lowe	Staff Governor - AHP	I		I			AP		I			AP		3/5
Angela Akers	Staff Governor - Dental (until 30/10/16)	AP		A			AP							0/5
Vikki Morris	Staff Governor - Non-Clinical Support (until 30/10/16)	AP		A			I							1/5
Corina Casey Hardman	Staff Governor - Nursing and Midwifery	A		AP			I		I			I		3/5
Karen Worthington	Staff Governor - Nursing and Midwifery until 30/10/16	A		A			A							0/5
Helen Case	Staff Governor - Nursing and Midwifery (resigned September 2016))	A		A										0/5
Dr Deb Mandal	Staff Governor - Doctors/Medical	AP		I			I		I			A		3/5
Fiona Bremner	Staff Governor - Nursing and Midwifery (from 1/11/16)								I			I		2/5
Janet Rawlings	Staff Governor - Nursing and Midwifery (from 1/11/16)								I			I		2/5
Heulwen Sheldrick	Staff Governor - AHP (from 1/11/16)								I			I		2/5
Dave Smith	Staff Governor - Non-Clinical Support (from 1/11/16)								I			I		2/5
Janette Grey	Partner Governor - Higher Education	I		I			I		I			I		5/5
Cllr Judith Guthrie	Partner Governor - Warrington	AP		A			AP		AP			AP		0/5
Cllr Peter Lloyd Jones	Partner Governor - Halton (until May 2016)	I												1/5

Cllr Geoff Zygadlo	Partner Governor - Halton (from May 2016)			A			AP		I			I		2/5
Nigel Ash	Partner Governor - Wigan	I		A			AP		AP			AP		1/5
Alison Cullen	Partner Governor - Voluntary Sector	A		A			A		A			A		0/5

* A – Absent without apologies

NHS
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NHS Foundation Trust

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Quality first and foremost