NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Annual Report and Accounts 2017/2018






Quality first and foremost

Bridgewater Community Healthcare NHS Foundation Trust

Annual Report and Accounts 2017/18

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 2017 to 31 March 2018.

During 2017/18 significant progress has been made across all boroughs served by Bridgewater towards the creation of integrated models of care to best serve our local communities. Across all boroughs and with sensitivity to the pace dictated by the local requirements, the Trust is playing a leading role in the establishment of integrated care organisations. In some cases, working from shared bases with increasingly shared systems and processes with partners is already starting to reap some of the benefits of this work; improved communication between teams, less duplication of work are supporting our work to provide seamless packages of care for some of the most vulnerable in our communities. Further detail on each borough is provided in the service developments section in the Profile.

Following last year's CQC inspection, the Trust was expecting to receive a further visit from the CQC this year. Although our re-inspection did not take place in the year due to the changes in the inspection regime, 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 2017/18 Quality Report, contained within this document.

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. At the year end, the Trust was not able to meet its control total of a deficit of £0.5m, instead posting a deficit of £3.6m. The reasons for this are well understood by the Trust and in part is due to the late notification in 2016/17 that the Liverpool Community Healthcare transaction would not continue. This year has seen a real focus on understanding the Trust's cost base on a town by town basis in order to improve the financial sustainability of the Trust. We remain committed to providing safe and effective healthcare services that offer the best value for money for taxpayers, whilst reforming what we do, in partnership with others.

This year has also seen some changes to the Board of Directors. Whilst sorry to lose several valued colleagues, we have welcomed four new executive directors and are excited about the experience and fresh perspectives the new team members bring to the Board. There have also been changes to the non-executive directors of the Trust, with Bob Saunders leaving the Trust after many years' valuable service on the Board, particularly as the Chair of the Quality and Safety committee. Harry Holden, Chair of the Trust since its inception as the Ashton Leigh and Wigan PCT provider arm has announced his decision to leave the Trust in early 2018/19. We wish Harry very well as he embarks upon his well-earned retirement; suffice to say, his successor has a very hard act to follow.

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

2017-18 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 overwhelmingly positive patient feedback 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. During the first part of the year, we did not meet the mental health data completeness target, which only applies to one of our services. A detailed data improvement programme was put in place in quarter one and the Trust has now exceeded the expectations of the target from August onwards. The six-week target for diagnostic waiting times has had some in-month challenges in 3 services but these are largely mitigated. Overall, performance remains high allowing the Trust to meet the requirements of the Single Oversight Framework.

The Trust extended its provision of services for Health and Justice this year, with the acquisition of the services to HMPs Wymott and Garth in April 2017. As the Trust's knowledge of the service developed in the early part of the year, it became apparent that there were significant pre-existing quality issues to address. The Trust has undertaken a significant amount of remedial work with its partners at Greater Manchester Mental Health NHS FT, the prison establishment itself, the Care Quality Commission and NHS England as the commissioners of the service. The level of risk remains high but the Trust is confident it understands the requirements of the service and the necessary mitigations.

The Trust served notice to NHS England and exited the provision of GP services at Willaston. The Trust's strategy has changed since it took on the practice three years ago and it was the right decision to consolidate our approach.

In common with the wider NHS, this year has been challenging in financial terms. Our Use of Resources Risk Rating (UOR) score of 3 by the end of 2018/19, consistent with that achieved in 2017/18, confirms the Trust's financial position as of minor concern from a regulatory perspective. At the year end, the Trust was not able to meet its control total of a deficit of £0.5m, instead posting a deficit of £3.6m. In the context of achieving the wider performance targets against an increasing demand for services, the Board acknowledges and understands the reasons for this. Whilst the situation remains challenging, the Trust is confident it will be able to make significant improvements to the financial position during 2018-19.

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.

December 2017

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 9,200 public members from our local communities.

The average Full Time Equivalent (FTE) and Headcount of our staff for the period 01 April 2017 – 31 March 2018 was 2294.40 FTE and Headcount 3011 – the majority of whom are staff members of our Foundation Trust.

Our income for the year 1 April 2017 to 31 March 2018 totalled £151.8m and included:

CCG and NHS England	£107.5m
Local authorities	£31.0m

Health Education England £1.8m

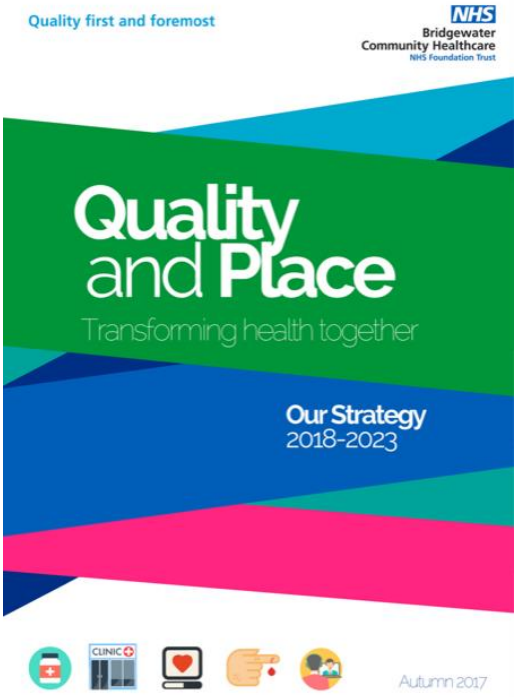
Other NHS Foundation Trusts (excludes non-FTs) £5.4m

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)).

The Trust's Strategy: *Quality and Place – Transforming health together*

During the summer and autumn of 2017, our staff, local people, carers, health and care professionals, partners and community-based leaders came together in each borough as part of a series of 'Big Conversation' events. These engagement events gave us a real opportunity to listen to staff, local people and our partners in the communities we serve and to talk to them about our plans for the future and what they want from local NHS community services moving forward. The result of this consultation exercise is *Quality and Place: Transforming Health Together, Our strategy 2018-2023.*

In addition, a follow-up series of 'Big Conversation' events took place in autumn 2017 as we continued to engage our communities, stakeholders and partners through regular, organised conversations. As well as allowing us to share information on how their feedback had been written into the strategy, these follow-up events enabled further discussion on our strategy implementation plans for 18/19. Our Public Governors were heavily involved every step of the way and we all benefited from their experience and local knowledge. As critical friends throughout this process our Governors were invaluable and guided us with the voice of local people helping us identify the best ways and means to speak back.



Quality and Place. Transforming health together.

Our mission at Bridgewater is to improve local health and wellbeing in the communities we serve.

Quality and Place is our five year strategy to become an outstanding organisation for which people love to work and work with, and one from which people know they will receive great local care.

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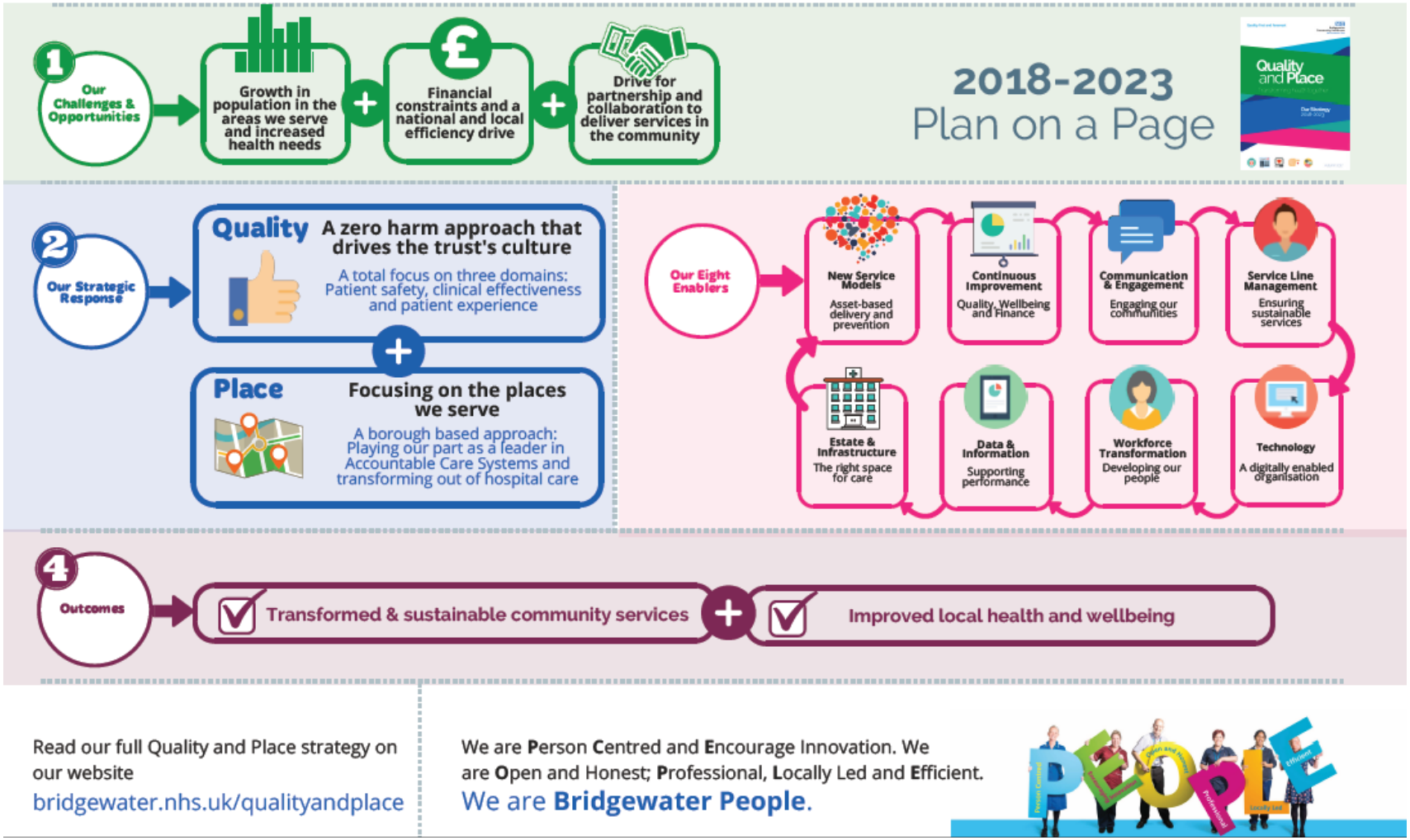


Read our full Quality and Place strategy on our website
bridgewater.nhs.uk/qualityandplace

We are **P**erson **C**entred and **E**ncourage Innovation. We are **O**pen and Honest; **P**rofessional, **L**ocally Led and **E**fficient.
We are **Bridgewater People.**

Key issues/risks

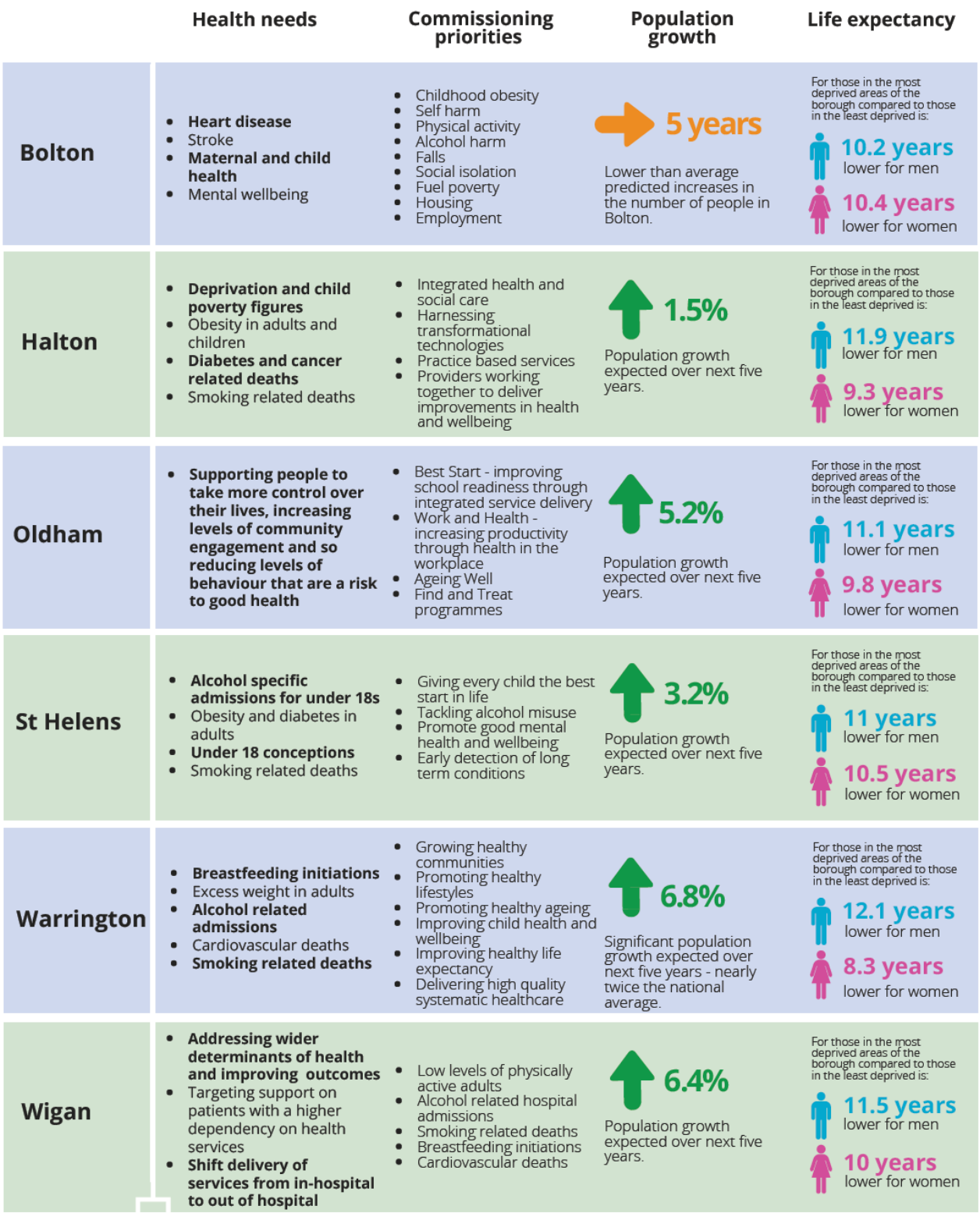
There is a growing demand for care as the population we serve is living longer, with an increasing prevalence of long term conditions such as diabetes, cancer, heart disease, lung disease and dementia.

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 health priorities for each borough are shown below. Our response to these key risks is discussed in more detail in the Trust's strategy.

Key health needs, priorities, population growth and life expectancy in our boroughs



Going Concern

The financial statements have been prepared on a going concern basis. Commissioner intentions for 2018/19 are documented and contracts have been signed for the Trust's planned income for 2018/19. A detailed paper was reviewed by the Finance and Investment Committee on 20th April 2018 and subsequently by the Board on 26th April 2018. This paper set out the key financial indicators drawn from the Trust's Annual Finance Plan for 2018/19. These indicators show:

- A Statement of Comprehensive Income deficit position of £7.6m for 2018/19 compared to an actual deficit of £3.6m for 2017/18. A positive cash balance throughout the year equating to £1.0m at the 31st March 2019.
- A Use of Resources Risk Rating (UOR) score of 3 by the end of 2018/19, which is consistent with that achieved in 2017/18 and confirms the Trust's financial position as of minor concern from a regulatory perspective.

As with any financial plan, there are potential risks and opportunities to its delivery. The Board is confident that any risks can be successfully mitigated through focused scrutiny on the output of the service line reporting programme implemented by the Trust in 2017/18 and in conjunction with our commissioners.

In the current climate the Trust does not see itself as an outlier in the NHS financial framework and has aspirations to get back to a break-even position on its income and expenditure account within the next five years as a maximum. Having considered the material uncertainties and the Trust's financial plans, together with the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis.

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 implemented. 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 were implemented in 17/18 that set out how metrics contribute to both the delivery of the strategic objectives. Ongoing development work will continue in 2018/19 to develop the metrics and outcomes measures providing focused intelligence at place based, 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. This will be supported by a self-service visualisation tool, guided analytics apps and dashboards, and reporting, all within a governed framework.

On a quarterly basis the Executive Management Team continue to focus 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'. 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 is used for all metrics that are off track and formulated into a clear improvement and recovery plan and the plan monitored via the formal committees of the Trust Board.

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.

Progress against our Strategic Objectives

During the 2017/18 financial year, we were guided by four strategic objectives, which we have continued to work towards during the course of the year. Examples of how we have done this include:

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

- Our Electronic Patient Records team were recognised at the 2017 North West Skills Development Network Informatics Awards for demonstrating tenacity, professionalism and a positive approach to managing one of the largest roll outs of electronic patient records systems in the country.
- A report by our commissioners at Oldham Council outlined how children in Oldham were benefiting from a better coordinated health service in their early years – just one year on from Bridgewater taking over the contract to deliver a Right Start service in April 2016.
- Our ' Talk to Us' forms revealed that in the first six months of the year 99% of respondents were very satisfied or satisfied with their overall experience of the service we provided. When asked how likely they were to recommend the service to a friend or family member, 97% said they were likely or very likely to recommend.
- Bridgewater launched its five year Quality and Place Strategy following an extensive engagement exercise which involved listing to staff, governors, local people and partners throughout the summer of 2017. The strategy has two key priorities which centre around Quality – ensuring that we deliver high quality, safe and effective care and Place – ensuring that we focus on the specific needs of the individual boroughs and communities we serve as well as fulfilling our role in each borough as a community provider and partner in each of the developing integrated care systems..
- In May staff from Bridgewater's IT team and clinical services worked tirelessly in the aftermath of the cyber attack on NHS computer systems to ensure safety and security of systems. Thanks to their efforts no patients were affected as a result of the alert.

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

- Halton's Health in Early Years Group, which consists of staff from Bridgewater, Halton Council and Halton Clinical Commissioning Group (CCG), won a prestigious national PIPUK (Parent Infant Partnership) Infant Mental Health award in June. The group, which consists of midwives, family nurses and health visitors from Bridgewater as well as staff from Children's Centres, Health Improvement and Public

Health from Halton Borough Council and Halton CCG, triumphed in the Locality Award for Mental Health Inclusion category.

- The Trust Board agreed to develop plans for a formal partnership with the GP Federations in Halton borough. This exciting development will support the One Halton programme by ensuring strong collaboration between primary care (GPs) and our own community services with the goal of transforming how care is provided to patients. It is a clear example of our focus on the development of joint working arrangements and greater integration of services in each borough and is central to delivering the key priorities of our strategy.
- Bridgewater has played a central role in the development of an integrated care system for the residents of Warrington. It focuses on delivering care as close to a person's home as possible and working across organisational boundaries, with shared resources, as part of an Integrated Care Partnership which is to be known as 'Warrington Together'. The plans for the borough focus on place, prevention and prioritising the resident and their community.
- Our Warrington Centre for Sexual Health was shortlisted for a prestigious regional award following its major involvement in a national research project promoting safer sex and regular testing to young people via text message. The service, which is based in Bath Street Health and Wellbeing Centre, participated in the Safetxt study and was a runner up in The Best Community Research Contribution category in the Greater Manchester Clinical Research Awards.
- Bridgewater is a key partner in the Healthier Wigan Partnership - an alliance of local organisations working together to help people live healthy, happy and fulfilled lives. Bridgewater is leading on one of key programmes of the partnership and since October 2016 staff from different NHS providers have been working more closely together with social care teams as part of an Integrated Community Service. This aims to deliver an improved service for residents and reducing unnecessary stays in hospital. Another key priority of the partnership is to deliver an integrated Start Well model for children and families. Bridgewater's school nursing and health visiting services are integral part of the Start Well place-based early intervention service.
- Staff in Bridgewater's Leigh Walk-in Centre and IT teams led the way in piloting a new system which supports sharing of child protection and safeguarding information. The Child Protection – Information Sharing (CP-IS) system is a new function on TPP's SystmOne patient information system, used by Bridgewater Community Healthcare NHS Foundation Trust. This new development allows sharing of information between social care and healthcare staff working in unscheduled care settings to enhance child protection.

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

- In April Bridgewater took over the contract to deliver health services at HMP Garth and HMP Wymott in a partnership with Greater Manchester Mental Health NHS Foundation Trust.
- Following a successful tendering exercise the Trust retained the contract for the Halton 0-19 service. The Trust was due to launch this re-designed more integrated service on 1 April 2018.
- The Trust also retained the contract for the Knowsley Hearing Screening service following a tendering exercise, with the new contract due to start on 1 April 2018.
- A Fit for the Future programme was launched to help the Trust meet the challenge of balancing quality and sustainability. Aiming to ensure our services are as strong and stable as possible, this programme included engaging managers in developing cost saving ideas and a Bright Ideas scheme to allow all staff to submit their own money saving suggestions.
- The Trust switched to an E-expenses system for all staff, following a successful pilot with teams across the Trust. Initial feedback on the system has been positive.
- The roll out of the Electronic Patient Record using mobile devices has continued during 2017/18, to free up clinical time, allow for the effective sharing of information and support integrated models of service delivery – reducing duplication, promoting greater transparency and providing our front line clinicians with the tools to more effectively manage patient care and reduce unnecessary form filling.
- During the year we transferred a number of staff from buildings that were not fit for purpose and released savings into the system by doing this. We supported greater integration of clinical teams with colleagues from health and social care.

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

- Bridgewater vaccinated 71.5% of frontline staff against the flu over the winter period, helping to protect our most vulnerable patients - an increase of more than 20% in comparison to winter 2016/17. The flu campaign proved extremely successful through providing more bespoke vaccination sessions for staff, a 'get a jab, give a jab' initiative with UNICEF and regular and consistent information about the importance of having the jab.
- During the year Bridgewater was certified as a Disability Confident Employer by the Department for Work and Pensions following a period of self-assessment. The achievement demonstrates our commitment to recruit, support and retain staff members who have a disability, and to further develop as an employer in these areas.

- The Trust launched a new Annual Performance and Personal Development Review (My Plan / My Space) documentation and guidance in September, with training already delivered to more than 600 staff.
- In November the Trust held its first in a series of 'Leader in Me' conferences which aim to build leadership capacity across the Trust and encourage staff to develop networks that will support them to develop new ideas and approaches to leadership. A second 'Leader in Me' event took place in March which focused on the concept and value of social leadership. Conferences are planned to take place three times each year.
- In May we launched a 'MyBW' Staff App allowing staff to access Bridgewater info 'on the go' from their mobile device. As a community trust with a dispersed workforce we felt it was important to recognise the challenges faced by our staff. In its first year the app has been downloaded more than 750 times.
- Our Staff Health and Wellbeing Month (26 February to 23 March) inspired people across the trust to get out from behind their desks and become more active. Activities included salsa sessions, lunchtime healthy walks and taking part in office workouts on the hour, every hour as part of #BW6060.
- During the year we received 287 nominations for our Star of the Month staff recognition scheme and in September 136 staff, governors and partners attended our annual Staff Awards ceremony and Annual General Meeting at Haydock Park Racecourse.
- The Trust launched an Allied Health Professionals (AHPs) and Healthcare Scientists' (HCS) Forum to enable these staff to have a stronger influence within Bridgewater. The launch of the forum followed AHP events in the summer which gave staff the opportunity to influence how their knowledge, skills and experience can be enhanced across Bridgewater.
- Unison and Bridgewater's Human Resources team are joining forces to help tackle the issue of stress across the trust and to try and understand more about the levels of stress staff are experiencing as a result of increasing demand on services and work pressures.
- The Trust agreed a Staff Engagement Strategy 2017-2020 that has a monitored action plan to ensure that staff engagement objectives are met. A steering group for this strategy meets monthly to review progress against the strategy.
- A Staff Engagement Champions network, with more than 40 staff, has been established so that all boroughs have a network of champions who support staff engagement activity and the cascade of messages to other staff.
- Our staff have been supported by a variety of Leadership Development programmes offered by our Organisational Development Team. These include an Institute of Leadership Management programme for Band 7 Team Leaders and leadership development support for Band 6 staff who are awaiting their Specialist Practitioner Qualification. Other Leadership courses offered include 'Leading at the Speed of

Trust', Compassion in Leadership and courses focused on developing 'System Leadership skills' in specific boroughs. During the year the Trust also launched a 'Social Leadership Pioneers' programme to support this work.

Financial Performance for 2017/18

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 31st March 2018, Bridgewater Community Healthcare NHS Foundation Trust has reported a headline deficit of £3.5m, though the underlying operating deficit was £4.8m 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 Department of Health and Social Care Group Accounting Manual (GAM).

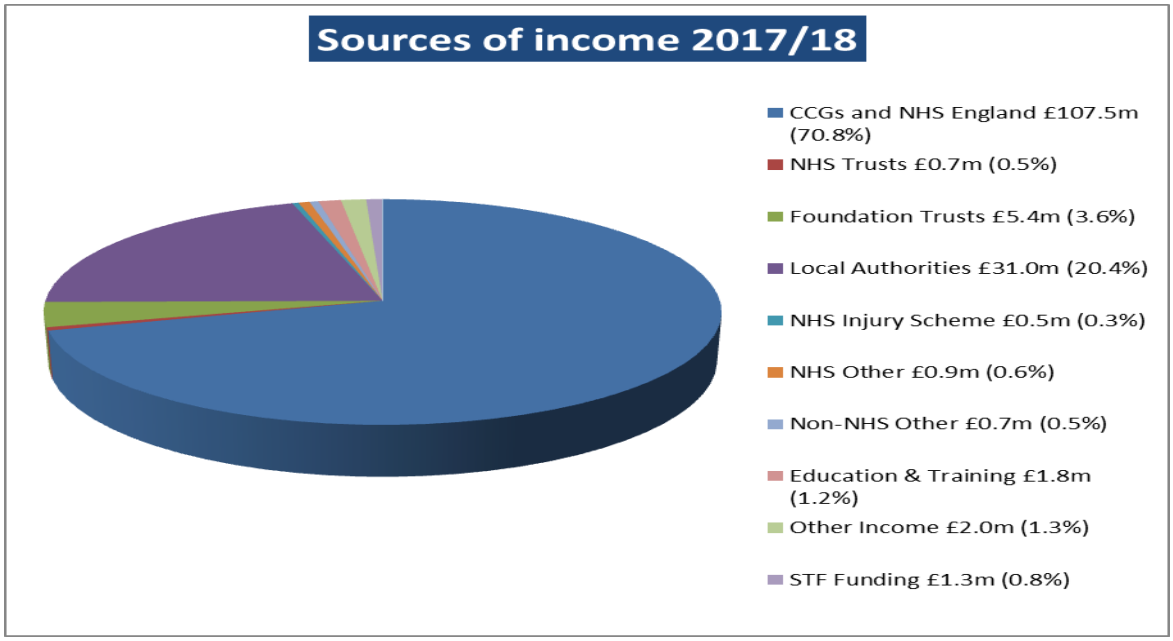
Capital Expenditure

The Trust incurred capital expenditure in 2017/18 of £3.5m, split between community home loan equipment £1.6m, IT investment and other schemes £1.9m.

Income

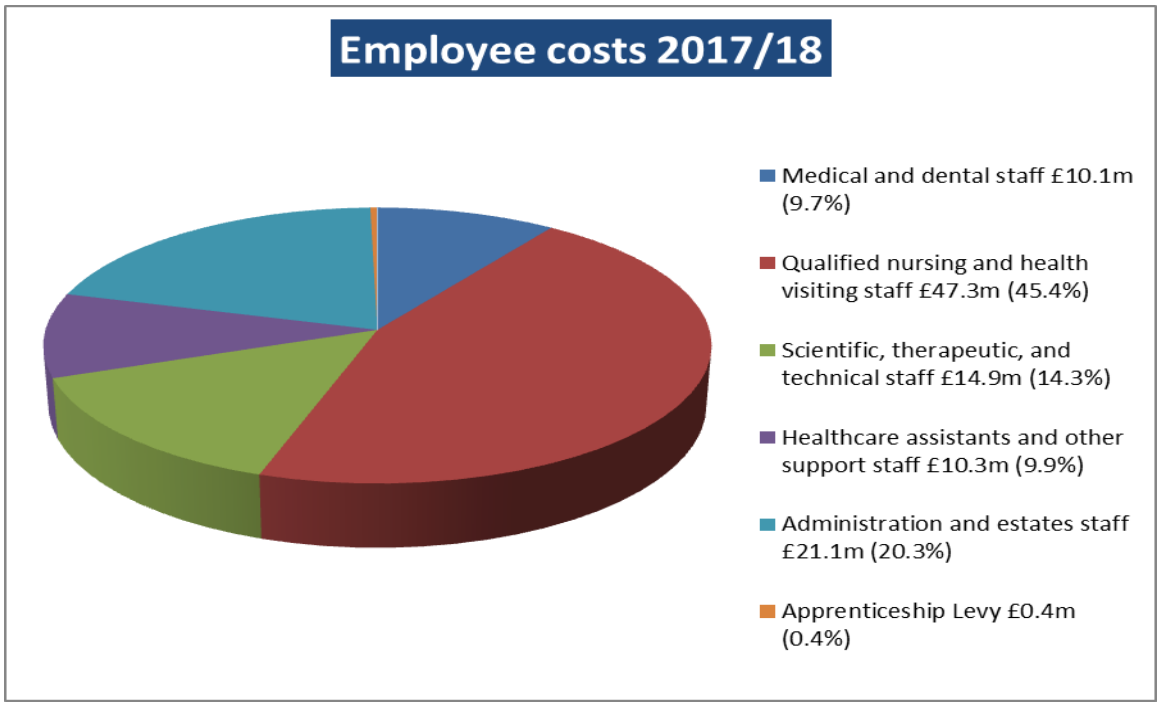
The Trust generated income in the accounting period of £151.8m. Income derived from Clinical Commissioning Groups (CCGs) and NHS England was £107.5m. The vast majority of the Trust's healthcare income is through 'block service level agreements'.

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.

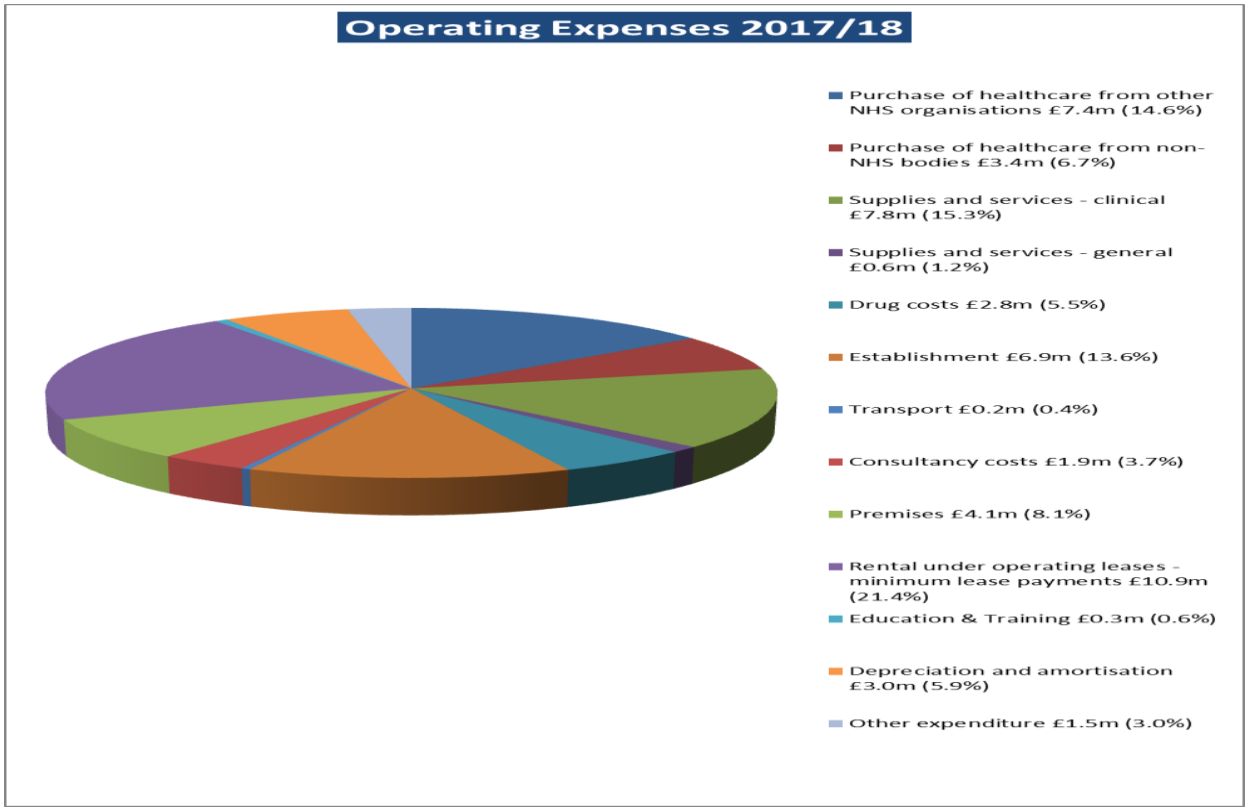


Expenditure

The Trust's main source of expenditure is Employee Costs (staff) totalling £104.1m representing 67% of total expenditure. The chart below highlights the breakdown of these costs.



Expenditure on Operating Expenses, excluding employee costs, amounted to £50.8m. 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

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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 reduced its Cost Improvement Programme (CIP) target for 2018/19 to 2% of operating expenditure in line with the recommendations of the report of the Liverpool Community Health Independent Review issued by Dr Kirkup in January 2018. 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.

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 the NHS Counter Fraud Authority's (NHSCFA) 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 the NHSCFA'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.

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. 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. 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.

The Trust's approach to environment and estates was refreshed in our strategy, *People and Place – Transforming Health Together* which looks towards 2021 and beyond. This approach acknowledges that property and the built environment play an important part in the delivery of high quality services in to the communities served by the Trust. The sustainability of the environment from which the Trust operates is a core principle, aligned to locality based operational and service delivery plan whilst developing the Trust's approach to agile working using information technology as an enabler to reduce the Trust's impact in terms of transport.

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.

In 2017/18 the Trust launched a new strategy for the next five years. Quality and Place has been developed in partnership with local communities and our healthcare partners in each borough.

The two key strategic priorities headlined in the strategy title demonstrate the Trust's commitment to providing high quality healthcare that is place based. The second priority, place, recognising the diverse communities and differing needs that we need to understand in order to achieve the first priority of high quality healthcare.

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 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 analysis and submission of Gender Pay Gap data
- 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 23 May 2018.

Accounting Officer Colin Scales (Chief Executive)

25 May 2018

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 2017 to 31 March 2018 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 also chairs the Nominations and Remuneration Committee.

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

On the 28 March 2018 Harry has announced his decision to retire from the role in June 2018. Arrangements have been commenced in the Trust in order to allow the Council of Governors to appoint a new Chairman to allow for a smooth transition.

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, Deputy Chief Executive

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 and was appointed Deputy Chief Executive from March 2018.

<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 current term of office runs until 31 March 2020.

Karen holds the position of 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.

Marian held the position of Chair of the Workforce and Organisational Development Committee from July 2017 until March 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 current term of office runs until 31 March 2020.

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 and left the Trust on 1 January 2018.

Qualifications

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

BA (Hons) Public Administration – University of Glamorgan

Wendy Hull –Interim Finance Director

Wendy Hull returned to the Trust in 2018 in the Interim Finance Director capacity for the period of time between 8 January 2018 until 23 February 2018.

Sue Hill – Director of Finance

Sue is a chartered accountant and started her career in the private sector at Spillers Foods Limited. She qualified with the Chartered Institute of Management Accountants in 1996 and also holds the Chartered Institute of Public Finance and Accountancy qualification.

Sue has a broad range of experience in both public and private sector finance and immediately prior to joining Bridgewater, Sue was Deputy Director of Finance at St Helens and Knowsley Teaching Hospitals NHS Trust. She has extensive private sector experience, in a diverse range of companies, including Marconi, United Biscuits and Barclays Bank.

Sue's interest in community services was prompted by personal experiences when a family member needed support at home and she is committed to supporting the quality and sustainability of the local clinical services we deliver.

Sue joined the Board of Bridgewater on 26th February 2018.

Qualifications

Chartered Institute of Management Accountants, 1996

Chartered Institute of Public Finance and Accountancy qualification

NHS Leadership Academy - Nye Bevan Programme 2016

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. Esther left the Trust on the 31st March 2018.

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

Lynne Carter - Interim Chief Nurse

Lynne has been Chief Nurse in acute, community and integrated providers and has also been Head of Governance and Chief Operating Officer. She has extensive experience in developing new roles in order to meet the changing needs of healthcare including Advanced Clinical Practitioners, Nursing Associates and Consultant Nurse and Therapists.

As an interim Lynne has delivered financial turnaround, safeguarding systems and new clinical pathways and is confident in all areas of leadership and management.

Lynne remains a committed clinician with a strong professional perspective and belief in supporting healthcare services which meet the needs of local populations.

Lynne joined the Trust on 23 March 2018 as an Interim Chief Nurse and was appointed in substantive role from the 1 May 2018.

Qualifications

Post Graduate Diploma Medical Law

Post Graduate Diploma Professional Studies in Management

BSc (Hons) Nursing Studies

Registered Nurse - Learning Disabilities

Registered Nurse - Adult

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.

Qualifications

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. Chris left the Trust on the 25 February 2018.

<u>Qualifications</u>

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 re-appointed to the Bridgewater Board in April 2013 and then retired from the role of Non-executive Director on the 31st March 2018.

Bob also held the position of Chair of the Quality and Safety Committee until his retirement.

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 and left the Trust on the 16 October 2017.

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

Dr David Lewis - Interim Medical Director

David acted as Interim Medical Director from 16 October 2017 to 30 April 2018.

Dr David Valentine – Medical Director

David joined the Trust on the 1 April 2018.

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 current term of office runs 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

The Board also benefits from regular attendance of non-voting members:

Caroline Williams – Interim Operations Director

Sharon Barber – Director of Adult Services for Wigan Borough

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. Deloitte LLP have provided a development programme focused on board impact and effectiveness. 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 2017/18, 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 2017/18 the Committee consisted of six Non-executive Directors, one of whom is the Chair.

The Committee has met on four occasions throughout the reporting period. The Chair, Maggie Pearson, 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 2017/18 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 17 internal audit reviews, covering both clinical and non-clinical systems and processes.

The detail of these audits is provided in the Annual Governance statement.

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.

External Audit

The Trust's external auditor, Price Waterhouse Cooper (PwC) attends the Audit committee on a regular basis and is able to meet in private with members of the committee throughout the year. The year-end external audit emphasises matters in relation to risks faced by the Trust, its use of resources, value for money, ability to continue as a going concerns and any areas of material uncertainty which the Audit Committee then uses to direct its work in the subsequent year.

The Annual Report and Accounts 2017/18 includes PwC's external audit opinion. The adverse conclusion around value for money and material uncertainty on going concern paragraph was discussed with the Audit Committee on 23 May 2018, and the committee noted the conclusions of PwC in this regard.

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	**64.1**
Further assurance services	**3.4**
Other services	**-**
Total	**67.5**

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

The Trust last undertook a tender exercise for external audit services in the autumn of 2016. This is therefore the second year end audit undertaken by PwC.

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 Chief Nurse. 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.

Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee provides assurance to the Board on the development, implementation and effectiveness of Workforce, Staff Engagement, Learning and Development and Organisational Development strategies.

The Committee's duties include assurance to the Board that the implementation of the 'people elements' of the organisational strategy to develop a clinically led, locality-based organisation is well designed and operating effectively.

The Committee enables the Board to obtain assurance that the Trust is compliant with all Human Resources, legal and regulatory requirements in line with the Trusts licence, employment legislation and best practice.

Well-led Framework

During 2017/18, the Trust commissioned an external partner to review it against NHSI's framework. Following a tender exercise, Deloitte LLP were appointed to undertake the review, which is ongoing at the time of this report.

In preparation for the Well-led review, the Trust is updating its self-assessment and is using the existing CQC action plan to ensure its services have due regard to the requirements of the framework. Regular updates on progress against the CQC requirements, including well-led are provided through the Quality and Safety Committee. Significant detail about the Trust's approach to supporting its leaders, as the precursor to being well-led is provided in the quality report.

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.

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 2017/18 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)	Vacancy	
Public: Ashton, Leigh and Wigan (3)	Rebecca Reece	1/11/16 to 31/10/19
Public: Ashton, Leigh and Wigan (4)	Dr Gary Young	28/10/15 to 27/10/18 (second term)
Public: Ashton, Leigh and Wigan (5)	Ken Griffiths	28/10/15 to 27/10/18
Public: Halton (6)	Diane McCormick	1/11/16 to 31/10/19 (second term)
Public: Halton (7)	Vacancy	
Public: Halton (8)	Vacancy	
Public: St Helens (9) and Lead Governor	Rita Chapman	1/11/16 to 31/10/19 (second term)
Public: St Helens (10)	Bill Harrison	1/11/16 to 31/10/19
Public: St Helens (11)	Canon Geoff Almond	28/10/15 to 27/10/18
Public St Helens (12)	Derek Maylor	28/10/15 to 27/10/18 (second term)
Public: Warrington (13)	Paul Mendeika	28/10/15 to 27/10/18
Public: Warrington (14)	Alan Guthrie	28/10/15 to 27/10/18

Public: Warrington (15)	Vacancy	
Public: Warrington (16)	Vacancy	
Community Dental (17)	Vacancy	
Rest of England (18)	Vacancy	
Staff: Registered Nurses and Midwives (19)	Fiona Bremner	1/11/16 to 31/10/19
Staff: Registered Nurses and Midwives (20)	Corina Casey Hardman	1/11/16 to 31/10/19 (second term)
Staff: Registered Nurses and Midwives (21)	Janet Rawlings	1/11/16 to 31/10/19
Staff: Allied health professionals/other registered healthcare professionals (22)	Steven Lowe	1/11/16 to 31/10/19 (second term)
Staff: Allied health professionals/other registered healthcare professionals (23)	Heulwen Sheldrick	Left the Trust on 3/12/17
Staff: Clinical Support Staff including Assistant Practitioners/ Healthcare assistants and trainee clinical staff (24)	Vacancy	
Staff: registered Medical practitioners (25)	Dr Deb Mandal	28/10/15 to 27/10/18
Staff: Registered dentists (26)	Vacancy	

Staff: Non-clinical support staff including managerial and administrative staff (27)	Dave Smith	1/11/16 to 31/10/19
Partner: Wigan (28)	Vacancy	
Partner: St Helens (29)	Marlene Quinn	14/10/13 to 13/10/19
Partner: Halton (30)	Cllr Geoff Zygadlo	19/05/16 to 13/10/19
Partner : Warrington (31)	Cllr Judith Guthrie	23/06/14 to 13/10/19
Partner: Higher Education (32)	Janette Gray	14/10/13 to 13/10/19
Partner: voluntary sector (33)	Alison Cullen	10/06/15 to 13/10/19

Council of Governors Tenures – narrative

(2) Vacancy – position previously held by John Prince (who also held the Lead Governor role) from 1/11/16 to 06/06/17

(9) Rita Chapman elected as Lead Governor from 19/07/17

(23) Vacancy – position previously held by Heulwen Sheldrick from 1/11/16 to 3/12/17

(28) Vacancy – Nigel Ash stood down as Partner Governor on 26/04/17

Governors can be contacted via a dedicated email address:

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

Non-Executive Directors routinely attend Council of Governors meetings and all Governors are routinely invited to attend to observe those meetings of the Board of Directors which are held in public. Executive Directors attend meetings of the Council of Governors by invitation only for specific agenda items. The agendas for these meetings are structured to enable Governors to ask questions of the Board of Directors and to hold the Non-Executive Directors to account for the performance of the Board.

Each Trust Board Committee (with the exception of the Nominations and Remuneration Committee) has a nominated Council of Governors attendee at each meeting, primarily to observe the performance of Non-Executive 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

This year our membership played an integral role in supporting the organisation to develop its strategy for the next five years: Quality and Place - Transforming health together. This engagement with our membership gives the Trust the opportunity to improve patient care by hearing what is important to them.

Over the course of the summer in 2017 we spoke to hundreds of people in the boroughs served by Bridgewater and asked what was important to them and how might Bridgewater better support them to live healthier lives.

Many of those we spoke to are public members of Bridgewater, living and working in the communities where we provide services. We also spoke to our staff to better understand how the organisation could better support them to deliver community services in the towns where they work.

Our membership is drawn from two constituencies:

Public constituency all those aged over 14 who live in the boroughs served by Bridgewater – many of our members are patients who use our services, their family, friends, carers and others are members of the public with a general interest in healthcare services. As at March 31, 2018 we had 9,293 public members.

Staff Constituency – this is open to all permanent members of staff – staff are given the option to opt – out- as of March 31, 2018 we had a total of 3,108 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 groups within the organisation:

- Nursing and midwifery
- Allied health professionals
- Medical
- Dental
- Non Clinical Support staff
- Clinical Support Staff

During the past year there has been significant focus on recruiting younger members to Bridgewater and understanding what's important to them when accessing health services.

Together with our colleagues from education we have attended recruitment fairs and have highlighted the many opportunities available to people within the NHS – both clinical and non-clinical.

Boosting the number of younger members has provided us with a great sounding board to test the water around a number of service developments and initiatives.

We have also taken the opportunity in the past 12 months to work very closely with our public and staff governor colleagues and have supported the organisation's presence at a number of public-facing events.

These events allow us to highlight the work we do in these boroughs and provide our staff with an opportunity to talk to patients/service users to find out what's working well and where we might make improvements.

Our governors have also played an important part in recruiting to senior posts within the organisation; including Non-Executive Directors and Director of Finance.

During the year we were sorry to say goodbye to our lead governor John Prince who has served the organisation since 2012. John who represented the Wigan borough was a

staunch advocate of community services and played a pivotal role in the development of our Council of Governors.

Following John's decision to retire Bridgewater held an election for a new lead governor. Rita Chapman, public governor for St Helens was duly elected and since her appointment in September, she has made a significant contribution to way in which our Council of Governors works.

Our Council comprised our public, staff and partner governors are primarily focused on representing the interests of their members. A significant amount of their time is spent talking with service users, colleagues, staff and partners.

At local Council meetings i.e. those held in the towns where we provide services, we focus on the key issues that are impacting on the quality of care we provide on those boroughs.

These borough specific meetings allow them to understand the challenges, pressures and opportunities within these towns. This knowledge is then used in discussions with their Bridgewater and commissioner colleagues to better understand how the organisation can respond and react to situations.

In the past 12 months we have heard how our staff have been actively supporting their colleagues in the hospitals to support the discharge of patients from hospital back into their homes. Our Walk in Centre staff have also been working above and beyond to provide our local communities with access to highly skilled professional healthcare 365 days a year.

This work has been widely recognised by our patients, our governors and colleagues. Below are just a few examples of the comments we have received during the past 12 months.

We have included comments from each of the boroughs served by Bridgewater including comments from users of our Health and Justice services.

Nurse… (name withheld) is the modern day Florence Nightingale; she has so much duty of care and is always concerned over all prisoners health, just so lovely. Nurses do care. This wonderful nurse always gets my full respect because she deserves it." – Health and Justice Service.

"Everyone is friendly and approachable, being with other children helps." Healthy School Service, Bolton.

"The dentists are really kind. They talk to the children all the way through the procedure in calm, soothing way." Community Dental.

"The staff were genuine people and the service was very good and accommodating." Halton RARS.

“Good manners and pleasant disposition and efficient. The nurse was great.” Walk in Centre, St Helens.

“Much better for me being at home and the nurses are very good to explain everything.” Community Intravenous Therapy Service, Warrington.

“Feel at ease and was able to ask questions. They gave me the confidence in the appliance and the person fitting it.” Surgical Appliances, Wigan.

Systems of Internal Control

As outlined in the previous section, the Board and its committees 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.

Ongoing assurance that the Board is sighted on its key strategic risks is provided in the Board Assurance Framework (BAF). The Board reviewed its use of the Board assurance frameworks as a key system of internal control at a seminar during quarter four. It is preparing for a Well-led review during 2017/18 and self-assessment is underway.

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.

	2017/18 Number	2017/18 £'000	2016/17 Number	2016/17 £'000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	30,649	37,083	28,017	30,353
Total Non-NHS Trade Invoices Paid Within Target	14,374	19,165	19,734	20,392
Percentage of Non-NHS Trade Invoices Paid Within Target	46.9	51.7	70.4	67.2
NHS Payables				
Total NHS Trade Invoices Paid in the Year	1,772	30,901	1,470	20,882
Total NHS Trade Invoices Paid Within Target	1,139	23,017	637	8,131
Percentage of NHS Trade Invoices Paid Within Target	64.3	74.5	43.3	38.9

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
- Appointments & Remuneration Committee
- Senior Remuneration Policy
- Non-executive Director Remuneration
- Salaries and Allowances – Table x 2
- Pay Multiples
- Exit Packages
- Service contracts
- 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 5 occasions between 1st April 2017 and the 31st March 2018.

During the period, the remuneration committee reviewed the salary levels of all directors against national comparators as a part of the appointment process following the departure of previous incumbents. In order to reflect the prevailing market conditions salary levels of Medical Director, Director of Finance and Chief Nurse were revised. The salary of the Director of the Strategic Development was reviewed to maintain parity with his peers. In addition the directors received 1% cost of living rise in line with the national VSM agreement.

Harry Holden

Chair

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 Chief Nurse 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 Council of Governors 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 to 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.

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.

As outlined above, salary levels of the directors have been reviewed in year. The Trust is required to explain the steps taken to ensure remuneration is reasonable where one or more senior managers are paid more than £150,000. The CEO's salary is the only one greater than £150,000. The Remuneration Committee considered the market rates using NHS Providers Annual Remuneration survey to provide benchmarking information, prompted by the need to recruit new directors, but extended to ensure parity between those already in post and newly appointed staff.

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 Trust's 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 £6,400 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: £12,926 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 2017 to 31 March 2018.

Governor and Director Expenses

During the reporting period, a total of 2 governors claimed a total of £901 in expenses. A total of 7 directors claimed a total of £24,870 in expenses.

Salaries and Allowances

Period from 1 April 2017 to 31 March 2018.
(The following table has been subject to audit)

Directors

	Salary at 31.3.2018	Taxable benefits at 31.3.2018	Performance pay and bonuses at 31.3.2018	Long term performance pay and bonuses at 31.3.2018	All pension-related benefits at 31.3.2018 (1)	TOTAL at 31.3.2018
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	40-45	0	0	0	N/a	40-45
Colin Scales Chief Executive	155-160	6	0	0	32.5-35	185-190
Christine Samosa Deputy Chief Executive Executive Director of People, and Organisational Development In post from 1/4/17 to 25/2/18	95-100	0	0	0	5-7.5	100-105
Esther Kirby Chief Nurse and	105-110	0	0	0	5-7.5	110-115

Director of Quality In post to 31/3/18						
Caroline Williams Associate Director of Operations - Children	90-95	0	0	0	17.5-20	105-110
Carole Hugall Associate Director of Operations - Adult In post from 1/4/17 to 8/5/17	5-10	0	0	0	5-7.5	10-15
Michael Barker Executive Director of Strategic Development	105-110	0	0	0	20-22.5	125-130
Gareth Davies Executive Director of Finance In post from 1/4/17 to 1/1/18	80-85	50	0	0	22.5-25	110-115
Karen Slade Medical Director In post from 1/4/17 to 16/10/17	60-65	0	0	0	0	60-65
David Lewis Medical Director In post from 1/10/17 to 31/3/18	25-30	0	0	0	0	25-30
Wendy Hull Interim Executive Director of Finance In post from 2/1/18 to 25/2/18	20-25	0	0	0	0	20-25
Sue Hill Executive Director of Finance In post from 26/2/18	10-15	0	0	0	37.5-40.0	45-50
Bob Saunders Non-Executive Director	10-15	0	0	0	N/a	10-15
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 Director's Remuneration (£'000s)		155-160				
Median Total Remuneration (£)		22,161				
Ratio		6.9				

All of the above Directors were in post for the year ended 31 March 2018 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 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 Non-Executive Director	10-15	0	0	0	N/a	10-15
Karen Bliss	10-15	0	0	0	N/a	10-15

Non-Executive Director						
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 Director's Remuneration (£'000s)		150-155				
Median Total Remuneration (£)		22,683				
Ratio		6.7				

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

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 2018 was £152,500. This was 6.7 times the median remuneration of the workforce which was £22,683 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 2018 there were no exit packages.

Service Contracts

Name and Job Title	Date appointed to Trust Board	Tenure	Notice Period	Left the Trust
Colin Scales, Chief Executive Officer	1 November 2014*	Permanent	6 months	N/A
Christine Samosa, Director of People and Organisational Development, Deputy Chief Executive	1 November 2014*	Permanent	6 months	25 February 2018
Gareth Davies, Director of Finance	1 February 2016	Permanent	6 months	1 January 2018
Karen Slade, Medical Director	17 March 2016	Permanent	6 months	16 October 2017
Esther Kirby, Director of Quality and Chief Nurse	1 April 2015	Permanent	6 months	31 March 2018
Mike Barker, Director of Strategy	24 October 2015	Permanent	6 months	N/A
Dr David Lewis, Interim Medical Director	16 October 2017	Temporary	N/A	30 April 2018
Dr David Valentine	1 April 2018	Permanent	6 months	N/A
Wendy Hull, Interim Finance Director	8 January 2018	Temporary	N/A	23 February 2018
Lynne Carter, Chief Nurse	23 March 2018 as an Interim Chief Nurse and was appointed in substantive role from the 1 May 2018	Permanent	6 months	N/A
Sue Hill, Director of Finance	26 February 2018	Permanent	6 months	N/A
Caroline Williams, Associate Director of	1 April 2015	Permanent	6 months	N/A

Operations				
Carole Hugall, Associate Director of Operations	1 August 2015	Permanent	6 months	Currently on secondment to another NHS organisation from 1 October 2017

*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 2017 to 31 March 2018
(the following table has been subject to audit)

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 2018	Lump sum at pensionable age related to accrued pension at 31 March 2018	Cash Equivalent Transfer Value at 1 April 2017	Cash Equivalent Transfer Value at 31 March 2018	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	30-35	70-75	408	466	53
Christine Samosa Deputy Chief Executive Director of People and Organisational Development In post from 01/03/17 to 25/2/18	0-2.5	0-2.5	45-50	140-145	889	968	63
Esther Kirby Chief Nurse and Director of Quality In post to 31/3/18	0-2.5	2.5-5	40-45	125-130	833	904	63
Caroline Williams Interim Director of Operations	0-2.5	0	20-25	50-55	272	307	33

Carole Hugall Associate Director of Operations - Adult In post to 8/5/17	0-2.5	0-2.5	30-35	90-95	567	620	5
Michael Barker Director of Strategy	0-2.5	0	15-20	35-40	205	237	30
Gareth Davies Director of Finance In post to 1/1/18	0-2.5	0	5-10	0	77	95	13
Karen Slade Medical Director In post to 16/10/17	0	0	20-25	50-55	415	325	0
Sue Hill Director of Finance In post from 26/2/18	0-2.5	0	5-10	0	77	101	2

There are no entries in respect of pensions for both David Lewis and Wendy Hull as neither contribute to the NHS pension scheme.

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 **25 May 2018**

3.3 Staff Report

Staff Analysis

As at 31 March 2018 (Actual FTE and Headcount as at 31st March 2018), Bridgewater employed staff 2972 (2483.26 FTE), the majority of whom are clinically trained, including district nurses, health visitors, specialist nurses, occupational therapists, speech and language therapists, physiotherapists and Clinical Admin. Our staff numbers by staff group is as follows:

Staff Group	FTE	Headcount
Add Prof Scientific and Technic	62.54	75
Additional Clinical Services	350.77	433
Administrative and Clerical	660.17	778
Allied Health Professionals	326.67	392
Estates and Ancillary	7.77	9
Healthcare Scientists	10.73	13
Medical and Dental	60.87	91
Nursing and Midwifery Registered	1003.73	1181
Total	2483.26	2972

Of these staff, 2,954 people (2,390.83 WTE) have a permanent contract of employment and 114 people (88.43 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	2.58	2	2.00
Other Senior Managers	22	23.10	88	84.18
Employees	240	219.33	2611	2152.07
Total	265	245.01	2701	2238.25

The sickness absence rate for the Trust for this period was 5.46%. This equates to a Long Term Sickness Absence rate as 4.20% and Short Term Sickness Absence rate as 1.26%.

The top three reasons for sickness absence are stress/anxiety (30.03%), other musculoskeletal problems (7.60%) and back problems (4.90%).

Audited staff cost

			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	79,433	1,714	**81,147**	85,082
Social security costs	6,927	218	**7,145**	7,621
Apprenticeship levy	377	9	**386**	-
Employer's contributions to NHS pensions	10,080	276	**10,356**	11,126
Temporary staff		5,595	**5,595**	7,083
Total gross staff costs	**96,817**	**7,812**	**104,629**	**110,912**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**96,817**	**7,812**	**104,629**	**110,912**
Of which				
Costs capitalised as part of assets	548	-	**548**	442

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 2018.

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, the NHS 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. Day to day work on equality and inclusion is the responsibility of the Equality & Inclusion Officer who provides assurance to Board of equality compliance via the internal committee structure. Board level responsibility for equality sits with the Chief Executive Officer.

In 2017, to meet our legal and contractual duties and to further promote equality, diversity and inclusion in the Trust our work has included:

- Progression to becoming a Disability Confident Employer
- Renewal of our commitment to address mental health stigma and barriers to employment as a Mindful Employer for a further three years
- Committing to the Working Forward campaign
- Continuing to implement the NHS Accessible Information Standard across the Trust
- Introduction of a new Equal Opportunities Policy, replacing the previous Equality Statement
- Introduction of a new Equality Impact Assessment Policy and Toolkit
- Successful application to the Navajo Charter Mark for LGBT people - with external assessment to begin in early 2018
- Publishing of our first Gender Pay Gap report
- Publishing of our annual EDS2 grading, and work on a new EDS2 project with partners in Merseyside and Cheshire
- Publishing of our annual WRES report and action plan
- Publishing of our Equality & Inclusion Annual Report

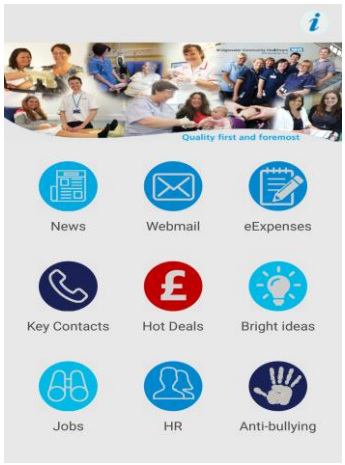
We have a number of actions planned for 2018/19 including roll out of a new equality analysis of all services and the start of a new project to provide access information for each clinic venue on the website. Work in the coming year will be very much influenced by the results of our Navajo assessment, the Equality Objectives determined by our work with our partners in EDS2, the results of our WRES and preliminary WDES (Workforce Disability Equality Standard) work, and the results of our Gender Pay Gap reporting in March 2018.

More information on equality, diversity and inclusion within Bridgewater, including contact details, can be found on our website.

Employee Engagement

The Staff Engagement Strategy 2017-2020 was launched in March 2017 and is monitored by the Staff Engagement Strategy Steering Group; who meet monthly. Since its launch, all of the objectives set have been achieved and Staff Engagement Champions throughout the Trust also support this agenda. There are 73 champions in total who all receive gold lanyards and personal development opportunities.

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 Brief presentation from the Chief Executive to senior managers which is designed to be cascaded throughout the organisation by managers and team leaders. This contains key messages to keep staff informed on new developments, performance (including HR performance measures, financial and quality performance). Staff have the opportunity to ask questions during the briefing session. 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'.



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. Directors also share updates on key achievements and priorities through regular blogs and the Bridgewater 'Friday message'. The Chief Executive has also used video messages for staff to communicate key messages.

During the year the Trust launched a staff mobile application (Staff App) to allow staff who are working out in the community to access key contacts, information and news. By the end of the financial year more than 800 staff had downloaded it and initial feedback has been overwhelmingly positive.

Director staff engagement visits occur monthly and in all boroughs. They enable staff to meet members of the Executive Team to showcase the services they deliver and discuss what it is like to work for the Trust. During these visits, the directors also observe treatments delivered to patients by staff in the community.

During the year the Trust held a series of staff and public engagement sessions in all boroughs which contributed to the development of the Trust's strategy, *Quality and Place: Transforming Healthcare Together*.

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

Big Conversation events are held across the Trust and allow staff to suggest improvements in their area of work and/or location. In 2017, all Health Visiting teams and staff in the boroughs of Halton, Oldham, Wigan and Warrington, had the opportunity to take part in Big Conversations either by attending events or via surveys. The staff suggestions have been disseminated to all staff engagement champions and local LiA groups as well as reported to the LiA trust sponsor group and staff engagement strategy steering group for action.

A Pulse Check is a 15 item questionnaire that is also disseminated to staff in all boroughs. It was undertaken in September 2017 by 660 staff and again in March 2018 by 360 staff. The results are published on the Trust's intranet for all staff to view. Although the response rate has dropped, the results improved throughout the whole metrics in March.

In addition to the direct engagement work with staff, bespoke development programs are delivered internally to strengthen staff relationships and allow time for employees to explore their values and behaviours to drive the cultural change that is necessary to equip the Trust to face the challenges of the future.

These programmes include:

- Our bespoke ILM accredited Leadership Development Programme.
- Delivery of the FranklinCovey 'Leading at the Speed of Trust' Programme which supports managers to build trust within teams.
- Our values and behaviour based PDR framework that focuses on: individual wellbeing, your role, behaviours, the individual fit and impact within the organisation; to identify development and training needs.

- The development and implementation of a Talent Management strategy linked to succession planning
- The delivery of a 7 Habits of Highly effective people programme which commenced Q3 2017. The aim of the programme is for staff to explore their own personal effectiveness and build effective relationships
- To continue to offer staff a suite of appropriate change management tools
- Rolling out our System leadership program, developed following a successful bid for funding from the North West Leadership Academy

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 innovate 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 287 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 which is held in September each year. This is held as a daytime event and combined with our Annual General Meeting to encourage greater participation in the latter by our staff. At the 2017 event more than 136 governors and partners attended the event at Haydock Park Racecourse.

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 regular basis and this is discussed at Finance, Workforce and Performance meetings.

Health and wellbeing data is also available in the integrated performance report.

In a snapshot, within the last financial year the Health and Safety team have undertaken the following:

- Fire Risk Assessments in 15 Freehold sites and 4 leasehold sites – reports generated and action plans produced
- New Fire Management Plan Template
- New Personal Emergency Evacuation Plan (PEEPS) documents
- Building Health and Safety Risk Assessments - 15 Freehold sites and 4 leasehold sites – reports generated and action plans produced
- Health, Safety, Fire and Security Group meetings – 3 per year
- Security Report
- Newsletter: Safe & Secure
- Performance with regards to NHSPROTECT 'Security Standards' and 'Self Review Tool (SRT)
- New Management of Lone Working Procedure
- Review of Conflict Resolution Training (CRT) as per core skills requirements standards
- Assistance/facilitate with Counter Terrorism Training

Guidance and support to managers has been provided throughout the year.

Staff Survey

The Trust takes part in the national annual NHS staff survey, and this year received a response rate of 44%. 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 2017 score very slightly deteriorated by 0.05 in comparison to 2016 from 3.73 to 3.62. 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

The key findings are grouped. There are nine 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

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 and is monitored at the Workforce & Organisational Committee that was established in September 2017. The Committee reports to the Trust's Board.

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	**2016**		**2017**		**Trust Improvement/ Deterioration**
	Trust	National Average	Trust	National Average	
*KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	6%	7%	5%	8%	1% improvement
*KF28: Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month	18%	20%	18%	21%	Same
*KF16: Percentage of staff working extra hours	67%	71%	69%	72%	2% deterioration
***KF15: Percentage of staff with opportunities for flexible working patterns.	56%	57%	60%	57%	4% improvement
***KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	90%	90%	88%	88%	2% deterioration

* 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	2016		2017		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
***KF11: Percentage of staff appraised in the last 12 months	87%	89%	80%	91%	7% deterioration
**KF19: Organisation and management interest in and action on health and wellbeing	3.57	3.69	3.55	3.75	0.02 deterioration
***KF6: Percentage of staff reporting good communication between senior management and staff	23%	36%	24%	32%	1% improvement
***KF24: Percentage of staff/colleagues reporting most recent experience of violence	58%	72%	64%	76%	6% improvement
***KF29: Percentage of staff reporting errors, near misses or incident witnessed in the last month	92%	92%	89%	93%	3% 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 will be developed 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	2016	2017	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%	20%	19%	15%
KF21: percentage of staff believing that the trust provides equal opportunities for career progression or promotion *(The higher the score the better)*	90%	88%	88%	92%

KF26 has improved by 3% and is slightly above the national average for community trust response rates. KF21 has deteriorated by 2% since 2016 but remains in line with the national average for community trusts.

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.

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
- 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
- Personal Development Reviews (PDR) – a review of the process has been carried out and a new approach called MY SPACE was launched in September 2017. PDR compliance remains a key focus as does the monitoring of the same

This will be reviewed by the Trust on a regular basis, including:

- Bi monthly Workforce & Organisational Development Committee Meetings
- Bi monthly Corporate Partnership Forums, comprising of Executives, Senior Management and Staff-side colleagues
- Monthly Finance, Workforce & Performance Meetings
- Quarterly reviews with the Executive Management Team (EMT)
- Quarterly reviews with our respective CCGs

Expenditure on consultancy

The Trust spent £1.9m on Consultancy, of which £1.0m was in relation to the Financial Improvement Programme undertaken with NHS Improvement and service improvement within Health and Justice.

Off-payroll engagements

The Trust had the following off-payroll engagements as at 31 March 2018, for more than £245 per day that last longer than six months.

No. of Existing engagements as of 31 March 2018	60
Of Which…	
No. that have existed for less than one year at time of reporting	1
No. that have existed between one & two years at time of reporting	10
No. that have existed between two & three years at time of reporting	9
No. that have existed between three & four years at time of reporting	23
No. that have existed for four or more years at time of reporting	17

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 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months:

No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	1
Of Which…	
No. Assessed as caught by IR35	
No. Assessed as not caught by IR35	1
No. Engaged directly (Via PSC contracted to department) and are on the departmental payroll	
No. of engagements reassessed for consistency / assurance purposes during the year	1
No. of engagements that saw a change to IR35 status following the consistency review	

Off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year. (1)	1

No. of individuals that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both off-payroll and on-payroll engagements. (2)	1

Exit packages

There were no exit packages paid during 2017/18.

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.

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 took advantage of the FIP2 (Financial Improvement Programme Wave 2) during 2017/18.

This segmentation information is the Trust's position as at 3 May 2018. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHSI website.

Finance and use of resources

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	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	4	1	4	1	1	1
	Liquidity	1	2	2	2	2	3
Financial efficiency	I&E margin	4	4	4	4	2	3
Financial controls	Distance from financial plan	3	1	1	1	1	2
	Agency spend	3	2	2	2	3	3
Overall scoring		**3**	**3**	**3**	**3**	**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 23 May 2018.

Accounting Officer Colin Scales (Chief Executive)

Date 25 May 2018

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 2018 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 2018/19 The Nomination and Remuneration Committee of the Board oversees the outcome of these meetings.

As set out in the Risk Management Policy, the Chief Nurse 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.

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. He is the designated Chair of the Information Governance Group and the Chair of the Clinical Governance Sub-committee (CGSC) 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 Serious Incident Review Panel (SIRP - monitoring serious incidents) and the vice-chair CGSC 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 Executive Lead for Safeguarding.

During 2017/18 the Director of Operations and the Director of Community Services (Wigan) have ensured a focus on their respective boroughs, both in terms of service delivery and the needs of the commissioners. Their monthly Operations and Performance meetings received reports and offered leadership on incidents and risk issues within those services. These two overarching directorate teams explain any exceptions and describe the planned responses in the Integrated Performance Report (IPR) received by the Board.

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.

Lessons Learned were identified by the SIRP 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 Director of Operations and Director of Community Services via the QSSGs and the Operations and Performance meetings which then escalated exceptions to CGSC (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, ensures that all related policies and guidance have been reviewed and updated in line with the Data Protection changes under GDPR (General Data Protection Regulation). 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. The 2017/18 toolkit was audited and 'significant assurance' was given. 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 CGSC 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 Operations and Performance meetings and the CGSC.

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 CGSC. Services are subject to objective visits by managers and findings collated for the Operations and Performance meetings 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 Quality and Safety sub-groups with any significant issues escalating to the Operation and performance meetings and the CGSC and the Quality and Safety Committee (with strategic risks) for assurance.

During 2017/18 the Trust recognised the most routinely reported significant operational risks likely to remain the focus of treatment during 2018/19 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 2017/18 as follows:
  - If the operational Run Rate exceeds resources and impacts on forecast outturn position, it may lead to impact on overall financial position, increased impact on cash position, impact on service delivery
  - If the non-pay expenditure exceeds resource it may lead to impact on the financial position, impact on cash balances, impact on CIP programme, impact on risk rating
  - If the CIP / Efficiency programme is not delivered it may impact on financial position, impact on cash balances, impact on CIP programme, impact on risk rating
  - If there is a worsening of working capital balances leading to minimal cash balances it may lead to failure to make payments, potential cessation of deliveries, potential clinical risk, reputational damage, impact on risk rating

Actions and controls to mitigate the above risks include:

- Development and implementation of 'Service Line reporting' to facilitate contract management by commissioner.
- Monthly Reports to F&I committee include :-
  - Financial Position
  - Forecast Position
  - Top 25 overspending cost centres
  - Top 25 Agency spend
  - Cash Committee Report
  - Capital report (quarterly)
  - TIF report (inc. minutes)
- Monthly Cash Committee
- Weekly Aged Debt Review meetings
- Monthly review of CIP performance at Management Team
- Directorate governance structure established – finance resource aligned to services

- Contractual invoices raised in advance to allow for prompt payment. All contractual payment terms reflected in invoice process.
- Agency management through a single engagement provider
- Approval and authorisation levels reviewed and amended within the revised Standard financial Instructions and Standing Orders – Regular reviews set up to ensure SFI are fit for purpose
- Executive and directorate performance meetings
- Clinical attendance at contractual finance meeting
- Detailed cash flows and forecasts are reviewed on a regular basis to manage working balances.
- CIP schemes for 2018/19 currently being developed.

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 Significant Risks (15)
- 7 risks scoring High (12)
- 1 risk scoring Medium (9)
- 0 risk scoring Low (4 to 6)
- 0 risks scoring Very Low (1 to 3)

Risks scoring Significant (15):

Failure to deliver safe and effective patient care. There is a risk that the Trust may be unable to achieve and maintain the required levels of safe and effective patient care; this could be caused by inadequate clinical practice and/or ineffective governance. If this were to happen it may result in widespread instances of avoidable patient harm, this in turn could lead to regulatory intervention and adverse publicity that damages the Trust's reputation and could affect CQC registration.

Staffing levels If the Trust fails to have an appropriately resourced, focused, resilient workforce in place that meets service requirements; Caused by an inability to recruit, retain and/or appropriately deploy a workforce with the necessary skills and experience; It may

result in extended unplanned service closure and disruption to services across divisions, leading to poor clinical outcomes & experience for large numbers of patients; failure to achieve constitutional standards; unmanageable staff workloads; and increased costs.

Risks scoring High (12)

Failure to implement and maintain sound systems of Corporate Governance. If the Trust is unable to put in place and maintain effective corporate governance structures and processes; Caused by insufficient or inadequate resources and / or fundamental structural or process issues; It may result in sustained failure to achieve constitutional standards; disruption to multiple services; reduced quality of care for patients; unmanageable staff workloads; increased costs and regulatory sanctions.

Managing demand & capacity If the Trust is unable to manage the level of demand; Caused by insufficient resources and / or fundamental process issues; It may result in sustained failure to achieve constitutional standards in relation to access; substantial delays to the treatment of multiple patients; increased costs; financial penalties; unmanageable staff workloads; and possible breach of license.

Financial sustainability If the Trust is unable to achieve and maintain financial sustainability; Caused by the scale of any deficit and the effectiveness of plans to reduce it;
It may result in widespread loss of public and stakeholder confidence with the potential for regulatory action such as parliamentary intervention, special administration or suspension of CQC registration. The Trust's FT licence requires 'that it shall at all times act in a manner calculated to secure that it has or has access to the Required Resources' so failure to do so would lead to breach of licence.

Organisational sustainability (a) If the Trust fails to effectively manage key relationships; Caused by a failure to identify and understand the needs of key stakeholders and commissioners; It may result in the loss of existing contracts or a failure to win new business.

Organisational sustainability (b) If the Trust fails to adapt and respond competitively to changes in the market place; Caused by a failure to identify and understand the risks within current or potential service developments and or a lack of an appropriate level of due diligence being undertaken; It may result in the loss of existing contracts, a failure to win new business and or taking on business at unsustainable margins.

Organisational sustainability(c) If the Trust fails to effectively integrate new services; Caused by a lack of planning and or understanding of service requirements; It may result in

the new service failing to deliver effectively and or efficiently resulting in patient harm and or increased costs.

IM&T systems which do not meet the requirements of the organisation If the Trust's fails to maintain IT systems which meet the needs of users in a secure, effective and efficient manner; Caused by a lack of investment, poor IT strategy or lack of suitably qualified and experienced staff; It may result in the failure of the IT systems resulting in a lack of access to patient records by front line staff with poor standards of care delivered as a result and or lack of sufficiently robust information on which to make informed decisions

Remaining risk not prioritised as Significant or High but remaining under review during the year and as a foundation for considering the 2018/19 Strategic Risks:

Staff engagement & morale If the Trust loses the engagement of a substantial proportion of its workforce; Caused by ineffective leadership or inadequate management practice; It may result in low staff morale, leading to poor outcomes & experience for large numbers of patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover.

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 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 and committee 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, local authorities 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 2017/18 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 17/18 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 undertakes a range of engagement with its stakeholders, through Governors, 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 Executive Management 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 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 is 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 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. For serious incidents, the Head of Risk and Patient Safety completes a Directors' notification for the Board.

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 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.

As reported in last year's annual report, the Trust was subject to a full announced inspection by the CQC during 2016/17. The full report was published in February 2017 and gave the Trust a rating of Requires Improvement. During 2017/18, the Trust has worked to deliver its action plans in place against each of the recommendations made and expected a further visits to re-inspect areas identified in the report. Changes in the CQC's approach to inspection means that this has not yet taken place and so the rating remains 'requires improvement' at the end of 2017/18.

During quarter four of 2017/18, the Trust sought a partner to support its Well-led assessment and appointed Deloitte LLP to work with the Trust. Work is ongoing at the time of writing on this review. In addition, the Trust has just received its provider information request from the CQC, indicating that it will receive its Well-led inspection in the coming months.

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. In 2017/18, the Trust asked to take part of NHSI's Financial Improvement Programme (FIP2) as a response to the news, received in late March 2017 that the Liverpool Community Healthcare transaction, the basis for the Trust's plans for 17/18 was not going to progress. This effectively meant that the Trust was not able to finalise its efficiency savings plans until well into 2017/18. KPMG were appointed by NHSI as the Trust's FIP2 partner and supported the process of finding possible savings schemes. The Transformation, Innovation and Improvement group oversaw the identification and delivery of the identified £7.5m CIP programmes, of which £4.5m was finally delivered. The majority of the remaining schemes were not able to be delivered due to the timescales and many feature in the 18/19 programme 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 benefited from the best available rates for the staff it required. During 2017/18, a review of the Committee Structure of the Trust introduced a Workforce and Organisational development Committee to provide the necessary oversight of this important area of work.

Whilst the Finance & Investment Committee provided assurance to the Board from a financial stand 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	2017/18 scores				2016/17 scores	
		Q4	Q3	Q2	Q1	Q4	Q3
Financial sustainability	Capital service capacity	4	1	4	1	1	1
	Liquidity	1	2	2	2	2	3
Financial efficiency	I&E margin	4	4	4	4	2	3
Financial controls	Distance from financial plan	3	1	1	1	1	2
	Agency spend	3	2	2	2	3	3
Overall scoring		**3**	**3**	**3**	**3**	**2**	**2**

Information governance

Bridgewater Community Healthcare NHS Foundation Trust Information Governance Assessment Report for 2017/18 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 2018 to evaluate and validate the Trust's self-assessed scores. The final report from Mersey Internal Audit Agency granted the Trust "Significant Assurance".

The GDPR (General Data Protection Regulation) has resulted in significant changes in Data Protection law. The Trust has been working towards ensuring compliance and has full Board buy-in to the changes. The Information Governance Subgroup, which is chaired by the Caldicott Guardian and has the Senior Information Risk Owner (SIRO) as a member, is overseeing and monitoring the changes required. The Head of Information Governance has been appointed the statutory role of Data Protection Officer.

There were three information governance serious incidents during 2017/18 that required reporting to the Information Commissioner's Office, all incidents were reported within the 72 hours timeframe, they were:

- The Trust was subject to the national ransomware attack
- A member of staff was subject to a burglary and Trust devices were stolen . The electronic devices were fully encrypted and properly closed down, so could be remotely wiped. We know there was one attempt to access laptop but, due to the encryption, this was unsuccessful, and
- A diary containing patient information was lost during a house move

The incidents were investigated by the Information Commissioner's Office and closed with no further action. The ransomware attack resulted in no information loss or compromise and the devices stolen during the burglary were fully encrypted so no information was lost or compromised. It was the Commissioner's opinion that the Trust acted appropriately on all occasions with good policies and processes already in place. A number of actions have been completed following the incidents, these included a review and update of internal processes following a ransomware attack, a review how information is stored in nurse's diaries and a communications plan internally to ensure these changes have been cascaded appropriately.

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 2017/18. 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 the quality and safety committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

During the year, the audit committee 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. During 2017/18, the Trust Board and the executive team commenced an externally facilitated development programme with the focus on the behaviours required in a unitary board, the characteristics of boards that make a difference and a review of board member roles and responsibilities as a whole and the impact of individual contributions. All Board members have an appraisal with the Chair or Chief Executive, the results of which are reported to the Remuneration Committee or the Governors' Nominations Committee. 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 2017/18 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 that 'Moderate Assurance, can be given that there is an adequate system of internal control, however, in some areas weaknesses in design and/or inconsistent application of controls puts the achievement of some of the organisation's objectives at risk. The overall opinion is underpinned by the work conducted through the risk based internal audit plan, including Key Financial Systems, payroll, IT Service Continuity, Health Records Management and Governor Effectiveness.

This opinion is provided in the context that the Board like other organisations across the NHS is facing a number of challenging issues and wider organisational factors.'

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 17 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**
Corporate Performance reporting	Limited assurance
Duty of Candour	Limited assurance
IT Service Continuity	Limited assurance
Health Records Management	Limited assurance
School nursing follow up report	Limited assurance
Payroll	Limited assurance
Governor effectiveness	Limited assurance
District nurse care planning follow up	Limited assurance
Information Governance Toolkit	Significant assurance
Business Development processes	Significant assurance
Key Financial Systems	Significant assurance
Health visitor record quality	Significant assurance

Consultant job planning	Significant assurance
Recruitment and Vacancy Management	Significant assurance
IT Third party contracts	Significant assurance
End of Life Care	Significant assurance
Assurance Framework briefing note	NHS requirements met

In addition, there are five reviews that will conclude early in 2018/19:

CQC Action plan

Risk Management

Attendance management

AHP Revalidation

Falls risk assessment

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

These audits were all supplied to the Audit Committee for oversight and to provide assurance. Individual committees take responsibility for tracking progress against recommendations and action plans. The Audit Committee and the Quality and Safety Committee were also in receipt of the progress of Clinical Audit programmes across the trust.

The Trust takes the view that Internal Audit is a key management tool for improvement and therefore consciously asks its auditors to review areas where it is aware it can benefit from advice or recommendations relating to good practice from elsewhere. All audits carry responses to any risks identified in internal audits. Those receiving Limited assurance and carrying outstanding high risk recommendations are shown below, with responses as follows: -

Corporate Performance reporting – reporting timescales and infrastructure to be revisited in line with the availability of the wider data set and the required board assurance process and the service line reporting work stream will continue to ensure the organisation can ultimately report at team level.

Health Records Management – clinical managers will be required to review a different records standard each month to ensure compliance. A communications plan will be developed and implemented. Standard operating procedures will be developed within services, incorporating password review. Tracking and tracing procedures to be reviewed and put into place with regular audits. Staff will be reminded of the importance of incident reporting. Mandatory training compliance actions being undertaken.

The Trust's external auditor, Price Waterhouse Cooper (PwC) attends the Audit committee on a regular basis and is able to meet in private with members of the committee throughout the year. The year-end external audit emphasises matters in relation to risks faced by the Trust, its use of resources, value for money, ability to continue as a going concerns and any areas of material uncertainty which the Audit Committee then uses to direct its work in the subsequent year.

The Annual Report and Accounts 2017/18 includes PwC's external audit opinion. The adverse conclusion around value for money and material uncertainty on going concern paragraph was discussed with the Audit Committee on 23 May 2018, and the committee noted the conclusions of PwC in this regard.

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' were addressed in 2016/17 and although the Trust expected the follow-up inspection during 2017/18 this did not occur and so the entire action plan has evolved and continues to be addressed in preparation for an expected re-inspection in 2018/19. 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: 25 May 2018

Bridgewater Community Healthcare
NHS Foundation Trust

4. Quality Report 2017/18

Quality first and foremost

Contents of the Quality Report

PART ONE

Quality first and foremost

Part 1 - Statement on Quality by Chief Executive

Bridgewater Community Healthcare NHS Foundation Trust has focused on delivering quality first and foremost during 2017/18. 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.

Our strategic objectives make clear our aspiration to:

- Deliver high quality, safe and effective care which meets both individual and community needs.
- Deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living.
- Deliver value for money, be financially and be commercially successful.
- Be a highly effective organisation with empowered, highly skilled and competent staff.

As a foundation trust we want to contribute to a wide-ranging programme of change that sees health, quality and care pathways co-ordinated across different providers and levels of care with a far greater focus on wellness, early intervention and prevention.

Our ethos is Quality first and foremost; our newly published strategy is entitled 'Quality and Place'.

Our focus is to reduce unwarranted variation in care by e*nsuring a zero harm approach that drives the Trust's culture*

This is a significant and stretching challenge that will involve three core paradigm shifts:

1. Promoting a positive culture by embedding learning from harms, serious incidents and complaints and supporting the development of patient safety improvements.
2. Supporting and enabling quality improvement methodology as part of our everyday work.
3. Promoting what good quality healthcare looks like in each service and celebrating success in delivering good outcomes.

To achieve this we are setting ourselves a triple aim.

Domain	Aim	What this means
Patient Safety	***To achieve a continuous reduction in avoidable harm and make measurable progress to embed a culture of patient safety, including through improved reporting of incidents.***	This reflects the Trust's ambition of having an aspiration of 'zero harm' that drives the Trust's culture
Clinical Effectiveness	***To achieve a continuous improvement in health outcomes for people using the Trust's services by engaging staff to improve and innovate***.	This reflects the Trust's strategic goals of delivering high quality, integrated and innovative services that improve outcomes Our aim is to ensure that systems within the Trust promote, support and facilitate delivery of best practice day to day and learn from outcomes, whether positive or adverse, to ensure that service delivery consistently delivers best practice
Patient Experience	***To achieve a continuous improvement in people's experience of healthcare by promoting the highest standards of caring through implementation of the Trust's values.***	Ensuring that people have a positive experience of care is one of the Government's ambitions for the health service. Also, one of the indicators of the Trust's strategic goal of having an aspiration of zero harm that drives the Trust's culture is the prevention of unacceptable variations in healthcare experience and ensuring that compassionate care and patient experience is viewed as equally as important as clinical care.

As Chief Executive I am assured 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

PART TWO

Quality first and foremost

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

Priorities for Improvement in 2018/19

Patients are at the heart of everything we do at Bridgewater Community Healthcare NHS Foundation Trust. As part of the Harm Free Care Programme, Pressure Ulcers and Medication have been chosen for further improvement programmes within the organisation. Our third priority is around promoting a positive culture by embedding learning from harms, serious incidents and complaints as this will strive towards the development of patient safety improvements.

Quality priorities for the year 2018/19 include:

Pressure ulcers: Pressure ulcers are recorded as the highest number of incidents within our community services and patients who have developed a grade three or four pressure ulcers are classed as a serious incident and are investigated by the Trust to ascertain the category of harm caused to the patient. It is also important to identify lessons to be learnt to reduce the number of all pressure ulcers in the future. The Trust has already developed Patient Safety Meetings and Harm Free Care Groups where projects on the management of prevention of Pressure Ulcers are being undertaken. The Trust wishes to continue this improvement work throughout 2018/19.

- Reduction in medication errors: Medication errors remain the second highest number of incidents that are reported in the Trust with the highest number of incidents occurring within our Health and Justice Service and District Nursing. In 2017 the Medicine Management Team appointed a Medication Safety Officer who has highlighted a number of training issues and policy and procedures that will need to be developed and implemented throughout 2018/19.

- As reported in the 2016/17 Quality Report, the organisation appointed a number of senior nursing leadership posts around quality. This senior leadership continues to promote a positive culture by taking action to reduce avoidable harm and prevent errors to patients within our care. Our objective is to further improve our processes around incident management and embedding lessons learned from harms, serious incidents and complaints and supporting our culture of enabling quality improvement methodology as part of everything we do.

During the summer of 2017, our staff, local people, carers, health and care professionals, partners and community-based leaders came together in each
borough as part of a 'Big Conversation' to influence and shape the development of our Quality and Place strategy. One of the key themes was on 'prevention' which will align our prevention of category grade three and four pressure ulcer work and the reduction in medication errors. Our work around improving our processes around Serious Incident reporting was a result of our own internal findings and working with our Commissioners who had raised the same concerns with regards to improving timely reporting.

In the table below the implications on workforce and finance are displayed.

Quality	Workforce	Finance
Pressure Ulcer Prevention.	Training	Claims/ cost of dressings/medication
Reduction in Medication Errors	Training	Claims, cost of medication
Improve processes for reporting harm and promote an open and honest culture in which the organisation can learn and innovate.	Training	Potential cost of updating the risk management system.

Review of progress against the 2017/18 Priorities for Improvement

Priority for Improvement	Update
Fall Safe Programme	The Fall Safe Programme continues to be implemented in the in-patient unit at Padgate House and was also implemented in Alexander Court in 2017. Clinical Guidelines have been written for staff based on NICE (National Institute for Health and Care Excellence) guidance. A falls audit was undertaken in February 2018 for Padgate House which demonstrated that the care bundle implemented; demonstrated higher results than the national picture. For example: Call Bell: Our result 87%, national result 77% Safe Footware: Our result 87%, national result 58% Environment free from clutter, trip, slip: Our result 83%,

	national result 75% Mobility aid in reach: Our result 87%, national result 38% A Quality Matron will take the lead on monitoring the programme through the organisations Harm Free Care Group. The programme continues to be part of our Harm Free Care programme of work and will be monitored within our Quality Strategy 2017-2020.
Management of Sepsis	The Trust now has a Sepsis Identification and Screening policy for clinical staff to follow and there is training available via an E Learning package. Information for clinical staff has been set up on a specific Sepsis Trust intranet page so that information on sepsis is in one place. A Quality Matron has been given the lead on further enhancing the work on sepsis and this is also reflected and will be monitored within our Quality Strategy 2017-2020.
Co-ordination of end of Life Care (EOL)	2016 saw the appointment of the Associate Director for End of life Care. (EOL) During 2017/18 the team have been working closely with NHSI on a training project on End of Life medication. They have attended national events and delivered presentations on their project and this work is ongoing. For clinical staff they have also written a Pain Assessment Clinical Guideline and borough specific information on EOL is available for staff on a specific EOL Trust intranet page. Their work is reflected and monitored within End of Life Strategy 2017-2019.

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

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

During 2017/18 the Bridgewater Community Healthcare NHS Foundation Trust provided and/or sub-contracted 224 relevant health services.

Bridgewater Community Healthcare NHS Foundation Trust 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 2017/18 represents 97% of the total income generated from the provision of relevant health services by the Bridgewater Community Healthcare NHS Foundation Trust for 2017/18.

AUDIT

During 2017/18 six national clinical audits covered relevant services that Bridgewater Community Healthcare NHS Foundation Trust provides.

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

The national clinical audits and national confidential enquiries that Bridgewater Community Healthcare NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

- National Chronic Obstructive Pulmonary Disease Audit programme (COPD) – Pulmonary Rehab
- National Diabetes Audit - Adults (foot care)
- National Audit of Intermediate Care (NAIC)
- UK Parkinson's Audit
- National Audit of Inpatient Falls
- Learning Disability Mortality Review Programme (LeDeR)

The national clinical audits and national confidential enquiries that Bridgewater Community Healthcare NHS Foundation Trust participated in during 2017/18 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of the audit enquiry.

Title of National Audit	
National Chronic Obstructive Pulmonary Disease Audit programme (COPD) – Pulmonary Rehab	100%
National Diabetes Audit - Adults (foot care)	100%
National Audit of Intermediate Care (NAIC)	100%
National Audit of Inpatient Falls	100%
UK Parkinson's Audit.	100%
Learning Disability Mortality Review Programme (LeDeR)	100%

The reports of 5 national clinical audits were reviewed by Bridgewater Community Healthcare NHS Foundation Trust in 2017/18 and the following actions to improve the quality of healthcare are provided in the table below

1.	**Title:** National Chronic Obstructive Pulmonary Disease Audit programme (COPD) – Pulmonary Rehabilitation
Actions: Add Medical Research Council score to our post-course paperwork so that it is consistently measured at discharge. Explore the usefulness and feasibility of measuring muscle strength pre and post course.	
2.	**Title:** National Diabetes Audit - Adults (foot care)
It is acknowledged that early access to a full Diabetes multidisciplinary team* (MDT) if needed, improves outcomes for patients. **Warrington and Halton Boroughs:** Foot protection teams are well established in the community i.e. specialist intervention for the 'at risk foot'. Work is now underway to align foot care pathways between community and Acute setting Service now participates in a Multidisciplinary Foot Protection clinic (5 days a week) in the acute setting in line with NICE CG19 that can be referred to from Primary care, Community and Acute **Wigan Borough:** For the Wigan area the service provides a highly skilled foot protection team involved in wound care in community settings. Good pathways to Acute care (Vascular and Orthopaedics) are in place The Trust is working with the local commissioners in relation to establishing an all-purpose Diabetes MDT in Wrightington, Wigan and Leigh NHS Foundation Trust. This will enable community services to refer patients for high risk foot episodes whereby the patient can see a diabetologist, vascular consultant, microbiology, wound care professional and orthotist.	

**multidisciplinary team is a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programmes for complex medical conditions.*

3. Title: National Audit of Intermediate Care (NAIC)

The results of this audit mainly inform commissioning decisions and their review of intermediate care provision. For Bridgewater Community Healthcare NHS Foundation Trust this service is provided at Padgate House. The results of the audit were shared with the Greater Manchester Health & Social Care Partnership to inform their review.

No specific service related actions were identified.

4. Title: National Audit of Inpatient Falls

Actions:

- The service has discontinued the use of the FRAT (falls risk assessment tool) and replaced it with the Fall Safe bundle in response to the statement in the audit "Do not use a falls risk prediction tool* – Where these are still in use, we suggest that the group reviews the strong evidence and logic underpinning the NICE guidance, reviews the place of falls risk assessment and prevention in the acute care processes, and works with colleagues to remove these where necessary".
- Daily huddle board-MDT. Safety huddle at the start of each shift. Weekly MDT meeting. Monthly falls meeting/monthly therapy meeting. Quarterly full staff. meeting
- Regular falls PowerPoint presentation & discussion with staff and with patients/carers.
- Post falls care plan - Physiotherapist reviews & reassesses patients mobility & updates the Moving & Handling plan
- All patients assessed by a therapist on admission. Patients provided with an appropriate walking aid & moving & handling plan. Mobility and moving & handling plan reviewed daily. Carers check walking aid is in reach on hourly rounding. All staff check throughout the shift that all walking aids are in reach
- On admission all patients are provided with a pendant alarm & instructed in the use. Patients who are a high falls risk are provided with a falls clip/cushion/sensor mat as indicated. Orange lanyard attached to pendant alarm to allow quick visual identification of very high risk falls patients.

5. Title: UK Parkinsons Audit

Action

- Development of condition passport, for patient to document with professional input and plans.
- Parkinsons' well-being map to be used as standard when completing patient reviews

- Legal Power of Attorney information to be added to MDT initial assessment form
- Implement Preferred Priorities of Care Documentation

The reports of 22 local clinical audits were reviewed by the provider in 2017/18 and Bridgewater Community Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided – please see Clinical Effectiveness section of this report for further detail.

Participation in Clinical Research

The number of patients receiving relevant health services provided or subcontracted by Bridgewater Community Healthcare NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 160. The number of new studies approved during 2017/18 was 20.

Goals agreed with Commissioners - Use of the CQUIN Payment Framework

A proportion of Bridgewater Community Healthcare NHS Foundation Trust income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Bridgewater Community Healthcare NHS Foundation Trust 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 2017/18 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 £1.974m subject to final confirmation from commissioners regarding quarter 4 data.

The monetary total for the associated payment in 2016/17 was £1.723m.

Care Quality Commission (CQC)

Bridgewater Community Healthcare NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is full and unconditional registration.

As reported in last year's annual report, the Trust was subject to a full announced inspection by the CQC during 2016/17. The full report was published in February 2017 and gave the Trust a rating of Requires Improvement. During 2017/18, the Trust has worked to deliver its

action plans against each of the recommendations made and expected a further visit to re-inspect areas identified in the report. Changes in the CQC's approach to inspection means that this has not yet taken place and so the rating remains 'Requires Improvement' at the end of 2017/18.

The Care Quality Commission has not taken enforcement action against Bridgewater Community Healthcare NHS Foundation Trust during 2017/18.

Bridgewater Community Healthcare NHS Foundation Trust has participated in special reviews or investigations by the CQC during the reporting period.

St Helens

ST HELENS CQC LOOKED AFTER CHILDREN (LAC) INSPECTION REPORT

The CQC implemented an area review of service for LAC Children and Young People in the St Helens area between 6th and 10th November 2017. The final report has been published and Bridgewater worked with St Helens CCG, North West Boroughs Healthcare NHS Foundation Trust and St Helens and Knowsley Teaching Hospitals NHS Trust to develop a joint area action plan that has been submitted to the Clinical Commissioning Group (CCG).

<u>For Bridgewater services there was positive feedback relating to the following</u>

- Good quality assurance arrangements by the LAC health team for both St Helens looked after children and those who are placed into the area from other boroughs.
- The innovative approach of having an Advanced Nurse Practitioner role working alongside the Community Paediatrician
- The positive role of the team support worker who assists with the engagement and information sharing during the initial health assessments and how she enhances the experience received by children and young people and their families.
- Bridgewater structure of a Clinical Manager for St Helens covering both Community Paediatrics and LAC
- The work of the team to ensure the children have good access to GPs, dentists and opticians
- GPs are routinely consulted, by the LAC team, prior to the health assessment appointment taking place to ensure information from primary care is included
- The LAC team awareness of building relations with the 0-19 team, who are in a different organisation
- Provision of health passports for young people about to leave care

Recommendations for Bridgewater from the report, which are part of the joint area action plan:

- Strengthen the collection and use of feedback from looked after children so that they continue to play a positive part in ongoing service development
- Improve process to ensure the lived experience or voice of the child is better captured in both IHAs and RHAs ensuring those children and young people are better involved and take ownership of the process.
- Ensure screening tools, available for practitioners to use in their work with looked after children, are used to identify additional needs and that managerial oversight of the process is in place
- Improve the use of systems currently in place to identify the timeliness of IHAs and RHAs to further identify risk in those who are difficult to engage in the health assessment process.
- Ensure plans following IHAs and RHAs are more robust and further that there is more quality assurance and oversight of progress made to meet those needs and goals identified.
- Ensure that assessment scoring mechanisms are used to support and meet mental health needs of children and young people.

For the entire St Helens system there is feedback that

"The health provision for looked after children in St Helens is fragmented" This means that the ability to maintain oversight of the health needs of looked after children has become more challenging, compounded by the reduced capability of the looked after children nurses to influence or challenge practice.

Bridgewater is working with St Helens CCG to address the above with all our partners across the system.

ST HELENS SPECIAL EDUCATIONAL NEEDS INSPECTION REPORT

CQC and Ofsted implemented a joint area inspection of services for Children with Disabilities and Special Educational Needs provision in the week commencing 29th January 2018. All Bridgewater St Helens Children's Services were highly involved in the inspection. There were a range of focus groups for Bridgewater including Community Nursing services, Community Paediatrics, Specialist Looked After Children's Nurses, Speech and Language Therapy and Paediatric Continence.

The staff involved fed back positively about their experience of the inspection and the final report is awaited.

HEALTH & JUSTICE SERVICES

Barton Moss Secure Children's Home

Ofsted Report, July 2017

The report found that young people's health significantly improves while being at the home. This is due to their access to an extensive health team, which assesses monitors and reviews their physical and emotional well-being. Young people benefit greatly from the detailed assessments of their health needs. They attend routine health appointments and check-ups, and access ongoing therapy when required, that builds their emotional resilience and good mental health and well-being. A young person said, 'We meet to talk about our health and diet.' This considerably enhances their current and long-term health outcomes.

St Catherine's Secure Children's Home

Ofsted Report, July 2017

Young people's physical, mental and emotional health needs are well met. A healthy lifestyle is promoted and staff work in partnership with the children looked after nurse to promote young people's awareness of the importance of maintaining healthy lifestyles. Their needs are assessed at the point of admission and are routinely monitored throughout their time in placement. They are supported to access a range of health professionals, as per their individual needs and plans. This includes doctors, dentists and opticians, as well as more specialist support in relation to sexual health and substance misuse. Young people also have access to a range of mental health professionals, including a clinical psychologist who is actively involved in helping develop a therapeutic model of working in the home. This includes providing direct support for young people, developing behaviour management strategies and interventions and providing guidance and support for staff. As a result, young people's known and emerging health needs are holistically and consistently met.

HMP&YOI Hindley

Verbal Feedback from CQC & HMP, December 2017

Staff are open, honest and welcoming. Despite the forthcoming closure* of the prison and the resulting staff shortages in services such as mental health, staff were praised by inspectors in the informal feedback report in December for their positive outlook and for being open, honest and welcoming with inspectors.

The service's leadership, partnership working with prisons and commissioners and staff supervision and training were all commended.

Other areas described in positive terms include the mental health service and transfers, reception screening, sexual health testing and pre-discharge arrangements. Medication processes and compliance checks were also highlighted as positive with the inspector impressed by patients having an in-possession medication risk assessment. The pharmacy technician was also said to be good and thorough but it was noted there was a lack of cover for their annual leave/sickness. There was also praise for the health development nurse for their work to support smoking cessation as the prison took on a strict no smoking policy in October 2017.

Where improvements are needed

The Care Quality Commission contacted Bridgewater on 23 January 2018 to highlight areas of concern which require improvements. These include:

- Systems, processes and governance - systems and processes to assess, monitor and improve the quality and safety of the services need to be improved and wider trust governance arrangements need to be more effectively embedded into the prison.

  Action the Trust has taken: Chaired by the Associate Director for Quality Governance a quality meeting has been set up for the directorate which feeds into the Trusts Quality and Safety Sub Group and is attended by each Head of Healthcare. The chair reports by exception into the Trust wide Quality & Safety Sub Group and onwards to the Clinical Governance Sub Committee, the Quality & Safety Committee and Trust Board depending on the level of risk.

- Infection, prevention and control - risks need to be appropriately identified with regular quality monitoring and audits taking place so that timely and effective action can be taken and appropriate training is required for the local infection, prevention and control lead.

  Action the Trust has taken: Infection Prevention and Control link nurses are in place at each prison and secure home will now undertake peer to peer audits of each others sites to support and scrutinise adherence to infection control standards. Issues emerging from audits will be escalated through the governance system described above to ensure Trust oversight and support to address issues.

- Patient complaints - the CQC highlighted that patient complaints were routinely added to their electronic clinical records which did not support their confidentiality and risked discriminated as staff could see their complaint when they accessed the system. Complaints that were dealt with locally were not routinely quality assured or analysed to share learning and improve the quality of the service.

  Action the Trust has taking: Complaints are no longer scanned into patient records. The local complaints will be logged on the Ulysses PALs module which will facilitate the analysis of trends and quality assurance of responses. This information will be included in the Trust wide Quarterly Complaints Group.

- Patient feedback- service users were not asked for feedback about their experiences and overall engagement with patients was inconsistent and did not contribute to service development.

  Action the Trust has taken: HMP&YOI Hindley have adopted the Queensland approach to Patient Experience. Patients have been recruited into a Queensland Forum focussing on Health and Well-being. The first monthly meeting took place in January 2018. Patient Experience data is also sought via surveys, which are in place in the healthcare outpatients department.

- Incidents - incidents and serious incidents need to be appropriately recorded, investigated and monitored are to ensure necessary actions are taken to mitigate further risks. Incidents should be used to improve the service and learning shared with staff.

  Action the Trust has taking: A new risk manager is in post and training on the reporting and management of incidents has been prioritised for staff at HMP&YOI Hindley.

  ****There was a decision made not to close HMP Hindley***

NHS Number and General Medical Practice Code Validity

Bridgewater Community Healthcare NHS Foundation Trust submitted records during 2017/18 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
- 98.9% for Walk in Centres and Urgent Care Centres

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 Walk in Centres and Urgent Care Centres

Information Governance Assessment Report

Bridgewater Community Healthcare NHS Foundation Trust Information Governance Assessment Report for 2017/18 was 78% 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 (MIAA) during February 2018 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 2017/18 that required reporting to the Information Commissioner's Office, they were:

- A nurse was subject to a burglary where Trust items including a laptop and diary were stolen
- A district nurse lost their diary which included details of patients

Both incidents were reported to the Information Commissioner's Office (ICO) for investigation. The first incident has been closed with the ICO taking no further action. It was the Commissioner's opinion that the Trust acted appropriately with good policies and processes already in place. The second incident is still being investigated by the Commissioner.

The Trust has been preparing for implementing the General Data Protection Regulation (GDPR) with the Head of Information Governance taking the lead. They have undergone GDPR specific training and reporting to the Information Governance Subgroup and the Board on progress. There have been no high risks identified with the implementation of GDPR.

Clinical Coding Error Rate Validity

Bridgewater Community Healthcare NHS Foundation Trust was not subject to the payment by results clinical coding audit during 2017/18 by NHS Improvement.

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

Bridgewater Community Healthcare NHS Foundation Trust 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 uses MIAA to audit performance and performance management processes. The overall objective of the audits is to provide assurance that the Trust has an effective process-controlled system for performance reporting and ensure that mitigating plans are in place to achieve maximum performance and support patient quality.

The Trust has an agreed data quality policy to complement its data quality strategy and also has a data consistency programme that aims to ensure a consistent Place Based approach to recording data and performance management across all its Boroughs.

Data consistency implementation groups are in place who oversee data consistency progress aligned with data improvement, service redesign and System 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
- data definition work streams continue at individual service line level

Number of Deaths

During 2017/18 1,305 of patients receiving services from the Trust died. This number of deaths which occurred in each quarter of that reporting period is as follows:

Quarter	No of Deaths
Q1	302
Q2	347
Q3	346
Q4	310

During 2018/19, the Trust will be developing our framework for responding and learning from deaths. The objective of this will be to ensure that the Trust identifies and takes all possible action to learn any lessons that are highlighted from the review of deaths.

Number of Deaths by Quarter

The Trust has arrangement in place to review deaths as part of its incident management arrangements.

Of the incidents identified in section 27.1, the Trust has investigated three as incidents as these have been deaths in custody and NHS England commission the investigations.

In three cases the deaths were subject to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was as follows:

Quarter	No of Deaths
Q1	0
Q2	0
Q3	2
Q4	1

NHS England commission an independent investigation of deaths in custody, which includes a clinical review of the patient's management. The reports relating to these reviews are issued to the Trust by NHS England. The Head of Healthcare from the prison is responsible for managing all elements of the findings and lessons learned that relate to healthcare within their prison. The reports regarding these investigations are reviewed by the Trust's

Serious Incident Review Panel to generate assurance that the required actions are being addressed within Health and Justice Services.

Deaths Relates to Care in the Trust

There were no deaths during the reporting period that were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter this consisted of:

Quarter	No of Deaths considered due to problems in the care provided to the patient
Q1	0
Q2	0
Q3	0
Q4	0

None of the reviews attributed to the deaths to sub optimal healthcare provision; however all of the reports make recommendations to both the prison and healthcare settings. These have ranged from working more collaboratively on information sharing and working procedures around access to prisoner medication.

Each prison establishment has monthly forums where patients (Healthcare Champions) can feedback any issues relating to Healthcare. This is also an opportunity for these champions to feedback to other prisoners the outcomes from these monthly meetings.

An assessment of the impact of the actions described in item 27.5 which were taken by the provider during the reporting period.

There was one investigation and clinical review of a death relating to the period 2016/17, which were completed during the period 2017/18 which related to deaths that took place before the start of the reporting period.

One investigation clinical review of a death relating to the period 2016/17, which was completed during the period 2017/18, was judged to be more likely than not to have been due to the problems in the care provided to the patient. This has been investigated using the Root Cause Analysis (RCA) report commissioned by NHS England. All RCA's have are followed up with an action plan to address any identified lessons learnt.

A revised estimate of the number of deaths data for the previous reporting period is not available as NHS England sent the investigation report to the individual Prison Governor.

From 2017/18 this reporting period, the Trust has established processes for oversight of the investigation report and required actions in order to monitor and ensure lessons are learnt within all of Health and Justice Services.

Reporting against Core Indicators

In accordance with NHS England requirements Bridgewater Community Healthcare NHS Foundation Trust 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 Staff Friends & Family Test	Bridgewater 2015	Bridgewater 2016	Bridgewater 2017	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)	78% (reported as 79% in last year's report)	71%	67%	74%	82%	65%
% of staff that would recommend the Trust to friends and family as a place to work. (Q21c NHS Staff Survey)	49%	49%	45%	58%	68%	44%

Bridgewater Community Healthcare NHS Foundation Trust considers that this data is as described for the following reasons:

- There has been continuous change in the health economy that has impacted on staff. It is recognised that continuous financial challenge and change at national, regional and local levels can affect staff morale and their perceptions of the organisation and the NHS as a whole. Work has been on-going during 2017 to try to improve this; however, we have seen a deterioration of 4% with regards to our staff recommending the Trust as a place of work to their family and friends. Furthermore, there has been 4% deterioration in staff recommending the Trust as a place to receive treatment. Both these responses are below the national average of response rates for Community Trusts.

Bridgewater Community Healthcare NHS Foundation Trust intends to take the following actions to improve these scores, and so the quality of its services by:

- Continuing to undertake quarterly on-line surveys asking staff if they would recommend Bridgewater to their family and friends as a place of work and receive treatment. 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 the Trust's Staff Engagement Group, Workforce & Organisational Development Committee, Open Space and Big Conversations etc.
- Utilising our Staff Engagement Champions to work with the Trust's Staff Engagement Lead to further understand and address the reasons why staff would not recommend the Trust as a place to receive treatment or work.
- Continuing to develop and implement various initiatives to work further on staff engagement. These include, but would not be limited to: updating the intranet site – "The Hub", My Bridgewater App (available to all staff), monthly staff health and wellbeing newsletter and twitter messages, and our now well established staff health and wellbeing month, Director Quality Visits, Open Space Events, Professional Forums, Chief Executives Blog, Team Brief and Trust Bulletin, Star of the Month, Annual Staff Awards and our "you said, we did…..are doing" cascades and 'Listening into Action' groups. Running our internal Staff Pulse Check Survey on a quarterly basis which positions the two questions with staff to enable periodic 'temperature checks'.
- Continuing to report on our progress to the Trust's Workforce & Organisational Development that reports in to the Trust's Board.

The below indicators from 2014-2017 were reported from patients that attended Newton Hospital. From 2017 Bridgewater Community Healthcare NHS FT no longer provides this service or any other service where this indicator is applicable to and therefore is not applicable for 2017/18.

Core Indicator	2017/18	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.	NA	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

Core Indicator		2014/15	2015/16	2016/17	2017/18
The number and, where available, rate of patient safety incidents reported within the Trust during 2017/18, and the number and percentage of such patient safety incidents that resulted in severe harm or death	The number and, where available, rate of patient safety incidents reported within the trust during 2017/18	3,999 incidents reported of which 1321 (33%) were submitted to the NRLS as patient safety incidents	3,986 incidents reported of which 1,293 (32%) were submitted to the NRLS as patient safety incidents (as of 6/4/16)	4,676 incidents reported of which 1,217 (26%) were submitted to the NRLs as patient safety incidents (as of 31/03/17)	4,811 incidents reported of which 1,176 (24%) were submitted to NRLs as patient safety incidents (as of 03/04/18).
	The number and percentage of such patient safety incidents that resulted in severe harm or death	There were 24 incidents resulting in severe harm or death, 11 of which met the criteria for a patient safety incident	There were 20 incidents resulting in severe harm or death, three of which met the criteria for a patient safety incident	There were 16 incidents resulting in severe harm or death,12 of which met criteria for patient safety incident	There were 28 incidents resulting in severe harm or death, 19 of which met the criteria for patient safety incident

The Bridgewater Community Healthcare NHS Foundation Trust considers that this data is as described for the following reasons, compared to 2016/17: -

During 2017/18, 4,811 incidents were reported (as of 31/3/18); 1,176 (24%) of these were submitted to the National Reporting and Learning Service (NRLS) as Patient Safety Incidents.

There were 19 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.

Compared to 2016/17 the volume of Patient Safety Incidents has decreased by 41 (3.4%) 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 2016/17:

- the volume of Patient Safety Incidents has decreased by 41 (3.4%) and is a negligible difference due to maintaining closer scrutiny and more accurate reporting, of these,

- The overall volume of Patient Safety Incidents decreased, the ratio of No Harm incidents (Near Miss, Insignificant outcomes) decreased by 4%.
- The number of Serious Incidents from 2017/18 was 160. The top three cause groups were slips, trips and falls, medication errors and pressure ulcers. From 2016/17 to 2017/18 there was the increased number of reported incidents indicating that the incident reporting culture is evolving in the Trust. The Trust will be further developing this culture by providing training to all staff regarding the process of reporting and management of incidents.

The Bridgewater Community Healthcare NHS Foundation Trust has taken the following actions to improve this data and indicators, and so the quality of its services, by:

- Introducing a dedicated root cause analysis training program for staff in the Trust, which will be a permanent resource. This will enhance the quality of incident investigations in the Trust, by ensuring that investigators are aware of the concepts of root cause analysis and are able to prepare robust investigations reports.
- Maintaining support for incident investigators and managers in completing investigation documentation, incident management, risk assessment, and risk register maintenance
- Ensuring the routine scrutiny of incidents on a daily, weekly, and monthly basis by the Risk Team and senior clinicians which increases data quality and accuracy.
- Maintaining the production of weekly and monthly automated aggregate reports regarding incidents to assist monitoring by managers and the Trust

PART THREE

Quality first and foremost

Part 3 – Quality of Care in 2017/18

Trust Quality Measures

In 2017/18 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.

The data for the Patient Safety Indicators are taken from the Risk Management Solutions Software system known as 'Ulysses'. This data base is a mechanism for staff to report incidents directly into a data base in order that they can be recorded and managed in a safe and secure way.

Indicator to be measured	Change compared to previous year	2017/18 full year position	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	↑	41.26%	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)	↑	162	106	45	80	54	The volume of reported SIs increased by 53. The top three cause groups were slips, trips and falls, medication errors and pressure ulcers.
Proportion of incidents with outcome of "No Harm "	↓	49%	53%	40%	45%	34%	Reported patient safety incidents with "No Harm" (near miss, insignificant) outcomes decreased to 49% of the incidents reported.
CDI reported as lapse in care and apportioned to the Trust	↓	0	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	0	For further information please see HCAI section.
Ratio of patient falls (In Patient facilities – Padgate House)	↓	1.8%	5%	6%	5%	3%	There was a significant reduction in the numbers of falls incidents, as the management responsibility for Newton Community Hospital passed to St Helens & Knowsley Hospitals.
Percentage of admitted patients that have been risk assessed for VTE (Newton Hospital)	N/A	No longer applicable	99.79%	99.19%	98.75%	99.46%	This indicator is no longer applicable as Newton Hospital moved to different provider on 1/4/17

Clinical Effectiveness							
Percentage of patient facing staff that have been vaccinated against flu	ALW ↑ Warrington↑ Halton↓ St Helens- Dental ↓ Total ↑	65% 53% 49% 47% 36% 70%	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)	N/A	No longer applicable	4	8	7	1	This indicator is no longer applicable as Newton Hospital moved to different provider on 1/4/17
Patient Experience							
Staff who would recommend our services to friends and family	↓	3.51	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↑ Wigan ↓ Halton ↑ St Helens	98% 80% 98% N/A	97% 78% 91% 93%	97% 89% 85% 82%	97% 87% 81% 95%	95% 86%	Warrington have demonstrated an increase from previous year Wigan have seen a decrease in those patients achieving their PPC which has been attributed to acute admissions to hospital Halton have demonstrated an increase year on year in the number of patients supported to achieve their PPC by District Nursing St Helens are no longer part of the Bridgewater service from April 2017

Percentage of patients indicating they had a good overall experience	↔	99%	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	↓	92	94	88	91	88	

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.
- Pressure Ulcers – see the Pressure Ulcer Section.
- Falls – see the Falls section.
- 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.

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 2017/18 compared to the national average.

Percentage of harms (all)	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
National	5.81%	5.68%	5.78%	5.78%	5.80%	5.65%	5.61%	5.65%	5.56%	5.87%	5.93%	5.99%
Bridgewater	4.64%	5.04%	5.85%	5.82%	5.24%	6.43%	5.79%	5.70%	3.09%	5.70%	4.48%	6.03%

Percentage of harms (New)	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
National	1.98%	1.97%	2.04%	2.07%	2.08%	2.05%	1.95%	2.07%	2.06%	2.08%	2.12%	2.14%
Bridgewater	1.68%	1.23%	3.33%	1.24%	2.20%	2.44%	2.03%	1.46%	0.49%	1.71%	2.31%	1.76%

Percentage of harm free	Apr 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
National	94.19%	94.32%	94.22%	94.22%	94.20%	94.35%	94.39%	94.35%	94.44%	94.13%	94.07%	94.01%
Bridgewater	95.36%	94.96%	94.15%	94.18%	94.76%	93.57%	94.21%	94.30%	96.91%	94.30%	95.52%	93.97%

Between April 2017 and February 2018 our level of harm free care for the majority of the months has been above the national average which means that patients receiving care from the Trust experienced less harms. There were months during the reporting period that showed a lower percentage of harm free care than the national average meaning that the organisation reported that patients experienced more harms whilst under our care. These harms were a mixture of new and old harms. For the period the organisation reported an increase in harms a deeper dive was undertaken to understand the rationale for this. It was noted that there was an increase in the numbers of new VTE's being reported. On further review of this it highlighted a data quality issue in that VTE's not occurring whilst under the care of Bridgewater were being recorded as new VTE's. The national data definitions were

recirculated to all teams to support the correct interpretation of and reporting of harms. A Quality Matron is now monitoring any reporting of new VTE's to confirm the correct reporting. The continued evaluation of the safety thermometer data will continue to 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
2017/18 = 92	92	Not applicable	Not applicable

During the year, the Trust transferred the management responsibility for Newton Community Hospital and the Maple Unit to alternative care providers.

This resulted in a significant drop in the total number of reported falls, as 92 incidents were reported compared to 225 in 2016 / 2017.

The Trust has maintained responsibility for Padgate House, where the number of reported falls reduced by 4%.

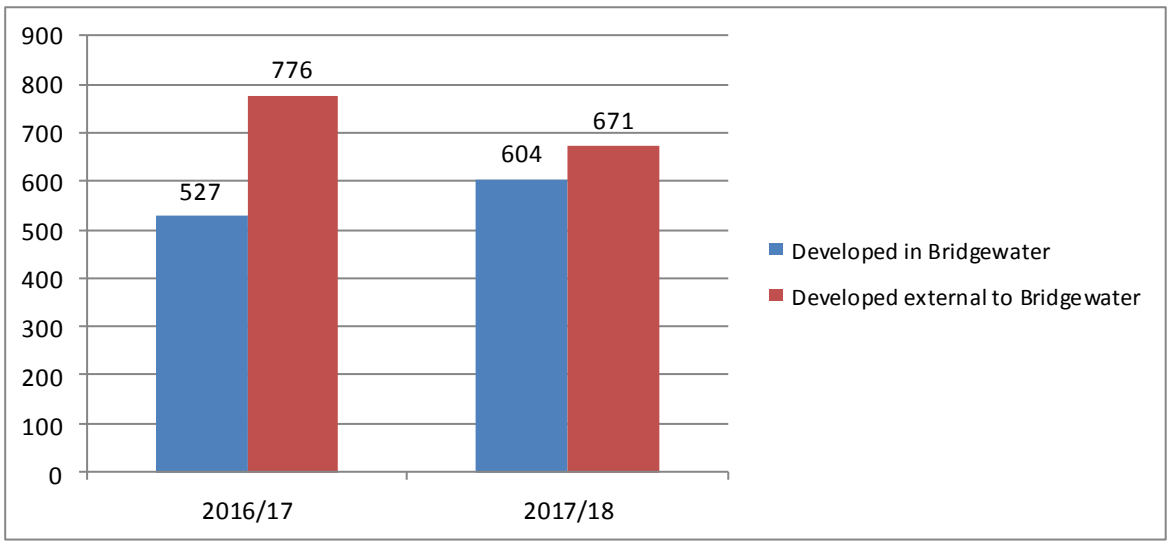
The Trust's staff continued to manage in patients in the safest possible manner, taking all possible action to reduce the risk of falls.

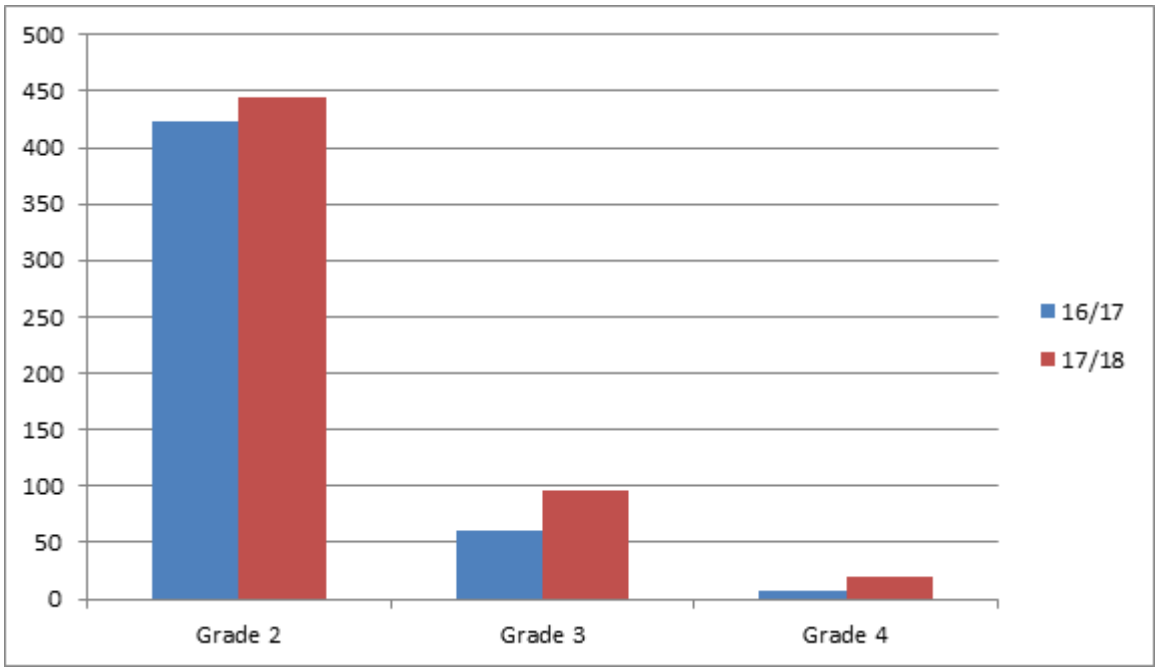
Pressure Ulcers

Between 2016/17 and 2017/18 there was an increase in the total number of pressure ulcers that developed within Bridgewater. There was a 14% increase from 527 incidents in 2016/17 to 604 incidents in 2017/18.

The proportion of more severe ulcers (grade 3 and 4) slightly increased. The Trust continues to actively encourage reporting of all grades of pressure ulcers in line with national requirements.

The Trust has continued to review all reported pressure ulcer incidents 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 enable us to 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 practice to reduce the risk of harm to patients.





Over the last year the Trust has continued to hold weekly Patient Safety Meetings which provide an opportunity to review moderate and severe pressure ulcers i.e. those categorised as category3 or 4. The category three and four pressure ulcers developed under the Trusts care continues to be reported externally to Clinical Commissioning Groups (CCGs) via a national reporting system. The weekly Patient Safety Meeting has provided a learning opportunity which captures areas of good practice and/or areas for improvements. These 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.

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 England (NHSE) 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 Trust are proactive in developing quality improvement initiatives to reduce pressure ulcer incidents and patient harm; in line with the ten commitments of *Leading Change Adding Value*.

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 2017 we completed a thematic review of root cause analysis investigations to identify common recurring themes for improvement.

This thematic review has been used to implement a pilot study within District Nursing Teams to improve best practice standards being met in a timely manner thus reducing the incidence of harm. The pilot study aims to:

- Improve communication and adherence to Trust Policies (identified via investigations of pressure ulcer incidents) by adopting a systematic approach based on best practice to enable timely interventions to reduce harm.
- Improve the knowledge and skills at team level in relation to pressure area management
- Reduce the incidence of deterioration of pressure ulcers and the development of pressure ulcers in the care of the DN Service

The pilot will be reviewed utilising a Plan, Do, Study, Act (PDSA) approach prior to rolling out across the Trust and will be monitored and reported via the Tissue Viability Nursing Service.

Quality of care relating to pressure ulcer management 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 promote the reporting of medication incidents and to encourage staff to reflect and identify lessons learnt.

As a result of a strengthened medicines management team, specific high risk incidents and themes and trends of incidents were escalated through the governance framework and the need for a Medication Safety Officer was recognised. In November 2017, the Trust appointed a Medication Safety Officer to specifically support the management of medicines incidents. In a short period of time the benefits of this role have already been apparent with improved and demonstrable actions taken as a result of incidents and support for Clinical Managers in managing a medicines incident.

Throughout 2017/18, the Medicines Management team have worked with all many services in the Trust and there are clear improvements in the support available and medicines management standards. A number of guidelines and procedures have been written such as temperature storage guidance, medicines management in midwifery and the Medicines policy, safe and secure handling of medicines and controlled drugs standard operating procedures have been updated. The safe and secure handling follow up audit was completed and the audit cycle is continuing on a service specific rotation i.e. prisons, district nursing, dental with individual reports produced and learning being shared in teams.

The medicines management team have provided intensive support to HMP Wymott since April 2017 to manage the complex risks and delivery of medications to the large numbers of patients who require multiple and complex medication regimens. This has included the development of more robust procedures and processes which are also being implemented in the entire Bridgewater prison portfolio.

Medicine incidents continue to be reported on the Trust's incident reporting system (Ulysses), and are reviewed initially by the Medication Safety Officer who then contacts the incident reporter or Clinical Manager to manage the immediate actions required and to put a plan in place to manage the longer term actions.

On a quarterly basis, a medicines incident report and controlled drugs accountable officer report is submitted to the Clinical Governance Sub Committee and shared with the Clinical Commissioning Group Medicines Management Leads. Controlled drug incidents are also submitted to the local intelligence teams and regular local intelligence meetings for Greater Manchester, Cumbria and Lancashire and Cheshire and Merseyside are attended by the team.

In 2017/18, 606 medication related incidents 13% of the total incidents reported over this period) were reported by the Trust staff including 120 involving controlled drugs.

Around 26% 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

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 173 near misses (an average of approximately 14 per month) reported for 2017/18.

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

Non-Medical Prescribing

Bridgewater has approximately 509 Non-Medical Prescribers (NMPs) comprising of 104 independent/supplementary prescribers and 405 community formulary non-medical prescribers on its NMP register. New NMPs meet with the NMP Lead/ Senior Technician 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 safe and appropriate prescribing by NMPs. Prescribing data is reviewed quarterly for compliance against area prescribing formularies (Pan Mersey and Greater Manchester) and the Bridgewater Wound Care Formulary. Any off formulary prescribing is highlighted and individuals asked to provide a rationale. Repeat infringements will trigger escalation to clinical managers. All NMPs have been contacted to submit their current Approval to Practice form to enable prescribing to be reviewed against their defined scope of practice. Where required, prescriptions are recalled from the National Health Services Business Service Authority (NHSBSA). Compliance reports are shared with CCG medicines management.

In previous years, the Trust has taken part in the regional on-line clinician's audit but Health Education England (HEE) was unable to provide the support in 2017. The audit provided a valuable resource for evaluating the impact of non-medical prescribing on patient care and its potential economic value to the health service. Regional discussions are underway to address the benefit of rolling out the audit in the future.

In May 2017 HEE asked for proposed numbers of staff to undertake NMP. From our original request of funding for 20 V150 and 15 V300 candidates, we were only allocated funding which equated to 10 V150 and 6 V300 candidates. To-date the Trust has approved 15 applicants for the V300 and 16 applicants for the V150 Non-Medical Prescribing courses.

Safeguarding

Safeguarding is complex and challenging and Bridgewater recognises the rights of all individuals to live a life free from abuse and neglect and have their welfare promoted.

This is a brief overview report; each of the boroughs provides a detailed individual safeguarding children report and a safeguarding adult annual report.

The Safeguarding team is a specialist service that delivers high quality provision. Bridgewater employees are aware of the service offered through attendance at training and via the intranet page which is available to all Bridgewater staff and is regularly updated.

The Chief Nurse is the Lead Director for Safeguarding and Executive Lead for Prevent and The Medical Director is the lead for Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

The Safeguarding Team – Key Roles and Responsibilities

Associate Director for Safeguarding

- Strategic leadership and day-to-day running of the safeguarding function
- Strategic and professional lead across the Trust for Domestic Abuse
- Operational Lead for Prevent.
- Represent the Trust on each of the 10 LSCBs (Local Safeguarding Children Boards) and SABs (Safeguarding Adult Boards) across the boroughs.

Strategic Lead for Safeguarding

- Deputises for the Associate Director for Safeguarding responsibilities and provides support for the Named Nurses

Named Nurses for Children and Adult Safeguarding

- Professional leads on Safeguarding, working in collaboration with Local Authorities and Commissioners to provide a high quality, evidence based service.
- Attend and contribute to internal Trust meetings, 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
- Ensure the delivery of quality care to adults at risk and children within the Trust which includes being a source of expertise for the Trust and promoting excellent standards of professional practice in relation to Safeguarding, the Children Acts (1989 + 2004), the Care Act (2014), the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (2009).

2017/2018 brought a number of significant changes to the senior members of the safeguarding team. Two Named Nurses left their posts due to promotion as Designated Professionals, and the new position of Strategic Lead for Safeguarding was implemented to strengthen the safeguarding team. Two internal promotions to Named Nurse have been appointed in Wigan and Bolton and two new Named Nurses in Oldham and Safeguarding Adults.

The safeguarding teams in each borough are made up of a variety of professionals depending on the services we provide. Halton, Wigan, Warrington, Bolton have Children in Care nurses, this service sits with the Children Directorate in St. Helens. Wigan also has a Specialist Nurse for Child Sexual Exploitation. All boroughs have Specialist Safeguarding Children Nurses and dedicated administrative staff.

The Safeguarding Adult Team consisted of one full time Named Nurse Safeguarding Adults. An exciting opportunity for a 5 month secondment, 1wte Safeguarding Adults Support Nurse has been appointed to, starting in early 2018/2019.

As a health provider, Bridgewater demonstrates 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 LSCBs, SABs and Commissioners of services. Safeguarding assurance is provided to Commissioners through the KPIs (Key Performance Indicators) and the Safeguarding Audit Tool which is completed annually with quarterly reviews and there is a challenge of performance undertaken by the Commissioners.

The Safeguarding team is accessible to all Bridgewater staff and offer;

- Safeguarding training; PREVENT, WRAP3, MCA and DoLS and Levels 2 and 3 for safeguarding children and adults
- Advice and support to all staff in relation to all aspects of safeguarding
- Safeguarding supervision for staff ; 1;1, group, reactive, bespoke, ad hoc and reactive
- Supports the services for Children in Care/Looked after Children, to ensure health needs are identified and care plans monitored
- Supports teams in multi-agency working for Serious Case Reviews, Safeguarding Adult Reviews, Local Case and Learning reviews, and Domestic Homicides Reviews
- A robust process for review and approval of Policies, Guidelines and Procedures, ensuring they are up to date, reflect local and national policy and are easily available for all staff to access

Safeguarding Training

Throughout the year there has continued to an emphasis on training to ensure increased compliance in respect of Safeguarding Adult and Children training at all levels, particularly in level 3 adults and Prevent. The Safeguarding Teams have been working hard in collaboration with the Education and Professional Development (EPD) Team to target services, individual staff and relevant line managers to improve compliance rates. This is evidenced in a significant increase in compliance and a more educated, confident workforce. This approach has proved effective looking at the compliance rates; nevertheless, there is still a considerable amount of work to be done to reach compliance in every level of training.

A comprehensive Safeguarding Training Strategy, Training Needs Analysis and Framework setting out the safeguarding training requirements for all staff across the Bridgewater Community Healthcare NHS Foundation Trust are in place. This enables staff to identify the appropriate level of training, depending on their job role, and for managers to ensure compliance. Bespoke sessions are offered to specific staff groups to ensure the training is relevant to their sphere of work.

Safeguarding Training	Month 12 – 2016/17	Month 10 – 2017/18 (When this report was completed)
Level 2 Safeguarding Children e-Learning Target 95%	89.08%	93.72%
Level 2 Safeguarding Adults e-Learning Target 90%	89.76%	94.51%
Level 3 Safeguarding Children Face to Face Target 90%	83.26%	95.09%
Level 3 Safeguarding Adults Face to Face Target 90%	17.04%	67.70%
Level 4 Safeguarding Adults Face to Face Target 90%	Data not recorded	100%
Level 4 Safeguarding Children Face to Face Target 90%	Data not recorded	95.46%
Prevent Awareness e-Learning Target 85%	Awareness and WRAP3 data was combined at this time= 69.15%	78.74%
WRAP 3 Face to Face Target 85%		79.91%
MCA DoLS e-Learning	64.85%	85.31%

Target 90%		(Reported every 3 months- this is month 9 data)

Safeguarding Supervision

Safeguarding supervision is a requirement for all staff who comes into contact with adults at risk or who have face to face contact with children and young people. Bridgewater's *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 provide planned, individual, group, bespoke, ad hoc and reactive safeguarding supervision, ensuring support and guidance are available and to identify risk and protect vulnerable adults, children and young people. During the year, there were 16 new safeguarding supervisors trained by the NSPCC (National Society of the Prevention of Cruelty to Children), to offer this essential service to our staff. Work is ongoing in Oldham to increase access to safeguarding supervision, which in October 2017 was 7% and now is approximately 70%.

During the year there has been an ongoing and escalating risk recorded on the organisations risk register in relation to capacity within school nursing to make themselves available for and to appropriately prepare and engage in safeguarding supervision

The Named Nurses also receive individual safeguarding supervision from the borough Designated Nurse, which is crucial to their role.

Whilst there is not yet guidance on formal Supervision processes in Adult Safeguarding the support provided as part of the monitoring of concerns raised to Adult Social Care gives the opportunity for reactive supervision to take place.

Section 11 (Children Act 2004)

Section 11 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 Boards request. 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 submitted this year. Evidence scrutiny panels have taken place in Wigan and St Helens, where the Associate Director and Named Nurse for safeguarding attended. Action plans from these meetings have been developed.

The Care Quality Commission (CQC)

A review of services for LAC (Looked After Children) and Safeguarding by the CQC was completed in St Helens in November 2017. The focus was particularly in relation to children in care and the report published in January. Within the report there were a number of recommendations specific for Bridgewater. The CQC also undertook a SEND (Special Educational Needs and/or Disabilities) review in January 2018.

JTAI (Joint Targeted Area Inspection)

This new set of inspections that came into force to examine how local partner agencies - including local authorities, health and probation services and the police - are working together to protect children living with, or at risk of, neglect. These and are undertaken by Ofsted, the Care Quality Commission (CQC), Her Majesty's Inspectorate of Constabulary (HMIC) and Her Majesty's Inspectorate of Probation (HMI Probation).

Each set of joint inspections also evaluates the multi-agency response to a particular issue or theme, such as neglect.

Many of the boroughs have been preparing for these inspections by different methods, such as mock inspections, audits and planning meetings.
Cheshire West received an inspection in September 2017 and a review took place at Chester Children's Dental Team.

Allegations against Staff – LADO (Local Authority Designated Officer)
As outlined in 'Working Together to Safeguard Children' 2015, the LADO must be informed of all allegations against adults who work with children. For adults, cases are referred to the local authority.

The Assistant Director of Workforce is Bridgewater's lead for LADO and maintains the log and will work closely with the Associate Director of Safeguarding when cases are identified. A review is undertaken monthly to track cases and investigation outcomes.

During 2017/2018, Bridgewater have been involved with 6 LADO cases, 3 of these were reported from other external organisations. During 2016/17, Bridgewater was involved in a total of 3 LADO referrals.

PREVENT

Prevent is part of the UK's counter terrorism strategy, preventing people from becoming involved in terrorism or supporting terrorism. It is part of the Government counter-

terrorism strategy CONTEST2 and aims to reduce the threat to the UK from terrorism by stopping people becoming terrorists or supporting terrorism.
A comprehensive *Prevent* policy has been written and put into place across Bridgewater during 2017/2018.

The Associate Director for Safeguarding, as Operational Prevent Lead, liaises regularly within NHS England and is a member of the North-West Prevent sub-group. The Associate Director for Safeguarding ensures that systems and processes are in place support the delivery of the Prevent Programme and ensure compliance with *DH guidance 'Building partnerships, staying safe' (2011*). This will ensure that healthcare workers are confident and knowledgeable in addressing situations that cause concern and meet the requirements of the NHS National Contract.

Since Q2 Bridgewater has provided Prevent data, which include referrals to the Channel Panel and training compliance, via the electronic Unify 2 system as requested by NHSE.

Consultation On the draft '*WORKING TOGETHER TO SAFEGUARDING* CHILDREN' 2018

The national consultation for the draft Working Together Safeguarding Children closed on the 31 December 2017.

Revisions were made to reflect legislative changes in the Children and Social Work Act 2017, which follows the *Wood Review* of LSCBs. All agencies were encouraged to review and provide responses to this national consultation. Bridgewater Safeguarding Team have discussed in detail and submitted their comments both as an organisation and contributed towards the LSCBs contributions. The Government consultation response has been published in February and Bridgewater have been acknowledged as responding to the consultation. The final guidance is likely to be published in the spring.

MAKING SAFEGUARDING PERSONAL (MSP); the Care Act 2014

Emphasis on developing a safeguarding culture that focuses on the personalised outcomes desired by people with care and support needs that may have been abused or neglected is key.

The Named Nurse Safeguarding Adults has been embedding the 'Making Safeguarding Personal' approach across the Trust by establishing and developing:

- accessible information to support participation of people in safeguarding support by using a multi-agency approach
- advocacy
- person-centred approaches to working with risk

- developing policies and procedures that are in line with a personalised safeguarding approach
- strategies to enable practitioners to work in this way
- Incorporating principle of MSP into Safeguarding Adults Level 3

Clinical Commissioning Groups (CCGs)

Safeguarding assurance is provided to Commissioners through the KPIs and the Safeguarding Audit Tool, which is completed annually with quarterly reviews of performance by the Commissioners.
Halton's Community Paediatric service was served with a performance notice by Halton CCG in Q4. Concerns cited included findings from the Children in Care site inspection completed in Q2 in relation to the quality of Initial Health Assessment's for Children in Care.

NHS Commissioning Standards Audit Tools have been submitted where requested in all boroughs. Validation visits have been undertaken by the relevant CCG. Action plans have been developed to incorporate any red or amber areas and are updated quarterly to demonstrate progression towards achieving full compliance. Feedback has been positive and there are currently no red areas.

Oldham's safeguarding team sits within the 0-19 service and budget. Evidence is therefore provided to the 0-19 service manager to inform the reporting in to Commissioners to provide assurance regarding activity and compliance.

STAG (Safeguarding Team Assurance Group)

Bridgewater's STAG meets quarterly and seeks assurance that all safeguarding commitments and responsibilities are met. The high-volume of work continues to increase in safeguarding, which have necessitated monthly extra-ordinary STAG meetings for the majority of 2017/2018.

STAG provides strategic and operational direction in relation to safeguarding and in line with national, regional and local guidance. STAG has membership from all Directorates within Bridgewater and a deputy is named if a member cannot attend, so that information can be relayed down to ensure there is a safeguarding thread throughout our organisation. Our Designated Nursing colleagues are invited to part 1 of the STAG meeting on a quarterly basis.
The Trusts safeguarding assurance is provided through the quarterly STAG meetings reporting to the Trust's CGsC (Clinical Governance sub Committee).

The Named Nurse meeting is the operational sub group of the STAG and takes relevant action in regard to any operational safeguarding children and adult issues which have been identified.

SCRS/DHRS (Serious Case Reviews/Domestic Homicide Reviews)

A SCR is carried out after a child dies or is seriously injured and abuse or neglect is thought to be involved. It looks at lessons that can help prevent similar incidents from happening in the future (Working Together to Safeguard Children, 2015).

A DHR is conducted to review the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related or with whom he was or had been in an intimate personal relationship, or a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.
The Safeguarding Team are committed to contributing to these reviews and more importantly to work with partner agencies to embed learning from these cases.

The Safeguarding team are involved in the delivery of the multi-agency action plans from previously published SCRs, providing assurance to the Safeguarding Boards and support to health staff to embed the actions and learning at the front line, via safeguarding supervision or training.

Across the Bridgewater footprint the safeguarding team have been involved with 15 SCR / DHRs. This has had a particular challenge for the Wigan team where 6 SCRs and 2 DHRs were opened. This has the potential to impact on delivery of other safeguarding priorities. This has been added as a risk on the organisations risk register and will be continually monitored.

Warrington had two cases that were considered for SCR but were managed as Local Case Reviews. The learning from these and completed SCRs in Halton and St Helen's has been disseminated via workshops provided by the LSCB.

The Named Nurse has also contributed to Safeguarding Adult Reviews Local Case Reviews and processes and also leading on the review on behalf of Bridgewater by undertaking panel member duties. The Named Nurse Nurses have also lead on action plans and provided updates to the CCGs and the LSCBs and SABs on the progress of the action plans. Ultimately progress was overseen by the Safeguarding Board Panels and the Named Nurses presented evidence to the Board Panel to demonstrate outcomes against the required action.

VOICE OF CHILD/ADULT

Capturing the voice of the child and adult is an important part of safeguarding. Each STAG meeting provides a case study of the voice of the child or adult, to share with members.

In Bolton the Specialist Nurse for Looked after Children is a member of Bridgewater's *Voice of the Child Working Party*. This has allowed the profile of Looked after Children to be raised in relation to this area of work.

The voice of the child has been audited in the 0-19 service in Warrington which has provided positive results and demonstrated the impact of training and implementation of improved documentation ensures all staff considers the importance of children's voice in the delivery of their care which impacts on their outcomes.

Risks

The safeguarding risks on the Trusts Risk Register are monitored by the safeguarding team. The high risks are discussed at the STAG meetings and reviewed/escalated at QSSG meetings. The risks form part of the quarterly safeguarding children and adults reports that are shared with the CCGs.

Incidents

Incidents are reported to the Safeguarding team on a weekly basis. These are monitored and actioned should a safeguarding incident be identified.

CP-IS (Child Protection - Information Sharing)

The Government has introduced requirements for all Local Authorities and NHS unscheduled care or emergency departments to share information to safeguard children.

The CP-IS links the IT systems used across health and children's social care (using the child's NHS number).Social Care will be notified immediately that a child in their care or a child subject to a child protection plan has presented at an unscheduled care setting which is participating in CP-IS.

Nationally, as the roll out continues the number of health care settings participating in CP-IS is increasing.

The CP-IS flag system is live on SystmOne for all children. This is a new method of flagging children on child protection plans linked to the spine and will help to identify vulnerable children quicker including those from 'out of area'.

Bridgewater have gone 'live' with CP-IS in January, in 4 out of the 5 areas. These areas are;

1. Leigh WIC
2. St Helens MIU
3. Wigan GP Out of Hours
4. Warrington GP Out of Hours

Widnes will be processed during Q4.

Child Deaths

Sadly there have been a number of child deaths in each of the boroughs, some expected due to health issues and some unexpected.
Each child death is now reported on Ulysses. The Child Death Process is followed for each individual sad death.
The safeguarding team oversee Bridgewater's contribution to the CDOP (Child Death Overview Panel) process in relation to each of these child deaths.
Safeguarding Supervision is offered to all staff who has been involved with these sad deaths.

MASH (Multi Agency Safeguarding Hub)

This comprises of Health, the Local Authority and the Police.
Two of our boroughs (Oldham and Warrington) have a significant role to play in the local authority MASH teams.
The Oldham Safeguarding Team is based within Oldham's MASH. The current staff provision is 1 x WTE Specialist Nurse. The demand from the MASH to source and share information, attend strategy meetings and record the outcomes of these meetings on SystmOne exceeds the current commissioned staff resource. Commissioners are aware of the concerns and are reviewing provision.

Children in Care (CIC) /Looked after Children (LAC) Teams

As part of the safeguarding team there are LAC/CIC teams in Halton, Wigan, Warrington and Bolton. The roles and responsibilities vary slightly throughout the boroughs. Review Health Assessments (RHA) are completed by healthcare staff.

A significant issue in Bolton during 2017-18 has been the late completion of RHAs due to consents/Part A's not being received or received late from the Local Authority. The RHA Pathway, developed by the CCGs Designated Nurse, was approved by STAG in October. This process aids communication between the Local Authority and Health Providers, enabling early escalation by Health Providers where documentation is delayed.

Wigan and Warrington have a team of Specialist Nurses for Children in Care who continue to be recognised as high achieving teams. They report positively on improvements to service delivery and the impact of health interventions, through the LAC KPI's and they also provide a quarterly report to the CCG and Corporate Parenting Board which are always well received.

Challenges for 2017/2018

The main challenge has been around staffing capacity. Not only with the senior members of the team but within each team in each of the boroughs due to sickness, maternity leave and vacant positions. A number of the vacant positions became available due to successful promotions for our safeguarding team members.

Due to the safeguarding team's passion, commitment and hard work, these issues have been addressed at every juncture, escalated to the Trust Executive Board who supported the Associate Director with her plans. The safeguarding team has consistently worked hard and closely together to support each other and staff across the organisation and also to ensure that we safeguard adults and children who access our services.

Achievements in 2017/2018

- New appointments at all levels within the individual safeguarding teams
- Increased the number of safeguarding supervisors in Bridgewater
- Comprehensive update of policies , procedures and guidance
- Following completion of a procurement process which took place during Q3, Bridgewater has successfully retained the contract for provision of 0-19 services in Halton
- New appointment of Strategic Safeguarding Lead
- New appointment of Named Nurses in Wigan (Internal promotion), Bolton (Internal promotion) Oldham, and for Safeguarding Adults
- New appointment of a Specialist Safeguarding Adult Nurse to start in post early 2017/2018
- St Helens- Successful recruitment to a new post of Specialist Safeguarding Nurse Quarter 2 has ensured 3 day provision of support to the Bridgewater staff in the borough.
- Worked in partnership with the Local Safeguarding Boards in providing commitment and leadership in the safeguarding agenda
- Fully participated, reviewed and learned from local and national Serious Case Reviews and Domestic Homicide Reviews
- Increased the number of Safeguarding Supervisors across Bridgewater

- Worked 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
- Wigan and Warrington's Team of Specialist Nurses for Children in Care has continued to be recognised as a high achieving team
- The significant increase in safeguarding training compliance

Priorities for 2018/19

- Continue to promote all safeguarding training and increase compliance to ensure a competent workforce
- Work closely with the newly appointed Head of Risk Management & Patient Safety in managing risks and incidents
- Re-launch the Safeguarding Adult Champions, who act as a resource, role model and multidisciplinary link across the Trust. The Champions will provide support and advice in their clinical area and act under the supervision and support of the Adult Safeguarding Team
- To continue to work in partnership with the Local Safeguarding Boards in providing commitment and leadership in the safeguarding agenda
- Continue to effectively participate, review and learn from local and national SCRs and DHRs
- Work to achieve all action plans including CQC action plans in a timely and efficient manner
- Continue to work with SABs and 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
- Review the Safeguarding Supervision access and monitor compliance

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. Since the CQC visit in 2016, in which good infection control practices where described as good, the IPC team have ensured that all policies and procedure relating to infection, prevention and control remain updated.

Infection, prevention and control practice

- Sharps injuries have reduced by 57.5% in 2017 - 2918 since 2016 – 2017.
- Mandatory training for Infection Prevention and Control is:

INFECTION PREVENTION & CONTROL - LEVEL 2

	Total Number of Staff	Number of Staff Compliant	% Compliant
BRIDGEWATER	2114	1912	90.44%
CORPORATE	51	45	88.24%
EAST	1182	1096	92.72%
EAST ADULTS	567	513	90.48%
EAST CHILDREN	460	431	93.70%
DENTAL	141	139	98.58%
EAST DMT	14	13	92.86%
WEST	881	771	87.51%
WEST ADULTS	490	426	86.94%
WEST CHILDREN	290	263	90.69%
OFFENDER	84	65	77.38%
WEST DMT	17	17	100.00%

- Hand washing audits are completed twice a year by clinical staff; the audit is managed by the IPC team in conjunction with all departmental team leads. The overall results for 2017 – 2018 are:

Hand hygiene by Borough

Locality	April 2017 – September 2017	October 2017 – March 2018
Halton	98%	99%
St Helens	100%	100%
Wigan	99%	93%
Warrington	100%	98%
Bolton	100%	100%
Oldham	100%	99%
Dental	100%	96%

Cleanliness

- Audits continue to be completed by the IPC team and the cleaning providers; these are reviewed by the IPC team for discrepancies with the audit completed by themselves and where necessary the Head of Estates is notified. The audit calendar ensures that all premises where Bridgewater staff carry out clinical duties are audited every two years.
- The dental service completes its own audits; these are submitted to the IPC group for assurance.

Patient information

- Patient information around infection control is available in clinic settings via notice boards and available on the Trust intranet for both staff and patients to access. Further information can be obtained directly from the IPC team.

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 wish to review and monitor practice. The review of ANTT across the Trust was a priority for 2017/18 and roll out for 2018/19.

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 either Clostridium difficile, MRSA or E-coli 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 there has been no lapses in care to date of Clostridium difficile infection.

There have been no MRSA blood stream infections linked to a lapse in care across the Trust to date in 2017 – 2018. The IPC team have worked with the multi- agency teams to improve urinary catheter care, ensuring all patients receive education, support and a catheter passport following an incident at the beginning of 2016.

The Trust IPC team have multi agency meetings to support the delivery of the E-coli agenda and have started to complete PIR's on these blood stream infections. Regular meetings are held looking at ways of reducing the number as a health economy. Some joint education has occurred in the Warrington/Halton area.

Outbreaks

During December 2017 Padgate Intermediate Care facility staff informed the Infection, Prevention and Control Lead Nurse that four patients were suffering from diarrhoea. The care home was closed whilst awaiting the results of the samples and regular meetings via

telephone where held with the IPC lead nurse. The home was reopened after 14 days following a deep clean. A review of the Isolation of Patients with Infectious Conditions policy and the Diarrhoea and Vomiting Outbreak Clinical Guidance Guideline for Newton Hospital and all Inpatient Facilities supported by Bridgewater are to be reviewed to support future outbreaks. Training for staff in Padgate House is also planned.

January 2018 has seen three influenza outbreaks at the two of the Health and Justice Facilities managed by the Trust. HMP Wymott had two outbreaks, whilst HMP Hindley had one. There was heightened surveillance during the outbreak period. Both outbreaks where managed by an Outbreak Control Team (OCT) lead by PHE (Public Health England). The incidents were well managed by Bridgewater Healthcare staff, supported by the IPC team, Medicines Management team and PHE. Managing outbreaks in these facilities remains challenging due to the prison lay outs and environment, along with prisoners not always reporting symptoms in a timely manner.

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; this practice has now been implemented.

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. The campaign for 2017-2018 flu season was undertaken by the flu lead, a new seconded position created with the aim to improve

uptake. The vaccine was offered to all staff at their place of work and the flu lead was supported by the immunisation lead in the Bolton and Oldham area.

Bridgewater clinical staff uptake was 69.5% for this year, with each Borough/directorate broken down as follows for clinical staff:

- Wigan 58.9%
- Warrington 52.5%
- Halton 46.7%
- Bolton 83.6%
- Oldham 92%
- Health & Justice 82.8%
- Dental at 40.6%

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.

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.

Following on from last year's pledge by the infection, prevention and control team to improve staff and patient knowledge of the best use of antibiotics the IPC team continue to work with the Medicines management team in antimicrobial stewardship with regular meetings. Antibiotics remain an important medicine 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.

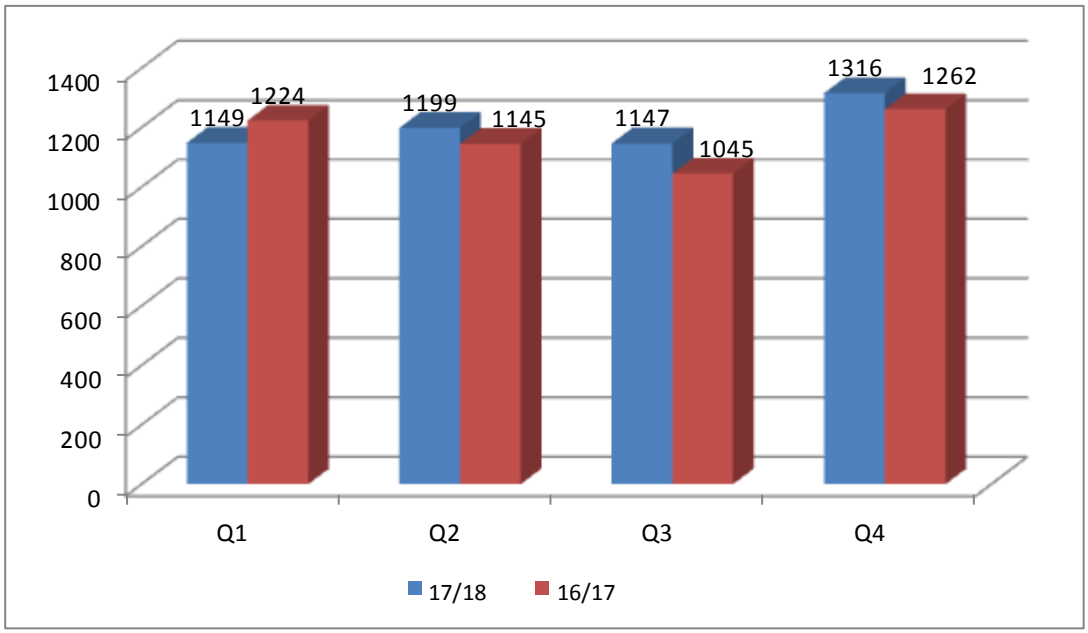
This year Public Health England have launched a campaign aimed at the public and health care professionals entitled 'keep antibiotics working'. A number of public information advertisements were shown on regional television and Trusts were asked to support this work. The infection, prevention and control and medicines management teams were eager to take part and have signed up to the campaign. This year the antimicrobial stewardship

group update the Trust's web page and advertised a crossword competition in the Trust bulletin to coincide with antibiotic awareness week.

Patient Safety / Incident Reporting

The Trust continued to use the web-based Ulysses Safeguard Risk Management System for reporting and management of all actual incidents and near misses, which did / could, have resulted in harm.

There was an increase in the total numbers of incidents reported in the Trust during the period 2017/18, when a total of 4,811 incidents were reported compared to 2016/17 when 4,676 incidents were reported. This is considered to be a result of the Trust's open culture for the reporting of incidents, resulting in increased staff awareness of the need to report incidents. Through the weekly Patient Safety meetings and the monthly Quality & Safety Sub Groups the Associate Chief Nurses & Quality and Safety Leads have continued to support staff in identifying and reporting incidents. Trust wide incident trend reports are reviewed at the monthly Quality and Safety Sub Groups (QSSG's), to raise awareness of high risks and to promote the effective management of such risks.



Commissioner	2016/17	2017/18
Bolton	113	132
Cheshire	77	40
Corporate	13	22
Dental	137	156
Halton	1,020	1,074
Knowsley	0	0
NHS England	5	2
Health for Justice	0	271
Oldham	146	151
Commissioner	**2016/17**	**2017/18**
Southport	2	0
St Helens	806	181
Trafford	16	11
Warrington	1,114	1,224
ALW (Wigan)	1,227	1,547
Total	**4,676**	**4,811**

All newly reported incidents are reviewed by the relevant senior clinical staff, responsible for the service area(s) involved in incidents. This is necessary to embed the accountability for risk management and prevention of incidents around the Trust.

Daily checks are also made of all newly reported incidents by the Risk Management Team, to check the quality of the data recorded in each incident. These daily checks are used to identify possible serious incidents for escalation.

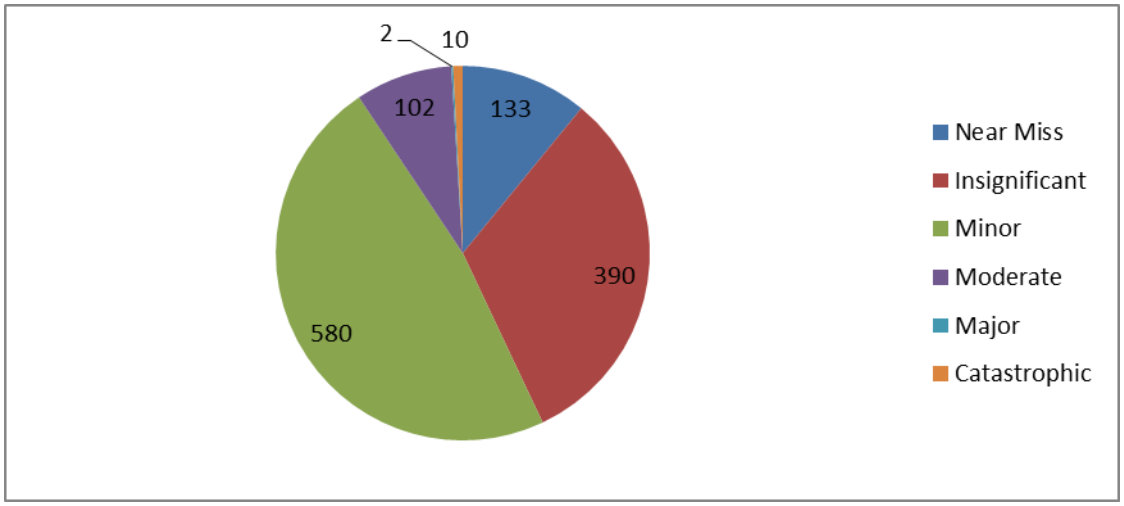
Pressure ulcers continue to be the most common type of incident reported in the Trust. Following review of serious incident reports, the Trust's Quality & Safety Lead for east, has introduced a "pressure ulcer huddle". This process ensures that all key steps in the management of pressure ulcers are followed and is being embedded into operational practice The impact of this huddle, will be monitored to evaluate its impact on the prevention and management of pressure ulcers.

There were 28 patient safety incidents that were recorded as [4] Major or [5] Catastrophic. For the Catastrophic category three out of the 5 were serious incidents and were uploaded onto the Strategic Executive Information System (STEIS). The remaining seven were notifications of deaths (safeguarding) and deaths in patients home.

Trust staff reported 4,811 incidents during 2017/18, 513 (44%) of which were categorised [1] Insignificant or [0] near misses effecting patient safety.

All patient safety incidents 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	2016/17	2017/18
	Total	Total
Near Miss	133	180
Insignificant	390	333
Minor	580	517
Moderate	102	128
Major	2	6
Catastrophic	10	12
	1,217	1,176



The overall volume of reported incidents 4,811 for the period 01st April 2017 to 31st March 2018 has increased compared to last year by 135 incidents. The volume of Patient Safety Incidents (1,217) has decreased by 46 (1%) compared to 2016/17.

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 2017/18 to improve our management of incidents:

- The Trust's Incident Reporting Policy was reviewed and updated during 2017 to fully reflect the requirements of the NHS England Serious Incident Framework that was published in 2015.
- The Directorate's Quality and Safety Sub-Groups met every month to analyse and escalate significant incidents, complaints, or risks for support from the directorate team meetings and to direct service change in response.
- Weekly Patient Safety meeting to review and monitor pressure ulcers.
- Automated monthly incident reports continued to be issued to senior managers at the beginning of each month, to ensure that they were sighted on all incidents within their areas of responsibility.
- Continued to use a case note review process to inform the management of pressure ulcer incidents and determine if further investigation was required.
- The Serious incident Review Panel, met on a weekly basis to maintain an overview of all serious incidents.

In order to nurture the Trust's approach to learning from incidents, a Quality Newsletter has been developed, which contains details of key lessons to be learnt in the Trust. This is in addition to the on line posting of lessons learnt, on the Trust's intranet.

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 the list of never events each year in February 2018, an amended list of 18 never events was implemented. If never events occur in the Trust, we are required to report these directly to the Care Quality Commission and our commissioners as Serious Incidents and investigate the incidents to establish root causes and formulate actions to prevent a reoccurrence of the incident(s). There was one never event during the period 01st April 2017 to 31st March 2018 which related to nail surgery and is currently under investigation.

Central Alerting System

Using patient safety 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 all NHS organisations which are then required to indicate their compliance with these patient safety alerts. All of these alerts have required target dates for completion and must be acknowledged on the Department of Health's website within 48 hours of receipt.

During the period 01st April 2017 to 31st March 2018 the Trust received 6 Patient Safety Alerts, 4 of these alerts were relevant to the Trust. The Risk Management Department cascaded the alerts to each Directorate in order that they could be actioned and confirmation provided that all required action had been taken in the service areas of the Trust.

Safer Caseloads in District Nursing

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 developed its approach to monitoring and reporting our DN staffing levels. From June 2017 the organisation commenced monthly collection 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 date the data collection tool and process has required adaptation and amendments supported by our performance team to allow for monthly collection, interpretation and monitoring of data. Further work is required with the teams to ensure a consistent approach to data collection and to provide assurance on data quality. Once assurance has been provided and data quality confirmed the outputs of the monitoring tool will be able to support future workforce planning and caseload management.

Freedom to Speak Up – Raising Concerns

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.

All NHS organisations have to appoint a Freedom to Speak up Guardian. The Trust has had a Guardian in place since 2016. The Trust has a staff APP for mobile devices and there is a section on the APP for staff to be able to make contact with the Guardian if they wish to raise a concern. There is also a link to the Trust policy and videos to help staff understand how they can raise a concern.

Bridgewater had six Raising Concerns issues raised in 2017/18 which is four more than the previous year. Three were raised directly with the Guardian and three were through contacting HR using the Freedom To Speak Up Policy. The concerns were related to:

1. Dignity at work/behaviour and conduct
2. Caseloads/caseload management
3. Working environment
4. Working practices
5. Working patterns, shifts and overtime
6. Secondary employment

These concerns have been investigated and have led to managers and the senior nursing teams working to together with 'distressed' teams to work through their concerns and work towards solutions that benefit both staff and our patients.

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 2017/18 there were 19 deaths reported through this route. Of these deaths:

- 11 were deaths in custody and non-attributable to Bridgewater.
- 10 were deaths at other providers and reported and investigated by them.
- 3 were considered by the Serious Incident Review Panel and no further investigation was recommended.
- The Serious Incident Review Panel did not request any further investigations of any of the deaths, as the reports review from NHS England were considered to be adequate.
- 12 were reported onto the Strategic Executive Information System (STEIS) to formally notify commissioners of the serious incident. These included the 11 deaths in custody and the 1 expected death at Alexandra Court Nursing Home. 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 regarding patients with learning disabilities in 2017/18.

All deaths in custody are reported through the Strategic Executive Information System (StEIS) to NHS England, who commissions the Trust's Health & Justice Services. NHS England commission root cause analyses regarding these incidents, which are carried out independent of the Trust.

In order to be assured that the outcomes of these investigations result in action plans that are delivered, the Trust in liaison with NHS England, has introduced a process that requires all reports regarding death in custody to be reviewed by the Trust's Serious incident Review Panel (SIRP). During the period 2017/18, 4 reports regarding death in custody were reviewed at the Serious incident Review Panel.

The Trust also contributes to Serious Case Reviews at the request of the Local Safeguarding Children's Boards. The Trust contributed to 5 Serious Case Reviews during 2017/18 for child deaths which occurred in the localities it serves. The Trust is also contributing to 8 ongoing local case reviews and working with local agencies to implement actions and learning.

In 2017 there were 8 inquests regarding deaths within the Trust, 3 of which were related to Deaths in Custody. Of the 5 community cases, there were no issues related to the care provided by the Trust.

During 2017/18 we have implemented a number of actions that all NHS Trusts were required to implement 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:

- Approval and publication of a "Responding to Death policy" on our public facing website.
- Nominated executive and non-executive leads.
- Completion of our initial assessment on the best dataset source, in order to collate and publish quarterly deaths information.

Next Steps for 2018/19:

- The Trust is to implement a Monthly Responding to Death Panel to sit in conjunction with the Serious Incident Review Panel. This will be overseen by the Clinical Governance Sub-Committee.
- The output will be quarterly reports to the board of numbers of deaths, lessons learned and an assessment of the impact of any actions taken.
- The Trust will be working with other Community Trusts, to establish a peer review process covering the North of England.

The Trust will undertake a training needs analysis/review and address any training needs of staff reporting deaths.

Quality Impact Assessments

The Trust's 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 Cash Releasing Efficiency Saving (CRES) schemes, or service developments within the Trusts CRES Programme on the quality of care provided by the Trust.

Our QIA panel has been established to oversee the Trust's QIA process, which is chaired by the Executive Medical Director. The panel reviews CRES schemes to ensure that they are safe and will not affect quality of service, agrees the arrangements for monitoring risks and stipulates the frequency of reviews and future reporting. The Trust's Executive Medical Director and Chief Nurse are the final arbiters for all QIAs, once presented to the QIA Panel.

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

The QIA process for the 2018/19 CRES programme has been enhanced to streamline the system, whilst ensuring that quality and safety are core to the programme. Firstly, the QIA documentation has been consolidated with the Project Overview Document (POD) that is routinely prepared for each scheme. This means that scheme leads now only complete a single document, which speeds up the process and eradicates duplication of information. It also means that the QIA panel has access to additional information about a scheme that was not available as part of the previous process. The second enhancement to the QIA system is the introduction of QIA by theme. Each of the schemes within the 2018/19 programme is aligned to a themed work-stream. This presents the opportunity to QIA schemes in groups, rather than individually, which significantly speeds up the QIA process and required less QIA panel meetings to complete.

Divisional Assistant Directors will perpetually monitor performance indicators for their division via monthly Finance, Workforce and Performance (FWP) meetings and will investigate and report any adverse changes to the Management Team, should they arise.

The 2018/19 CRES programme is overseen by the Trust's Management Team and progress with the QIA process will be monitored by this group, and ultimately reported to the Finance and Investment Committee.

Clinical Effectiveness

Clinical audit

"Clinical audit is a way to find out if healthcare is being provided in line with standards and lets care providers and patients know where their service is doing well, and where there could be improvements.

The aim is to allow quality improvement to take place where it will be most helpful and will improve outcomes for patients. Clinical audits can look at care nationwide (national clinical audits) and local clinical audits can also be performed locally in trusts, hospitals or GP practices anywhere healthcare is provided." https://www.england.nhs.uk/clinaudit/

In Bridgewater 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 that contains both national and local clinical audits which is 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 and associated key actions for any areas identified for improvement.

The table below shows the number of clinical audits undertaken during 2017-18. It shows some of the improvement achieved and where necessary shows what actions Bridgewater Community Healthcare NHS Foundation intends to take to improve the quality of healthcare provided.

Clinical Audits 2017/18

	Audit name / title	Key actions following the audit
1	Priority Audit of Leg Ulcers within District Nursing	Redesign service to improve accessibility and timeliness for patients with leg ulcers including a review of equipment and premises.
2	Priority Re-audit of Mental Capacity Act (MCA) within Dental Network	Undertake specific case reviews and re-issue guidance.
3	Priority Re-audit of Duty of Candour	Design and implement new processes around the management of incidents and communication with patients. Update Trust policies accordingly and provide training for staff.
4	Audit of Chlamydia Management	Training for staff on British Association for Sexual Health and HIV guidance. Explore IT options for providing patient information leaflets.
5	Priority Audit of Pressure Ulcer Care	Ensure all new paperwork is used for new referrals. This will prompt for all aspects of assessment to be recorded and timely referral to Tissue Viability.
6	Priority Audit of Stroke Care Bundle	Adapt nationally recognized assessment tools already in use to allow additional information to be recorded.
7	Audit of Heart Failure	Review and tighten up processes for patient follow up appointments.
8	Priority Audit of End of Life Care Bundle - Halton Haven	Undertake a joint service audit with the district nursing service following the patient's journey.
9	Priority Audit of Heart Failure Care Bundle	No improvement actions required. Undertake annual monitoring for assurance.
10	Priority Audit of Podiatry Care Bundles	No improvement actions required. Undertake annual monitoring for assurance.
11	Priority Audit of Antenatal and Postnatal Care (not Home Births)	Review records management process. Review and revise the design of electronic patient record and associated processes.
12	Audit of Care Pathway for Children with Speech Delay/Disorder	Standards achieved, however minor improvements in record keeping identified. Service to continue with the Trust record keeping audit and action where necessary on an ongoing basis.
13	Audit of Care Pathway for Children with Speech Delay/Disorder	Undertake a patient/carer survey relating to communication and sharing of information
14	Audit of the Diagnosis and Management of Attention Deficity Hyperactivity Disorder (ADHD)	Clinic letter to be copied to Special Education Needs Coordinator (SENCO) with parents' consent.
15	Audit of Wound Assessment (CQUIN)	Continue with improvements to both paper patient health records and electronic patient health records to ensure comprehensive documentation of wound assessments.

16	Mini-audit of Care Plans and Wound Photography	Working groups established to address audit findings and make improvements.
17	Audit of the Effectiveness of the Macmillan Physiotherapy Acupuncture Treatment	Produce guidance to describe local practice and processes to be followed.
18	Audit of Nexplanon Insertion	Standards met - minor improvements identified to update electronic templates
19	Audit of the Management of Urinary Tract Infections (females over 16 and under 65)	Undertake spot check audits on prescribing. Provide education and training sessions in differentiating between two or more conditions which share similar signs or symptoms.
20	Audit of Record Keeping	Managers identify improvements via this monthly audit, implement actions locally as indicated and monitor improvements on a monthly basis.
21	Audit of Continence Care Bundle and NICE Quality Standard 77.	The service manager has reviewed and revised all processes and paperwork. Undertake re-audit to ensure improvement has been achieved.
22	OCATS PROMS/shared decision making audit	Monitor via electronic patient record system that all outcome scores have been recorded at initial appointment and prior to discharge.

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 2018. To request a copy of the 2017-18 clinical audit annual report please contact clinical.audit@bridgewater.nhs.uk

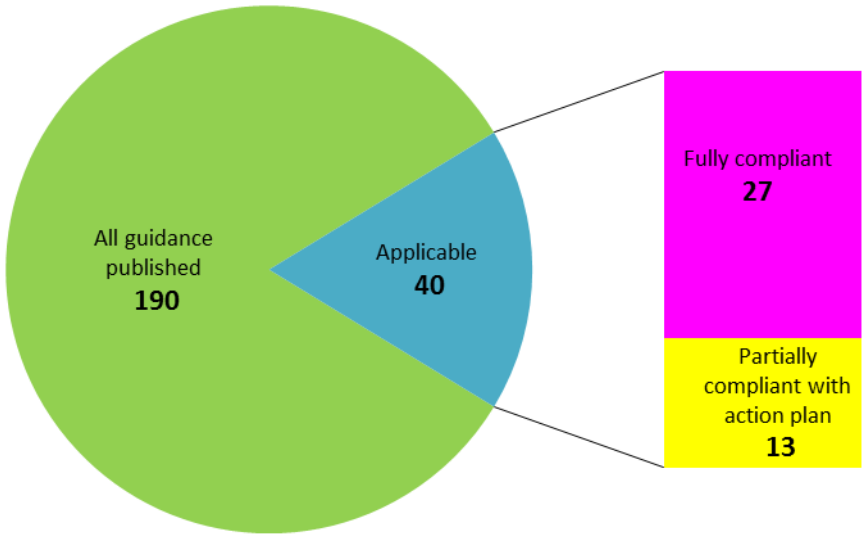
NICE Guidance

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 recommendation that the service is not adhering to at present. 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 the year April 2017 to March 2018, NICE published 190 pieces of guidance most of which relates to care provided in acute hospitals. There were 40 pieces of guidance applicable to services that the Trust provides. We are fully compliant with 27 and action plans are underway to bring us into full compliance with the remaining 13.



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. Below is an example of an audit that was undertaken against standards from NICE guidance.

Audit of Heart Failure Service (NICE guidance CG108: Chronic Heart Failure) Halton, St Helens and Wigan Boroughs
What we found
The audit found high levels of compliance with the standards taken from the NICE guidance. Nevertheless a couple of opportunities for improvements were identified as follows: ▪ 100% of patients had a review of medications although not all patients had a review within two weeks of any changes being made to medications ▪ 100% of patients had a plan based on their needs although it was not always clear within the record what engagement there had been with the patient.
What we are doing about it
▪ The service is implementing a process to ensure patients who have had medication changed by the service are offered a two week review for monitoring. ▪ Ensure that the new paperwork already introduced is being used consistently by all staff to capture all informed decision making and care plans agreed with the patient

Research and Development

One of the core duties of all NHS organisations as embedded in the NHS Constitution, the Health & Social Care Act 2012, and the NHS 5 Year Forward Plan, is to collaborate with our patients and the communities we serve to assist them to participate in and benefit from high quality research. At Bridgewater, we acknowledge that clinical and health service research has the potential to impact positively on the lives of the community we serve in many ways, including improved health, better understanding of conditions, and importantly the opportunity to shape future treatments.

Here are some excerpts from our patients outlining why they chose to take part in our research: *"I just thought I would help, because you (NHS) helped me". "I went to University and did research, I think it can help people by taking part and I think it's a good thing doing research".*

During 2017/18, 606 of our patients signed up to the '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. More information on this campaign can be found via the following website https://www.researchforthefuture.org/

During the period reported, research has played a central role in advancing our clinicians' practice to provide high quality patient centred care. Our staff generate research questions out of direct clinical practice, with an excellent example being the development of a croup pathway that has enabled staff within one of our Walk in Centres to treat children presenting with mild croup with a steroid medication. Introduction of this pathway has meant that children have been treated for mild croup at the Walk in Centre rather than having to attend Whiston Emergency Department. The impact of this pathway has been fantastic for patients and their families/carers.

During 2017-18, a Trust Speech and Language Therapist (SLT) working in the Halton borough was awarded a place on the National Institute for Health Research's prestigious Integrated Clinical Academic (ICA) Programme Internship Scheme, to research how hearing loss impacts on communication recovery following a stroke. This award is an important first for the Trust, and will provide our SLT with an introduction to the clinical academic research environment and research skills, whilst emphasising the benefits of conducting research as part of their clinical role.

For the third year running, Bridgewater was shortlisted in the annual National Institute for Health Research's Clinical Research Awards. In November 2017, the Sexual Health Team based at Bath Street Health & Wellbeing centre in Warrington were runners up in the Best Community Research Contribution category. The nomination was for the team's involvement in the Safetxt study, which seeks to find out whether delivering support using text messages over the course of one year is an effective way of reducing sexually transmitted infections by promoting safe sex and regular testing in young adults aged between 16 and 24 with a positive chlamydia or gonorrhoea test.

Research at Bridgewater continues to be overseen by a Trust Research & Development Strategy Group, which meet on a quarterly basis during 2017-18. Membership includes a broad range of clinical specialisms, Medical Director, Non-Executive Director, Public and Staff Governors. Research Management and Governance is assured via quarterly reporting to Board via the Trust's Clinical Governance and Quality & Safety Committees.

Library and Knowledge Services

In 2017, 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 assessment against the national standards contained in the NHS Library Quality Assurance Framework (LQAF).

The service scored 97% (95% in 2016) and further consolidated their 'green' service rating.

Patient Experience

The Trust recognises that eliciting, measuring and acting upon patient feedback is a key driver of quality and service improvement. The Bridgewater Service Experience Group provides a focus on the Trust wide, strategic issues for patients and carers, ensuring their views are instrumental in influencing service provision.

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 also 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 by the Service Experience Group with any lessons learned identified and cascaded across the organisation.

Complaints

We welcome complaints as they are a mirror to our services which shine a light to show where improvements need to be made. We aim to learn from all complaints as part of improving our patients' experience.

During 2017/18 we received 92 complaints compared to 94 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	4	17	39	3	11	17	1	92

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	72
Attitude of staff	6
Communication/Information to patient	6
Failure to follow agreed procedures	3
Appointments, delay/cancellation (outpatient)	3
Length of Time Waiting: Walk In Centres	1
Patients' privacy and dignity	1
Total	**92**

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 and cascaded via the Quality Newsletter.

Some examples of lessons learned include:

- Paediatric Community Medicine Service – Complaint about a child referred by GP into the service and not been assessed for a considerable period. Also delays in communication over several months.

  The reason was that there was no tracker in place to monitor referrals which led to delay in assessment questionnaires being sent out/received resulting in a delay in decision being made at panel.

  The service has now put a tracker in place so it is recorded when the assessment questionnaires are sent out and when they are received back into the service, which flags up any delays.

- Physiotherapy Service – Complaint about the treatment provided to patient who attended to have acupuncture. Patient was left in the cubicle for an hour and the therapist did not return to check on her. Patient became unwell and shouted for help.

  The service has purchased bells and timers to be placed in all cubicles so that this does not recur.

- District Nursing Service – Complaint about the care and treatment provided to patient following discharge from hospital. Inappropriate dressings applied to wound. Stitches removed and wound opened as soon as patient put pressure onto his leg.

  Dressings used on the wound prior to suture removal were of an inappropriate use. Due to location of wound it would have been preferable to remove stitches across two visits to patient's home.

  The service has addressed the issues by ensuring the staff member involved attends wound care training and will go through the competency process for removal of sutures; they will also shadow the Tissue Viability team to increase their knowledge and skills in relation to wound care.

- Walk in Centre – Complaint about the quality of the assessment undertaken, lack of privacy and dignity as the consulting room door was left open and the attitude of the triage nurse.

  All Walk in Centre clinical staff to be reminded to maintain privacy and dignity at all times, ensuring that patients are offered the opportunity for the door, as well as the privacy curtain, to be closed – on going reminders are given at monthly team meetings.

- Health and Justice – Complaint about the lack of care / treatment received and the withdrawal of medication without being seen by a Doctor.

  In future patients are to be informed on initial prescribing of the timescale of prescriptions or review date for all acute conditions. Discussions will take place with all doctors to ensure implementation.

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 27,143 people responded to the friends and family question and 96.7% indicated that they would recommend Bridgewater services.

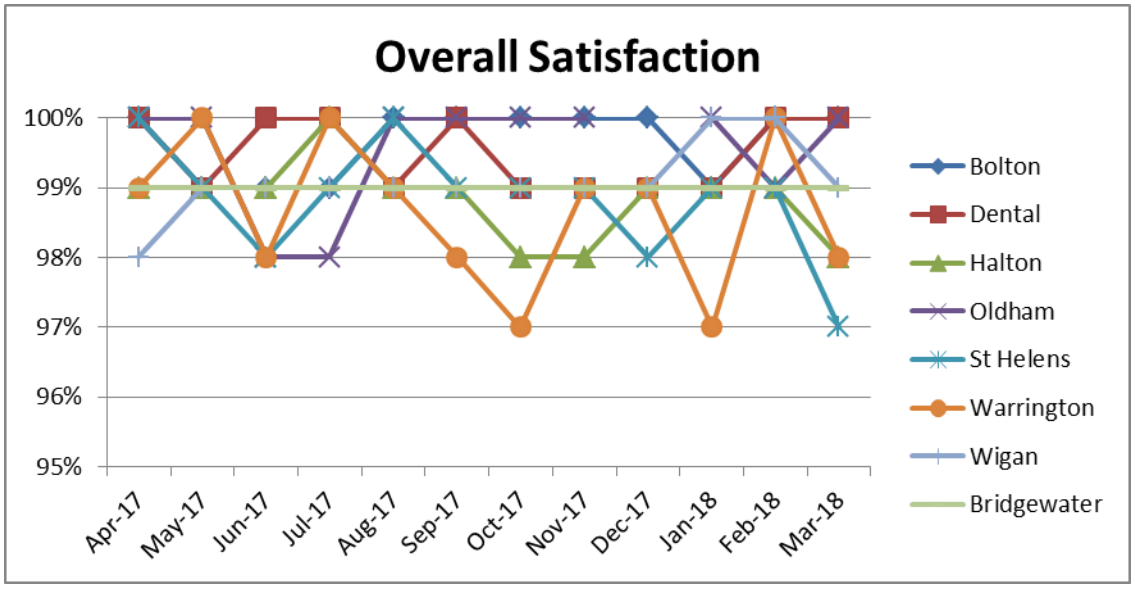
Borough/Service		Would Recommend	Would not Recommend	Number of Responses
Bolton		98.5%	0.2%	1225
Dental		98.2%	1.0%	1966
Halton		96.7%	1.3%	7622
Oldham		95.5%	0.4%	1146
St Helens		97.5%	1.5%	4484
Warrington		96.3%	1.6%	2758
Wigan		95.9%	0.9%	7343
Willaston (GP)		98.2	0.0%	56
Maternity Services	Antenatal	100%	0.0%	168
	Postnatal	99.2%	0.3%	375
Bridgewater Total		96.7%	1.1%	27,143

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 28,397 responses were received during the year and 99% indicated overall satisfaction with their care and treatment.

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.



The patient experience responses from the other key touch points are presented in the table below.

	Bolton	Dental	Halton	Oldham	St Helens	Warrington	Wigan	Willaston	Bridgewater
How do you feel about the length of time you waited to be seen?									
	96%	98%	93%	96%	95%	92%	95%	97%	94%
How do you feel about the way staff greeted you?									
	100%	100%	100%	100%	99%	100%	100%	98%	100%
How do you feel about the way staff listened to you?									
	99%	100%	99%	100%	99%	100%	100%	100%	99%
How do you feel about the information you were given (verbal or written)?									
	100%	100%	99%	99%	99%	99%	99%	100%	99%
How do you feel about the privacy, dignity and respect shown to you?									
	100%	100%	100%	100%	99%	99%	100%	100%	100%
How do you feel about the opportunity you were given to ask questions?									
	100%	100%	99%	100%	99%	99%	100%	100%	99%

How do you feel about the overall experience of your care or treatment?									
	100%	100%	99%	99%	99%	99%	99%	100%	99%
Number of responses	**1269**	**2023**	**8536**	**1192**	**4644**	**2855**	**7816**	**62**	**28397**

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 Continence Service, Halton

This story is from the Mum of a young patient regarding her experience of the clinical and emotional support provided by the Paediatric Continence Service at a time when the family felt vulnerable and isolated at home. This is not a condition that can be cured and will always need on-going support.

This little girl, despite her age and anxiety is very much in charge. She is kept informed and asked for input and consent during each step of her journey.

"Since the very first contact with the service the nurse has become a vital part of our lives. She is always available if there is a problem. I know she has my daughter's best interest at heart and she will fight for her. Our journey wouldn't have been so smooth if it hadn't been for this service.

Paediatric Speech and Language Therapy Service, Wigan

This story is about a child with severe autistic spectrum disorder, developmental delay and sensory processing disorder. The service worked closely with the family and supporting organisations to introduce them to a pre-loaded electronic application via an IPad, which enables the user to communicate and indicate their needs.

"My son quickly learnt how to use the application and was soon able to make requests, mainly food related at first but after a short while he used it to tell us what he had done and how he was feeling. More recently he has started to communication verbally, which is a significant development. The work undertaken with the service and the use of the

application has also reduced his anxiety levels. As a family we are confident that his development will continue and aid his challenging behaviour."

Community Specialist Rehabilitation Service, St Helens & Knowsley

A story from a patient who wished to share her experience of the Community Specialist Rehabilitation Service, following an injury that was to change her life as she knew it. The lady was unable to perform daily personal activities and found that she was becoming increasingly dependent on others.

The team worked with the patient in helping her to move forward and work towards meaningful and realistic targets.

"Initially I found the therapies beneficial in helping me to get through the week. The more I saw the team and with their support I eventually felt able to venture out into the community. I have grown in confidence and independence so much so that I have now returned to work on a part-time basis, performing adapted duties. I feel positive about the future and now enjoy life be it in a different way."

Right Start and School Nursing Service, Oldham

This is the story of a single Mum who was referred to the service following the birth of her first baby. Mum has complex health and social needs, with a history of limited engagement with services.

The service involved Mum to agree a programme of support to ensure key family needs were addressed whilst ensuring the child's health and development needs remained the focus for Mum.

"The support from the team has given us both so much confidence, especially as I suffer from anxiety. My child's speech and improved greatly and she is a happy little girl. The support has been fantastic and has shown me how to interact and play with my child. Going forward I now feel I would like to go to college and eventually get a job. I can't thank the team enough for what they have done for us."

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:

The Voice of the Child

The voice of the child is a phrase used to describe the real involvement of children and young people. It means more than seeking their views, which could just mean the child saying what they want, rather than being really involved in what happens. Children and young people should have the opportunity to describe things from their point of view. They should be continually involved, and have information fed back to them in a way that they can understand. There should always be evidence that their voice has influenced the decisions that professionals have made.

Bridgewater has a Voice of the Child forum, which brings together members from various disciplines across universal 0-19 services and specialist children's services.

Wide representation has been helpful in building a shared understanding of the 'voice of the child' which is relevant across professional disciplines.

Our aim is to develop organisational awareness and raise the profile of the child's voice at a service level as well as at an individual level.

The forum has developed a workshop to increase understanding about the importance of the Voice of the Child in children's services across Bridgewater.

Paediatric Speech and Language Therapy Service, Wigan

The Paediatric Speech & Language Therapy Service, with colleagues from the Adult Learning Disability Team, gathered information from young people and stakeholders to increase understanding of the challenges of health transition.

A key finding of the project was that safety for young people with Learning Disability goes hand in hand with how comfortable and confident they feel with all aspects of accessing ‘adult’ services. This includes how well they are prepared and supported to understand what is available in order to make informed choices about their care.

People's Voice Media was commissioned to help document the voice of young people within film.

Patient and Parent participation through the film has been key in highlighting particular themes around transition, including early information to support choice and help navigate mainstream services; and guidance around consent and capacity issues.

The project coincided with the implementation of the Transition NICE Guidance 2016 and this has also influenced the work that the Teams have undertaken in order to review care pathways and systems to help improve the patient journey.

Adult Speech and Language Therapy Service, Halton

The service has collected two patient stories for the creation of a video answering the question:

"What is the one thing you wish society could understand about communication difficulties?"

Two videos have so far been collected and saved within each patient's file. The aim is to use the videos to increase awareness around communication difficulties within the community. The videos will also be used for staff training on person centred care.

The service is also collecting patient stories from Head and Neck Cancer Patients. Patients have assisted with audio recordings by discussing the treatment and service delivery they had received from speech and language therapy. The aim was to gain feedback around aspects of service delivery and treatment that were going well and also what could be improved.

Feedback from patients indicated that they would like to meet other people in the same situation as themselves, in order for them to share stories and ideas for things that have worked and not worked for them around their eating and drinking difficulties following treatment. As a result, a dysphagia head and neck café was set for patients to meet on a monthly basis.

Patient Partners have been involved in the recruitment process for new therapy staff. Each Patient Partner was asked to have a conversation with the candidates on a one-to-one basis and to provide structured feedback and scoring afterwards.

Adult Learning Disability Team, Wigan

The service regularly seeks patient feedback about their experience of services across Bridgewater. The team has undertaken in-depth discussions with its patients to gain and understand their experience of the Occupational Therapy Service and the Speech and Language Therapy Service

The service has held focus group meetings involving the transition team, parents and carers to look at the pathway from children's to adult services. As a result an action plan was developed, to include some joint working between community services and hospital teams, to look at the way forward.

The service has engaged its Patient Partners in developing patient information leaflets plus a poster. The service has also done some joint working with a charitable organisation called 'Change' to develop some easy read information about Prostate Cancer

Paediatric Physiotherapy Service, Wigan

The service engages its patients in a variety of ways to gain feedback of their experience of the service including: emotions diaries, questionnaires, children's handwriting group, Yes/No counter boxes within clinics, comment cards and also through conversation.

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 2017/18 we received 1950 contacts across Bridgewater. These are summarised below.

	Bolton	Corporate	Dental	Halton	Health and Justice	Oldham	St Helens	Warrington	Wigan	Willaston	Total
Qtr. 1	2	10	13	79	10	2	62	87	147	0	412
Qtr. 2	4	11	14	102	37	6	53	108	163	1	499
Qtr. 3	4	23	16	81	30	3	63	88	178	0	486

Qtr. 4	4	24	29	100	29	1	62	104	200	0	553
Total	**14**	**68**	**72**	**362**	**106**	**12**	**240**	**387**	**688**	**1**	**1950**

Around 55% of the contacts were requests for advice and information, including signposting to other organisations.

Almost 27% 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 5 of the 1950 contacts went on to become formal complaints.

Further Information Regarding Quality of Services in 2017/18

Commissioning for Quality and Innovation (CQUIN)

National CQUIN schemes

In 2017 a national approach was taken to CQUIN schemes with local schemes being discontinued. This is with the exception of a local CQUIN in St Helens

There were 4 national CQUIN schemes that local commissioners agreed with Bridgewater were applicable to be delivered within community services these were:

Supporting proactive and safe discharge

The aim of this national CQUIN is to increase the proportion of patients, admitted via a non-elective route, discharged from acute hospitals to their usual place of residence within 7 days of admission by 2.5% from baseline based data relating to this category from Q3 and Q4 2016/17.

The aim of the CQUIN is to improve patient outcomes, improvement in patient flow, and reduction in delayed discharges. The CQUIN is reliant on data provided by the acute sector this will be an indicator of how well the whole system works to support timely discharge.

The CQUIN involves mapping and streamlining of existing discharge pathways across acute, community and NHS care home providers and roll out of protocols in partnership across local whole systems. In order to do these providers will need to work in partnership and cooperate to achieve the desired outcome of the CQUIN and improvements in patients.

The CQUIN requires working an integrating approach with acute and community providers to achieve the milestones and outcomes of the CQUIN. Achievement of the

CQUIN is dependent upon all partners achieving their milestones and an increase in patients being discharged to their usual place of residents within 7 days of admission.

Personal Care and Support Planning

The purpose of this CQUIN is to introduce the requirement of high quality personal care and support planning. More than half of the population live with long term conditions and 5% of these people account for more than 75% of unscheduled hospital admissions. Many of these people (35%) indicate they have low or very low levels of knowledge, skills and confidence to self-care, in order to manage their health and wellbeing and live independently. These people have a poorer quality of life, make more unwarranted use of public services and cost more to public services.

There are steps that can be taken, supported by this CQUIN, to address the above by incentivising the change in behaviours and methodologies that allow patients to take a greater control over their health and wellbeing. The core components are personalised care and support plans which encourage and support people with long term conditions to:-

- shape their pathway through services and keep control over their lives
- choose how, when and what treatments or other services they receive
- personalise services organised around their lifestyles
- develop the knowledge, skills and confidence to manage their own health and wellbeing

This CQUIN is to be delivered over two years with the aim of embedding personalised care and support planning for people with long-term conditions. In the first year, activity will be focused on;

- agreeing and putting in place systems and processes to ensure that the relevant patient population can be identified
- ensuring the relevant workforce receive appropriate training so that personalised care and support planning conversations can be incorporated into consultations with patients and carers

Preventing ill health by risky behaviours – alcohol and tobacco

This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the 5YFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN. The CQUIN

focuses on alcohol and tobacco screening, advice and onward referral were appropriate. Although primarily focused on acute inpatient settings CCG's in Warrington and Wigan requested that the CQUIN be delivered within some services within these boroughs.

Improving the assessment of wounds

Research evidence demonstrates that over 30% of chronic wounds identified in the CQUIN as wounds that have failed to heal for 4 weeks or more) do not receive a full assessment which is based on research evidence and best practice guidelines. Guidance on the components of a full wound assessment will be published via the Leading Change adding Value web page early in 2017.

Failure to complete a full assessment can contribute to ineffective treatment which therefore delays the rate of wound healing for patients. This has significant consequences for patients in respect of their quality of life as failure to treat wounds correctly can lead to delays in healing or failure to heal.

For providers and commissioners the delay in wound healing relates to the resources being consumed inappropriately. Managing patients with wounds and their associated co-morbidities is estimated to cost the NHS £5.3 billion; the average cost of unhealed wounds is more than double that of healed wounds. There is also significant variation in current practice.

All of the above national CQUINs are to be delivered over a 2 year period with milestones and reporting required quarterly during this period. All schemes are currently achieving against defined milestones and will continue during 2018/19.

Wigan

Wigan are participating in all 4 of the national CQUINs with the preventing Ill health and risky behaviours CQUIN being delivered by the Musculoskeletal Service and the Podiatry service.

St Helens

St Helens are participating in two of the national CQUINS: Health and well-being, and preventing ill Health and risky behaviours. The heart failure team are participating in the preventing ill health and risky behaviours. St Helens are also participating in a local CQUIN reporting outcomes of care with Speech and Language Therapy, Paediatric Continence Services, Community Paediatric Services and the Audiology Service.

Warrington

Warrington are participating in all 4 national CQUINs with the preventing risky behaviours CQUIN being delivered by Padgate House Bed based intermediate care service.

Halton

Halton are participating in 3 of the national CQUIN's. Halton CCG did not request that Bridgewater take part in the risky behaviours CQUIN as they did not feel that it was appropriate to be delivered within any of the services provided by Bridgewater in this area.

Further details regarding progress against all the agreed goals for 2017/18 is available electronically at: www.bridgewater.nhs.uk/aboutus/foi/cquin/

The Trust's corporate social media accounts are as follows:

- https://www.instagram.com/bridgewaternhs/
- https://twitter.com/Bridgewater_NHS
- https://www.facebook.com/BridgewaterNHS/
- https://www.youtube.com/user/BridgewaterNHS

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 last year, but did not meet if for this year.

Que	Health & Wellbeing – NHS Staff Survey Results 2017	2016	2017	Difference
9a	% saying their organisation definitely takes positive action on health and well-being	27	22	5% deterioration
9b	% saying they have experienced musculoskeletal problems	22	24	2% deterioration

	(MSK) in the last 12 months as a result of work activities			
9c	% saying they have felt unwell in the last 12 months as a result of work related stress	42	45	3% deterioration

HEALTH & JUSITCE

Service Specific Initiatives

Dedicated Data Analysts have been recruited for the Health and Justice Service. This will support the collection of data for all 7 sites, and will assist in the improvement of data quality along with the identification of areas for improvement in clinical practice based on performance against the Health and Justice Indicators of Performance.

Secure Children's Homes, Transition Workers. A business case was submitted to commissioners and approval and funding granted for the provision of transition support for the children at our Secure Children's Homes. This is an innovative role which is not readily available in similar services nationally. We recognised the need to support young people in developing into young adults who are able to make informed decisions about their health and wellbeing. This is particularly relevant when dealing with children and young people who for a variety of reasons may not have accessed general healthcare routinely; are prone to risky lifestyle behaviours and/or have been exploited. We expect to recruit 2 full time practitioners into post by April 2018.

Leadership and Development

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 programmes Leading at the Speed of Trust, 7 habits of Highly Effective People and Foundations of Success
- Listening in Action programme
- Team Journey – developing cohesive high performing teams through team leadership
- Compassion IN leadership approach
- System Leadership Pioneer programme
- Talent and succession management plan in development

Leadership Development Programme for Band 7 Team Leaders

During 2017 the OD team continued to deliver The Band 7 leadership development programme for Band 7 team leaders in community nursing and children's services. This programme covers 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. The second phase of 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

The third cohort of the programme will commence with 12 participants in March 2018.

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 was well evaluated so was delivered gain during 2017.
The objectives of the programme 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 Leadership Development programmes: - Leading at the Speed of Trust, 7 Habits of Highly Effective people, Foundations of Success & Productive Community Services

The Leading at the Speed of Trust and 7 Habits of Highly Effective People programmes are delivered as part of a license agreement with Franklin Covey and was introduced in the Trust in September 2016. To complement the learning gained on these programme the Foundations of Success workshops were commissioned to

achieve sustained, consistent improvements in business performance by managing workload and priorities more effectively and creating more time and energy for working priorities which are so often side-lined by urgent crises and daily fire-fighting.

Embedding and sustainability of the learning is supported through a range of opportunities:

- 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.
- Consistent messaging around attitudes and behaviours

The Productive Community Services Programme is the translation of Lean methodology into a healthcare setting and enables staff to objectively assess and improve a number of aspects of their working practices and 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.

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 and roll out continued throughout 2017/18.

Utilising lessons learned approaches from this work; the Innovation & Improvement Team designed a standardised Team Journey approach using the Aston University "Team Journey" package. This is offered as a training package to all team leaders to increase spread and capacity for delivery.

The first team to undergo the pilot phase of the new programme were the three finance directorate teams who 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. The approach enables participants to reflect on personal and team behaviours and further enhance an atmosphere of mutual support and compassion IN leadership. The programme was actively developed with an awareness raising-module on emotional intelligence and its impact on leadership. This approach to compassion IN leadership supports and enables the Wigan &

System Leaders Pioneer Programme

During 2017, as part of the implementation of the Quality and Place strategy, a proposal to deliver a System Leaders Pioneer programme was developed. The Trust was successful in obtaining £30,000 of funding from NHS Leadership Academy to fund the programme and the programme commenced in February 2018.

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

Work on the Talent Management strategy has continued throughout 2017 with plans in place to engage with the Clinical managers and band 1-4 staff during 2018.

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 undertook a review of its current policy for clinical supervision and this was updated. Work is now in progress supported by the quality matron to support services to develop local procedures on how they will deliver the standards outlined in the policy locally within their teams. This will detail any specialist or professional specific requirements. It is anticipated that all services will have a local procedure in place by the end of June 2018.A audit will be commenced in September 2018 to review compliance against the organisational policy to provide a baseline and ensure staff are aware of local procedures for accessing clinical supervision.

Quality Support Visits

Quality Support Visits have been undertaken within the Trust for some time. In February 2018 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.

Five visits were undertaken since October 2017 to February 2018 to pilot the new documentation. Actions were identified and are subsequently being monitored through to completion. The evaluation of the visits was positive with staff feeling supported, gaining increased knowledge in evidencing the CQC key lines of enquiry, and all making changes and improvements to their services.

Work is currently in progress for 2018/19 and includes a schedule of Quality Support visits to be undertaken. The Quality Support Visit Reports will be shared at the Quality and Safety Sub Group Meetings to promote shared learning across the Trust.

NHS Alliance Work

Our Five Year Strategy - Quality and Place

The Trust is supporting national requirements as detailed in our five year strategy "Quality and Place". This includes population level health improvement by focussing on community

assets and working with staff, patients and residents. The work is supported by a number of enabling strategies e.g. technology, workforce and estates. 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, acute and primary care colleagues within Halton, Knowsley, St Helens and Warrington so that patients receive the right care in the right place.

During 2017/18, we have:

- Published our five year strategy for health and well-being "Quality and Place" (November 2017)
- Quantified the opportunity to manage more non-elective care in an out of hospital setting - circa £10m in Halton and Warrington by 2020/21
- Developed our out of hospital model and published it in "Quality and Place".
- Led the implementation of the out of hospital model in Halton, in conjunction with the two GP Federations. A programme plan is being submitted to the One Halton Partnership Board at the end of February 2018
- In Warrington we have contributed to the development of the Strategic Outline Case (SOC) are now working closely with partners to develop the out of hospital model which will be published in a Full Business Case (FBC) to the Partnership Board in June 2018.

Borough Implementation Plans – 2018/19

Since December we have been working closely with over 150 of our operational, clinical and corporate staff to develop place-based strategy implementation plans (plus separate plans for dental and health and justice). These plans will put into practice the vision, objectives and out of hospital model described in the Strategy. Much of this work will be delivered in partnership with the community, primary care, mental health, local hospitals and the third and faith sector. The plans will be published at the end of March 2018

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 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 team.

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 and provides 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 11 successful planned home births and the service responded to and provided care for 5 un-booked home births. The service provides care 365 days per year and has an on call facility from 5pm-9am across 365 days.

Bridgewater is part of the regional Strategic Transformational Partnership across Cheshire and Merseyside and Halton midwifery service is involved in the maternity work-stream within that partnership. Ongoing work within midwifery nationally and locally include transforming the way that maternity services are delivered which involves collaboration across all the regional and local services and ensuring choice for women. The document Better Births (2016) published by NHSE outlines recommendations for service delivery in England and the partnership are working towards implementing these recommendations across the region.

The action plan devised within the midwifery service following the CQC inspection of the Trust in May 2016 has been addressed and all but 3 of the actions completed. The 3 outstanding are in progress but are dependent on other stakeholders. On-going progress of the actions is monitored within the Trust and 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.

Our annual midwifery service questionnaire was distributed to women during the month of June 2017. 500 questionnaires were distributed and 353 returned (70%).

Of the 353 returned 344 (97.4%) felt they had continuity of care from the team.

348 (98.5%) knew how to contact their named midwife.

348 (98.5%) would recommend the service to friends and family.

Comments from the women included suggestions for consideration such as 'more flexible clinic times', 'not enough evening antenatal classes' and 'more parking at the walk in' while positive comments included 'my midwife is amazing, professional and caring', 'Fab service' and 'Always satisfied by the care I received and questions answered'.

Midwifery supervision was removed from statute on March 31st 2017. The new model of A-EQUIP (Advocating for Education and Quality Improvement) was launched at the end of April 2017. The model will be delivered within services in England by PMA's (Professional Midwifery Advocates). Several papers on the new model have been presented to the Clinical Governance Sub Committee and 2 midwives from Bridgewater have commenced the PMA course in January 2018. The model is an employer led model and in the spirit of collaborative working across the region the Heads of Midwifery across Cheshire and Mersey have drafted a regional A-EQUIP model. The model has been sent out to midwives in the region for comment following which it will be launched at the end of March/April 2018.

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.

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.

Community Dental

The Trust provides specific and specialised dental services that are commissioned by NHS England, and also works in partnership with our Health and Justice Service to provide 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 and therefore managed by the Bridgewater's community dental service

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. Bridgewater has worked collaboratively in year across greater Manchester to manage the pressures on access to theatre for treatment under a general anaesthetic to below 18 weeks.

This year, following the CQC inspection we have enhanced our monitoring regime across sites. 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 completed this year included:

- Quality of dental radiographs
- Audit of Sedation incidents
- The reversal rate of intravenous sedation
- Dental specific records management
- Repeat rate of General Anaesthesia
- Compliance with HTM 01-05

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 and in addition via a monthly Dental Newsletter, incorporating a Lessons Learnt Bulletin.

Health and Justice

Healthcare services at Barton Moss Secure Children's Home, St Catherine's Secure Children's Home, HMP&YOI Hindley, HMP Garth, HMP Risley, HMYOI Thorn Cross and HMP Wymott are provided by the partnership of Bridgewater Community Healthcare NHS Foundation Trust with Greater Manchester Mental Health, Foundation Trust. We provide an integrated model of modern healthcare services to meet the full range of health needs of the residents at each site. Our services employ a wide variety of staff including general practitioners, general, mental health and learning disability nurses, therapists, dental staff, consultant forensic psychiatrists, clinical psychologists, and a comprehensive package of substance misuse services.
Each partner is responsible for the management of subcontractors who deliver specified aspects of service.

All health services work in partnership under the leadership and direction of the Head of Healthcare at the prison sites and Healthcare Manager at the Children's Homes. We work collaboratively with multi agencies from within and externally to the prison to provide an excellent service and quality of care. All patients receive a full health assessment on arrival, and are signposted and referred to the most appropriate service where needed.

The full range of primary care services: GP, nursing and therapy is available. All healthcare needs are care planned and intervention is provided on-site either in the healthcare department or to the residential units/wings. Immunisation and vaccination; national screening and health promotion programmes are all encouraged and delivered on-site. Referral and access to acute services is via local North-West hospital trusts and is facilitated by the primary care teams.

The mental health teams offer a comprehensive package of care to all prisoners referred into the service. They deliver an integrated stepped care approach to the mental health needs of the population which flows between mild to moderate and severe and enduring needs. The service delivers flexibly tailored care to support the needs of the population. The mental health team provide care planning, risk assessment and management, general mental health assessments, and treatment pathways. They work closely to support the homes/prisons and other agencies, and adapt to meet the needs of the patients.

The substance misuse teams offer a comprehensive package of care for all patients with substance misuse problems. This care flows seamlessly throughout healthcare services at

providing a balance of drug treatment regimens when required and a comprehensive flexible package of substance misuse interventions programmes.

Discharge is facilitated by the primary care team and discharge information is forwarded to the community GP and other community services were appropriate. In cases where a patient is not registered, local GP services information is given to the patient along with a discharge summary. In the case of the children's homes information and support is provided to the receiving adult, whether this is parents or other social care providers. All Looked After Children files are forwarded to the receiving Local Authority to ensure the continuity of care.

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. NHSI incorporated performance against a number of these standards in their assessment of the overall governance of Bridgewater Community Healthcare NHS Foundation Trust.

Single Oversight Framework (SOF) Operational Performance Metrics	Target	Quarter 1 2017/18	Quarter 2 2017/18	Quarter 3 2017/18	Quarter 4 2017/18	Average over 4 quarters
Maximum time of 18 weeks from point of referral to treatment in aggregate – patients on an incomplete pathway Ⓐ	92%	99.82%	99.78%	99.58%	99.46%	99.66%
A&E: maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	98.28%	98.82%	97.83%	97.39%	98.08%
All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer Ⓐ	85%	100.00%	100.00%	100.00%	98.44%	99.61%
Diagnostics six week waiters (% under six Weeks)	99%	99.31%	99.86%	99.72%	99.49%	99.59%
Improving access to psychological therapies: Proportion of people completing treatment who move to recovery (from IAPT minimum dataset)	50%	55.36%	57.07%	55.82%	55.11%	55.84%
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	95%	100.00%	99.88%	100.00%	100.00%	99.97%
Mental health data completeness: outcomes for patients on CPA	85%	76.48%	88.57%	92.93%	91.85%	87.45%

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.

The indicator is defined as the percentage of patients receiving first definitive treatment for cancer within 62 days of urgent GP referral for suspected cancer.

Data definition: All cancer two-month urgent referral to treatment wait.

Numerator: Number of patients receiving first receiving first definitive treatment for cancer within 62 days of 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 2017/18.

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-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Bridgewater	99.77%	100.00%	99.68%	99.91%	100.00%	99.42%	99.91%	99.56%	99.25%	99.69%	99.37%	99.33%

At the end of 2017/18 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 (2017/18).

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
> 11 weeks	9837	9713	9806	9932	9324	9122	9240	9291	9278	8852	8586	9729
11 to 17 Weeks	1252	1682	1497	1204	1223	1290	1451	1141	1532	1520	1787	1293
18 weeks +	106	84	106	134	81	82	131	105	172	109	106	111

At the end of 2017/18 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 2017/18:

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
All cancers: 31-day wait for second or subsequent treatment	N/A	N/A	N/A	100.00%	100.00%	N/A	N/A	N/A	N/A	100.00%	100.00%	N/A
All cancers: 62-day wait for first treatment	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.15%	100.00%
All Cancers: 31-day wait from diagnosis to first treatment	100.00%	100.00%	94.74%	100.00%	92.86%	100.00%	100.00%	100.00%	100.00%	91.67%	100.00%	100.00%
Cancer: 2 week wait from referral to date first seen	93.48%	96.40%	95.65%	93.10%	95.68%	93.80%	94.95%	93.50%	96.15%	95.14%	96.82%	92.59%

Equality and Diversity and Inclusion

It is important to Bridgewater that the health care services we provide in our boroughs, and the work opportunities we provide as an employer, are inclusive and meet both local and individual needs. This has been reflected in the development of the Trust's new strategy for 2018 – 2023, Quality and Place.

We have continued to work hard through 2017/18 to ensure both service delivery and employment are provided within the legal frameworks of the Equality Act 2010 and the Human Rights Act 1998. Responsibility for equality and inclusion in the Trust sits with the Equality & Inclusion Officer, with Board level responsibility up until 2018 resting with the Director of Workforce & Organisational Development (Deputy Chief Executive). Equality and inclusion updates are provided to the Trust's Workforce and Organisational Development Committee and the Service Experience Group, who provide assurance through the committee structures to Board.

We assess our equality performance annually through the NHS Equality Delivery System (EDS2). In 2017 we were achieving in staff and leadership outcomes, but remained at a developing grade for our patient outcomes; this is not a reflection of the quality of services we provide but a result of the inability to evidence more than five or six protected characteristics across all service records. To address this issue, we began work in late 2017 on adopting a new approach to EDS2; a partnership approach with other local Trusts that will use research and engagement to identify barriers and health inequalities and from this develop new Equality Objectives, action plans that should see a move to an achieving grade in these outcomes by 2019.

The NHS Workforce Race Equality Standard (WRES) is an annual assessment of race equality for staff. Our results in July 2017 show some positive changes, and some figures remaining fairly static. A Trust wide action plan has been addressing the bullying, harassment and discrimination indicators from the NHS Staff Survey, and it is hoped that in future years we may see an improvement in these areas for both White and BME staff. We recognise that all our results should be viewed with a degree of caution due to the very small numbers of staff involved. An action plan has been agreed for 2017/18 that will allow us to more fully analyse and understand the data available to us, and to gain further insight from our BME staff of their employment experience. The action plan and 2017 report can be viewed on our webpage.

WRES and EDS2 are both reported in full within our Public Sector Equality Duty Annual Report along with our equality objectives, available patient and membership data, interpretation and translation information, and information on equality project progress in the year. This can be found on the Trust's webpage.

During 2017/18 we have:

- Progressed to being a Disability Confident Employer
- Renewed our commitment to address mental health stigma and barriers to employment as a Mindful Employer for a further three years
- Committed to the Working Forward campaign
- Continued to implement the NHS Accessible Information Standard across the Trust

- Introduced a new Equal Opportunities Policy, replacing the previous Equality Statement
- Introduced a new Equality Impact Assessment Policy and Toolkit
- Commenced development of a Staff Disability and Carers Network
- Passed the first stage of becoming a Navajo employer, with external assessment to begin in early 2018

We have a number of actions planned for 2018/19 including roll out of a new equality analysis of all services and the start of a new project to provide access information for each clinic venue on the website. Work in the coming year will be very much influenced by the results of our Navajo assessment, the Equality Objectives determined by our work with our partners in EDS2, the results of our WRES and preliminary WDES (Workforce Disability Equality Standard) work, and the results of our Gender Pay Gap reporting in March 2018.

More information on equality, diversity and inclusion within Bridgewater, including contact details, can be found on the website.

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 2017/18 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

APENDICES

Quality first and foremost

Appendix A – Workforce Information

Our key workforce priorities and targets are:

- To improve on the national NHS Staff Survey results
- To improve the uptake of the NHS Staff Survey
- To increase the communication surrounding the NHS Staff Survey and our results
- To improve the national NHS Staff Survey 'Engagement' score
- To improve the national NHS Staff Survey score for Staff recommending the Trust as a place to work and receive treatment
- To improve the percentage of staff who would recommend the Trust as a place to work and receive treatment as per the national Staff Friends and Family Test
- To increase the Personal Development Review (PDR) rate against a target of 90% (staff appraisal)
- To increase the take up of staff Mandatory Training against a target of 90%
- To reduce sickness absence rates against a Trust target of 3.78%
- To achieve Trust target of a rolling 8% for staff turnover – those leaving the Trust
- To achieve 100% attendance at staff Induction – new starters to the Trust
- To promote apprenticeships and career development activities for young people within the local communities we serve

Our aims, objectives, benefits and outcome measures are captured as follows:

Workforce Priority 1: Trust Culture – Mission, Vision and Values

Aim: *to embed a value based patient centred culture with all staff being clear on the Trust's mission, vision and values.*

Key Objectives:

1. To promote, engage and embed the Trust's vision, values and behaviours in all that we do - our policies and procedures and everyday working practices
2. To listen and act on the feedback of our staff, demonstrating where feedback has been acted upon
3. To continue to maintain effective partnership working with our Trade Union colleagues/Staff-side Representatives and professional bodies
4. To have a workforce that is proud of the excellent services we provide, are motivated and inspired to continuously improve and are committed to working according to the Trust's values

Benefits and Outcome Measures:

- Staff Survey results – our performance locally and nationally against other Trusts

- Staff Survey 'staff engagement' score – to be above average and continuously improve year on year
- Employee relations cases (disciplinary, grievance, bullying cases) – low in number and managed efficiently where they arise
- High levels of personal and professional conduct (as above), including low numbers of referrals to professional bodies
- Reduced sickness absence rates against our target of 3.78%
- Turnover running at a healthy rate against our target of 8%, ensuring key staff are retained.
- All staff have the opportunity to partake in a performance development review (PDR) – attainment of 90% compliance target
- The level of Trade Union Representatives engaged in Trust business – Corporate Partnership Forum and Local Negotiation Committee meeting schedules and attendance at the same
- Regular programme of staff engagement activities such as 'Open Space', Director Drop-ins and LiA events – evidence that feedback is analysed and acted upon

Workforce Priority 2: Workforce Policies, Procedures, Protocols, Practices and Terms and Conditions of Service

Aim: *to continuously review and develop our HR policies, procedures, protocols, practices and terms and conditions service in line with national directives, legal requirements and best practice.*

Key Objectives:

1. To effectively review and manage the Trust's HR policies, procedures and processes to ensure they are fit for purpose and support the delivery of the Trust's current and future objectives
2. Increase both the efficiency and effectiveness of recruitment processes, maximising the use of technology and enabling assessment of both competency and fit with organisational values
3. To further develop the recruitment and selection skills of Managers to include behavioural and value based assessment techniques. Continuously improving recruitment processes and developing our service level agreement to ensure timely, robust systems are in place across the Trust
4. Reduce agency usage and spend
5. To establish a Temporary Staffing Office/internal Staff Bank

6. To implement e-Expenses, enabling staff to submit their travel expenses on line, reducing paper systems and time spent on processing paper claims
7. To partake in the Greater Manchester and Cheshire & Merseyside 'Streamlining Staff Movement' Project. The aim is to develop an Employee Passport which will make pre-employment checks portable across Trusts, ultimately streamlining the recruitment process
8. To ensure ongoing review of local and national terms and conditions of service (where applicable) to ensure they remain relevant in the current workforce market and are reflective of business needs
9. To ensure Managers have the confidence, skills and competence to effectively manage and support staff in line with Trust policies and procedures and also in line with the Trust's values and behaviours
10. To proactively source, monitor and review all current and future external contracts i.e. Occupational Health and Payroll Services for the benefit of patient care, staff wellbeing and public interests (seeking assurance of value for money)
11. Ensure that the provision of internal HR services offer high quality which includes value for money, measured via the HR Service Level Agreement (SLA)

Benefits and Outcome Measures:

- All HR policies, procedures, protocols and terms and conditions of service are regularly reviewed and are up-to-date
- All of the above meet legislative requirements and are reviewed proactively to ensure any changes are communicated in a timely manner
- Terms and conditions of service are in line with national guidance, where appropriate
- All local agreements are negotiated and agreed with Trade Unions and communicated to staff and recorded accordingly
- Agreed terms and conditions meet the needs of the Trust in terms of balancing the fairness to staff with the business and affordability needs of the Trust
- Management and leadership competencies are identified and appropriate training programmes developed as required i.e. HR Skills Programme
- All external contracts are regularly reviewed and provide best value for money with service standards and key performance indicators monitored for compliance
- Implementation of e-Expenses across the Trust
- Implementation of both ESR Employee and ESR Manager Self Service (the former includes Total Reward Statements)
- Accuracy of data on the Electronic Staff Record System (ESR)

Workforce Priority 3: Leadership & Management

Aim: *to develop capable and confident leaders and Managers throughout the organisation.*

Key Objectives:

1. To build organisational capacity and capability in quality improvement and change management skills and competence
2. To facilitate work within multi-professional and multi-agency Teams, responding to the shift of services from acute to community settings and integrating social care
3. To ensure a workforce that is flexible, more mobile and has greater confidence to develop new clinical practice and maximise new opportunities, partnerships and collaborative ways of working
4. To demonstrate strong clinical leadership, governance and confidence to manage
5. To establish a coaching and mentoring culture this supports autonomy, devolved accountability and a continuous learning/'no blame' environment
6. To recognise and reward our staff through ongoing opportunities and development aligned to focused talent management and succession planning

Benefits and Outcome Measures:

- Leadership Development Programme
- Managers trained in delivering organisational change, using the Trust's agreed approach to change and resilience management – there is a consistent approach to change adopted across the Trust
- Staff awareness programmes in place to support the impact of change on an individual and personal level – staff are more receptive and able to cope with change
- The establishment of a work place coach support system to build workforce capability and confidence – builds autonomy and accountability
- Evidence of regular coaching conversations occurring across all staff groups and levels
- An internal / external mentoring programme offered to all staff identified as part of the talent management and succession planning process
- As per workforce priority 2, all staff have the opportunity to partake in a performance development review (PDR) with agreed development plans
- Staff recognition schemes in place to acknowledge and reward innovation and ideas such as Star of the Month and the Trust's Annual Staff Awards

Workforce Priority 4: Staff Wellbeing

Aim: *to provide a workplace and environment where our staff feel supported, healthy, valued and committed to giving their best.*

Key Objectives:

1. Create, implement and embed a Staff Attendance, Health and Wellbeing Strategy focusing on promoting the wellbeing of employees in line with the Trust's values and behaviours, ensuring a focus on change management and its impacts (i.e. sickness absence, stress management, low morale).
2. To develop an action plan that logs all attendance, health and wellbeing activities.
3. To improve the NHS Staff Survey results that focus on attendance, health and wellbeing at work.
4. To pursue national health and wellbeing standards, initiatives and accreditations.

Benefits and Outcome Measures:

- A greater understanding of staff health and wellbeing
- Promotion of support, initiatives and programmes of work i.e. Staff Health & Wellbeing Week
- Achievement of national wellbeing standards
- Enhanced productivity and quality of care through improvements in staff health and wellbeing
- A safer and healthy workplace and systems of working with improved psychological and physical health and wellbeing of staff monitored via absence rates and the reasons staff are absent from work
- Reduced sickness absence rates / improved attendance against our target of 3.78%
- Increased staff engagement which in turn leads to increased morale and motivation – improvements in Staff Survey results and other staff engagement feedback mechanisms
- Ongoing review and further development of our Staff Mental Health & Wellbeing Booklet
- Ongoing review and further development of our A-Z of Staff Benefits

Workforce Priority 5: HR/Workforce Metrics and Targets

Aim: *to achieve Trust's targets and compliance with various workforce metrics and initiatives that are measured and are reported on up to Board level.*

Key Objectives:

1. To ensure compliance with agreed HR/Workforce priorities and targets:
    - ✓ To improve on the national NHS Staff Survey results
    - ✓ To improve the national NHS Staff Survey 'Engagement' score
    - ✓ To improve the national NHS Staff Survey score and Staff Friends and Family Test scores for Staff recommending the Trust as a place to work and receive treatment
    - ✓ To increase the Personal Development Review rate (Staff appraisal) against a target of 90%
    - ✓ To increase the take up of Mandatory Training against a target of 90%
    - ✓ To reduce sickness absence rates against a Trust target of 3.78%
    - ✓ To achieve Trust target of a rolling 8% for staff turnover
    - ✓ To achieve 100% attendance at staff Induction

Benefits and Outcome Measures:

- HR/Workforce Information Reports – monthly Integrated Performance Reports (IPR), including data reported to Trust Board, bi monthly
- Evidence of compliance reviews and compliance action taken within Services/Departments – Directorate Team Meetings and Operational Performance Meetings
- Achievement of targets
- Robust performance management of key performance indicators (KPIs)
- Staff Survey results
- Staff Friends and Family Test results

Staff Engagement

The Trust promotes effective staff 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. Following consultation with over 400 staff the Trust has agreed a Staff Engagement Strategy 2017-2020 which includes a monitored action plan to ensure that staff engagement objectives are met. A steering group for this strategy has been established and meets monthly to review progress against agreed actions and to support problems with implementation that may arise.

A staff engagement champions network, with forty plus staff, has been established so that all boroughs have a network of champions who support messages from frontline to senior management and vice versa. The champions are supported by the staff engagement lead and meet monthly to discuss actions and/or issues that need escalating for action. Staff engagement champions are identifiable by wearing gold coloured Bridgewater lanyards. The champions also work in conjunction with the borough Listening into Action teams.

A Staff Engagement page on the intranet hosts information about the strategy, steering group and champions contacts and also tips and tools/team charters for teams to engage with themselves.

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 bi-monthly video from the Chief Executive which is supported by notes for those with no access to video.
- A weekly trust-wide Bridgewater 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 weekly trust-wide Friday Message from a member of the Executive Team which focuses on a topical issue or key message to round off the working week.
- Blogs from the Chief Executive and other directors are cascaded to staff on a regular basis and are featured in the Trust Bulletin and also accessible to staff via the Trust's intranet
- A Bridgewater Staff App which is designed to allow staff to access key information and contacts whilst working out in communities.
- An Ask the Boss feature which allows staff to submit a question or comment to the appropriate senior manager and have their responses published on the trust's intranet.
- Over the past year, the Communications team has also started to work with partner organisations to develop system-wide communications channels for staff in all

partner organisations as the Trust supports the development of Integrated Care Systems in the boroughs in which we work.

- 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
- The Trust intranet known as 'the Hub' keeps staff updated with current information on the organisation; what is happening within the Trust, its services, organisational change, developments, initiatives, innovation and improvements
- Director staff engagement visits whereby the Executive Team has committed to one half day per month to visit teams across all boroughs and observe patient consultations where appropriate. This is to enhance the directors and staffs understanding of each other's roles.
- 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
- 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 engage with social media by following the Trust's social media accounts and engaging with their colleagues in Bridgewater and in partner organisations.

The Trust's corporate social media accounts are as follows (however many services also have their own accounts):

- https://www.instagram.com/bridgewaternhs/
- https://twitter.com/Bridgewater_NHS
- https://www.facebook.com/BridgewaterNHS/
- https://www.youtube.com/user/BridgewaterNHS

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. During 2017 the LiA programme was restructured into borough LiA teams that also support the staff engagement champions and actions that have arisen from LiA Big Conversation events and surveys. Thy borough LiA teams meet monthly to discuss actions and progression

NHS Staff Survey 2017 - Working with staff to understand key messages from the staff survey

In 2017, all staff were surveyed by paper – approximately 3200. Our response rate deteriorated very slightly by 2% as follows:

2016		**2017**		**Trust Improvement/ Deterioration**
Trust	National Average *	Trust	National Average*	
46%	51%%	44%	50%	2% deterioration

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 2017 score very slightly

deteriorated by 0.05 in comparison to 2016 from 3.73 to 3.68. 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 and is monitored at the Workforce & Organisational Committee that was established in September. The Committee reports in to the Trust's Board.

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	**2016**		**2017**		**Trust Improvement/ Deterioration**
	Trust	National Average	Trust	National Average	
*KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months	6%	7%	5%	8%	1% improvement
*KF28: Percentage of staff witnessing potentially	18%	20%	18%	21%	same

Top 5 ranking scores	2016		2017		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
harmful errors, near misses or incidents in the last month					
*KF16: Percentage of staff working extra hours	67%	71%	69%	72%	2% deterioration
***KF15: Percentage of staff with opportunities for flexible working patterns.	56%	57%	60%	57%	4% improvement
***KF21: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	90%	90%	88%	88%	2% deterioration

* 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	2016		2017		Trust Improvement/ Deterioration
	Trust	National Average	Trust	National Average	
***KF11: Percentage of staff appraised in the last 12 months	87%	89%	80%	91%	7% deterioration
**KF19: Organisation and management interest in and action on health and wellbeing	3.57	3.69	3.55	3.75	0.02 deterioration
***KF6: Percentage of staff reporting good communication between senior management and staff	24%	32%	23%	36%	1% improvement
***KF24: Percentage of staff/colleagues reporting most recent experience of violence	58%	72%	64%	76%	6% improvement
***KF29: Percentage of staff reporting errors, near misses or incident witnessed in the last month	92%	92%	89%	93%	3% 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	2016	2017	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%	20%	19%	15%
KF21: percentage of staff believing that the trust provides equal opportunities for career progression or promotion *(The higher the score the better)*	90%	88%	90%	93%

KF26 has improved by 3% and is slightly above the national average for Community Trust response rates. KF21 has deteriorated by 2% since 2016 but remains in line with the national average for community trusts.
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 now has a Staff Health and Wellbeing Team. This Team has created a monthly newsletter, developed and facilitated a 'Health and Wellbeing' month for staff, worked on an early intervention programme to support staff with lifestyle

choices, focussing on MSK and Mental health initiatives, engaging with staff to improve their health and wellbeing.

The Trust's sickness absence target is 3.78%. The absence rate at the end of March 2018 was 5.38% in comparison to 5.37% at the end of March 2017. 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.

During 2017, we established, in conjunction with our Staff-side Colleagues, a Stress Focus Group comprising of staff from across all areas of the Trust. We also launched BABAH, Bridgewater's Anti-Bullying and Harassment Campaign. Both developed staff surveys and introduced initiatives that support our staff's mental health and wellbeing.

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 2017 NHS Staff Survey in which 80% of respondents confirmed that they had been appraised in the last 12 months. The national average for Community Trusts was 91%.

Directorate	Percentage of Staff Compliance
East Directorate	85%
West Directorate	77%
Corporate Service	61%
BRIDGEWATER	80%

A full review of our PDR process has been undertaken with a new system launched in September 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 2018 was 14.10% (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 skill mix and age profiles of the Workforce have remained relatively stable over recent years but it will need to change to reflect and respond to local demand and productivity. Populations continue to grow and activity increases changes to the workforce will need to change to meet this future demand. 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 Education changes, new technologies and IT strategies i.e. patient systems and mobile working.

As a workforce planning approach and to meet the demands of Borough priorities we will focus on the borough based plans that 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. Externally, national and local policy guidance and commissioning intentions along with professional and expert group guidance also informed the plans and triangulated into workforce numbers.

We will work collaboratively with the STP plans as a key driver in the wider health economy, one of the Trust's key strategic priorities is retaining existing business and development of new business. This will be regularly reviewed in respect of capacity and skill mix.

We will be committed in line with our Human Resources Strategy and Operational Plans to deliver a robust, integrated workforce plan built on the following principles:-

- Planning at directorate, Clinical reference group and borough facing priorities
- Population Centric Workforce Modelling
- Service Transformation
- Greater clarity on roles and accountability in the delivery of patient care

- Estates and IM&T Strategies to support flexible and motivated workforce
- To support service transformation and accountability on roles and delivery of care not about 'how we have always done things'. The right balance of skills to deliver efficient and effective care.
- Recruitment and Retention plans – Workforce Shortages
- Within Financial Plans
- Succession plans and Talent management – Grow our own

As part of its commitment to improving quality and efficiency and in line with our HR Strategy we will continue to undertake capacity and demand modelling with key services. A clinically led approach, informed by patients' needs and supported by the service improvement team, staff have redesigned the workforce profile. This has resulted in a greater congruence between skill mix and case mix.

Workforce and development plans will continue to be developed and concentrate on significantly reducing reliance on temporary workforce through permanent recruitment to longstanding and newly established vacancies, reduce staff sickness further through support for staff health and wellbeing and effective absence management, incrementally implement revised staffing profiles through turnover where possible and restructure where necessary.

Plans will be based on local analysis and intelligence from teams within the organisation and the below points highlight plans for workforce transformation programmes for the future to meet demand and change:-

- Integrated working teams to align to new models of care
- National and regional policies
- Services delivered in the community e.g. community nursing in the future will be designed and commissioned jointly. If current services are agreed to be extended e.g. from services operating during the week to include weekends; then this will be incorporated in the final design model that the system agrees to.
- Multi-disciplinary models of delivery
- Reduction of reliance of temporary workforce
- Plans are fully aligned to the Trusts Strategic objectives and long term financial projections

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. **94%** (national target - greater than 90%) of our doctors have received an appraisal in the last 12 months. The remaining 2 incomplete appraisals are approved postponements by the RO, in accordance to our Medical Appraisal Policy.

The Annual RO report for 2016/17 was accepted by the Board in September 2017 and our Statement of Compliance submitted to NHS England within the agreed timescales.

Education & Professional Development

The primary aim of the Education and Professional Development (EPD) Service is to support all staff within Bridgewater to have up to date, evidence based knowledge, skills and abilities in order to ensure that they can support the delivery of and/or 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
- Managers of their mandatory training compliance figures.

During 2017 we had completed the attachment of competencies for all mandatory training onto the Electronic Staff Record (ESR) with a plan to move over onto the National Learning Management System (NLMS) in January 2018. This had been delayed due to the work taking place on enhanced ESR which went live at the end of December 2017. However due to both internal and external IT issues we were unable to progress as planned and now have a date of April 2018 to change to NLMS. This change will ensure that the ESR is updated immediately on completion of any eLearning modules and will improve the quality and accuracy of the compliance data. It will also mean that staff and managers will be able to see compliance for all mandatory training on a dashboard and to book directly onto any face-to-face sessions.

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 and arranging delivery of bespoke sessions for Services

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 (TNA) which is based on both individual learning and development needs, identified through Personal Development Review, and the commissioned service delivery. The TNA 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. Any application for funding is considered in relation to that services TNA and care delivery including priority areas. This will continue to ensure that staff have the right skills to deliver a high quality service to meet the identified needs of the population they serve.

During 2017/18 training has been provided on a variety of topics including:

- Clinical skills for all Services
- Mentorship
- Leadership and management
- Active communication/mediation
- IT
- Clinical supervision

The reduction in funding from Health Education England has impacted on the resources available but 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 that are deemed essential or required for service delivery and improvement in quality of care; these have included for example:

- Advanced Clinical Skills
- Apprenticeship frameworks, vocational qualifications and cadet programmes
- Clinical assessment and diagnostics
- Non-medical Prescribing (NMP)
- Prevention and early intervention

In 2017/18 we have delivered in-house NMP and educator courses to make the best use of available resources. As we move forwards into 2018/19 we will continue to network with other providers and Higher Education Institutes to deliver training in partnership to meet identified needs.

Talent for Care and Work Based Development Opportunities

During 2017/18 we have continued to provide a range of work experience opportunities and have been able to expand our offer by 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.

We have undertaking joint working with a Local Authority, other NHS Trusts and colleges to support traineeships with a focus on integration and plan to develop this further across our footprint. All staff at Bands 1- 4 within the Trust have the eligibility and are actively encouraged to access vocational and occupational development. These can be full Apprenticeship Standards or a range of shorter programmes that can be accessed for specialised areas of learning.

We are continuing to promote apprenticeships for all services and have to date commenced Trainee Assistant Practitioners, Data Analysts, Business Administration Level 2&3. There is a plan in place for Nursing, Trainee Nursing Associates, Healthcare, Customer Service, Project Management, IT, Finance and Warehousing.

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

At the beginning of 2017 the Trust was successful in two partnership bids to support the development of the new nurse associate role. We are currently employing five trainee associate nurses who attend Edgehill University and we are also 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

The EPD Service has a dedicated team of practice education facilitators who 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 2017/18 we have continued to support placements for undergraduate medical students from the University of Central Lancashire

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 2018/19 we plan to:

- Further develop our mandatory training offer as we move over to NLMS
- 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 to work in partnership with other providers and HEI's to deliver internal training programmes.
- Continue 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
- Traineeships and Pre-employment programmes
- Apprenticeships

Education and Professional Development Governance

We have an 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 View. 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.

Halton Borough Council Response

From: David Parr [mailto:David.Parr@halton.gov.uk]
Sent: 30 April 2018 13:59
To: Debra Harrop
Cc: Susan Wallace-Bonner; Eileen Omeara
Subject: Re: BRIDGEWATER DRAFT QUALITY REPORT 2017/18

Lynne

The Council's initial observations on the Report are as follows

The Report includes the appropriate level of detail - however, as Bridgewater are on enhanced surveillance the Council would expect Bridgewater to mention the challenges you are currently facing and what steps you are taking to address them and improve etc.

From a Halton specific perspective – the Council feel the Report could be strengthened.

For example, there is no mention of the integrated Intermediate care service and no mention of recent adult safeguarding review or CQC reviews

As you will be aware the Council have an event with Health PPB to scrutinise and comment on the quality accounts, prior to the publication and the PPB will respond directly on matters arising from this work.

David Parr LLB DBA

Chief Executive

Halton Borough Council

Municipal Building,

Kingsway,

WIDNES.

WA8 7QF

Tel. 0151-511-6000

Mob. 07770855965

Fax. 0151-471-7562

E-mail: david.parr@halton.gov.uk

It's all happening IN HALTON

Please don't print this e-mail unless you need to.

Wigan Borough Clinical Commissioning Group Response to Bridgewater Community Healthcare NHS Foundation Trust Quality Account 2017/18

Wigan Borough Clinical Commissioning Group (the CCG) welcomes the opportunity to comment on the Quality Account for Bridgewater Community Healthcare NHS Foundation Trust. The Trust will present a high level view of its Quality Account 2017/18 to the CCG Clinical Governance Committee in May 2018.

The CCG has worked closely with the Trust throughout 2017/18 in what has been a challenging year for the Trust and the wider NHS to gain assurances that services are safe, effective and caring.

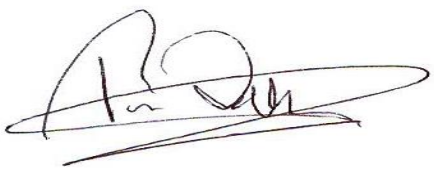
In respect of the 2017/18 quality priorities, the CCG notes the positive results of the Fall Safe Programme Audit, whilst recognising the Audit was not undertaken within a Wigan Borough. Progress in the management of sepsis has been encouraging. Work undertaken by the Trust to develop the co-ordination of End of Life Care which is defined and monitored within the End of Life Strategy 2017-19 is also a positive. The CCG anticipates demonstrable evidence of the impact from these quality priorities to be further evidenced during 2018/19.

During 2017/18 the Trust held multi-agency events to inform the development and aid the publication of the Trust's Quality and Place Strategy 2018/23. The strategy, which identifies the quality priorities for the next five years, was welcomed by the CCG.

Challenges in year have included significant changes within the leadership structure, workforce capacity, Medicines Management process and capacity issues and Serious Incident reporting processes. Reduced staff satisfaction reported in the 2017 NHS staff survey has also been a cause for concern and the Trust is currently subject to enhanced monitoring. The CCG continues to work with the Trust to support improvements in these areas.

The CCG supports the quality priorities identified for 2018/19 inclusive of the continued focus on reducing incidences of Grade 3 and 4 Pressure Ulcers. Continued improvement in the processes associated with incident management and the embedding of lessons learned from harms, serious incidents and complaints are also welcomed.

The CCG looks forward to working in partnership with the Trust and other stakeholders during 2018/19 to ensure the continuous focus upon improvement in order to provide the best possible care for our patients.



Dr Tim Dalton, Chairman, Wigan Borough Clinical Commissioning Group

15 May 2018

Wigan Life Centre • College Avenue • Wigan WN1 1NJ • www.wiganboroughccg.nhs.uk
Chairman: Dr Tim Dalton • Chief Officer: Trish Anderson

Healthy People, Healthy Place.

Report	**GOVERNORS' REVIEW OF THE QUALITY REPORT**
Date	18th May 2018
Attachment	

The draft Quality Account was circulated to Governors on the 8th of May 2018. It was accompanied by a letter from Sharan Arkwright stating the purpose of the review.

Attached above: draft version of the Quality Account which was circulated and the opening letter for reference.

By the 18th of May 2018, the following comments had been received:

Comments from Rita Chapman, Public Governor – St Helens, Lead Governor:

"My comments on the report are as follows:

Page 8 - Senior Nurse Leadership Posts around quality - clarify if they also cover other clinicians as well as nurses.

Page 14 - Clinical Research - I think the 20 approved studies should be listed, possibly in an appendix.

Pgs 17, 18, 19 - the word Action should be in bold, it would read better.

Page 44 - CQC - reference back to the outcomes earlier in the report.

Page 88 - Leadership Development For Community Nurses Band 6 - is there a similar programme for other clinicians and if not, why not?

Page 90 - Quality Visits - should state who are involved in the visits. As far as I know, no Governors were invited to those in late 2017 to test the paperwork.

Page 92 - used 5 Boroughs, their name has changed.

Page 97 - Health & Justice - looks to be a different font & spacing to rest of the document.

General - virtually no mention of Governors involvement in & contribution to the Trust business. Think we are only mentioned as members of the Research Group. As it's a quality report, this is disappointing."

Comments from Dave Smith, Staff Governor - Non-clinical support staff including managerial and administrative staff

"2 comments from me both discipline related

page 48 CPIs – Would be worth adding a sentence that Bridgewater were a National first of type using SystmOne for a fully integrated CPIS view within our single clinical system.

Page 121 Mandatory Training should be 'IT/IG and Cyber' given the profiles of the last two at the moment."

Comments from Paul Mendeika, Public Governor – Warrington

"I am happy with this year's report.
Some feedback for next year I would like to see more emphasis on patient experience/ engagement.
I know it's a set format reporting numbers is okay as far as it goes but feel this would be an improvement."

Comments from Dr Deb Mandal, Staff Governor - Registered Medical Practitioners

"Thanks for asking comments on Quality Report. Having looked at the report, my comments are about the lack of more information on 2 items: 1) No information on Medical Appraisal - is there an appraisal committee providing operational governance and assurance on quality? or the whole show is run by 1 or 2 individuals only, which will be worrisome. 2) what is the quality assurance for the approval process for new research projects in Bridgewater - again, is there a multi-disciplinary committee (can be virtual)?"

St Helens Clinical Commissioning Group

Knowsley
Clinical Commissioning Group

Nutgrove Villa
Westmorland Road
Huyton
Liverpool
Merseyside
L366GA

0151 244 4126

21st May 2018

Colin Scales
Chief Executive
Bridgewater Community Healthcare NHS Foundation Trust
Bevan House
17 Beecham Court, Smithy Brook Road
Wigan
WN36PR

Dear Colin

Bridgewater Community Healthcare NHS Foundation Trust Quality Account 2017/18

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group welcome the opportunity to comment on the Bridgewater Community Healthcare NHS Foundation Trust Quality Account for 2017/18.

The CCGs acknowledge the progress made against the 2017/18 quality priorities and that the progress will continue to be monitored through the Quality Strategy and End of Life Strategy:

Priority 1: Fall Safe Programme
Priority 2: Management of Sepsis
Priority 3: Co-ordination of End of Life Care

The Quality Priorities for 2018/19 are in line with some of the areas for improvement recognised and represent appropriate priorities;

Priority 1: Pressure Ulcer Prevention
Priority 2: Reduction in Medication Errors
Priority 3: Improve processes for reporting harm and promote an open and honest culture in which the organisation can learn and innovate.

The CCGs acknowledge the reference to Care Quality Commission registration, however, would consider it beneficial for the progress against the action plan from the previous CQC rating of 'Requires Improvement' to be captured within the accounts.

Chair: Dr Andrew Pryce

Chief Executive: Dianne Johnson

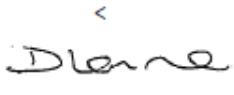
Knowsley.CCGCommunications@knowsley.nhs.uk

The importance of leadership is captured within the Quality Account specifically in relation to the appointment of Assistant Directors, however, the CCGs would like to reiterate the importance of leadership with a specific focus on the quality of leadership of the Trust Board. The work of the Trust Board could, therefore, be strengthened within the Quality Account.

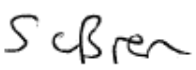
The Quality Priority for a reduction in medication errors has been supported by a new appointment and this commitment is very positive, however, the Quality Account does not reference the vacancy in relation to Non-Medical Prescribing Lead for several months during 2017/18. The CCGs are assured that this vacancy has now been recruited to.

NHS Knowsley Clinical Commissioning Group and NHS St Helens Clinical Commissioning Group will continue to monitor the quality of services provided by Bridgewater Community Healthcare NHS Foundation Trust through the bi-monthly Contract Review Meetings, to gain assurance that the quality and safety of .services delivered to patients continues to improve and that effective governance processes are in place and embedded throughout the organisation.

Yours sincerely



DIANNE JOHNSON
CHIEF EXECUTIVE
NHS KNOWSLEY
CLINICAL COMMISSIONING GROUP



SARAH O'BRIEN
CLINICAL ACCOUNTABLE
OFFICER
NHS ST HELENS CLINICAL
COMMISSIONING GROUP

Healthwatch Warrington
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89 Sankey Street
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contact@healthwatchwarrington.co.uk
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23rd May 2018

Re: Healthwatch Warrington's Response to Bridgewater Community Healthcare NHS Foundation Trust's Draft Quality Report 2017 - 2018 (May 2018)

Healthwatch Warrington is pleased to have the opportunity to review Bridgewater's 2017 - 2018 Quality Report (QR) and reflect on the current and future priorities in the document.

As Warrington's independent consumer champion for health and social care, we recognise the role that patient experiences have in shaping the quality and safety of services. It is positive to see that the QR has a clear focus throughout - to make quality first and foremost within the Trust. The QR and the Trust aims to work towards clear objectives in quality and safety through innovation and effectiveness, with a zero harm approach, which is commendable though challenging. The Trust has a clear aim to learn from negative experiences (e.g. complaints) while promoting good quality care and good practice.

Looking back at the Trust's performance in relation to its priorities in 2017 - 2018, we are pleased to see that different areas of improvement have been acknowledged within Safety, Clinical Effectiveness and Patient Experience, and these have been identified in partnership with patients, individuals, and stakeholders. Though Healthwatch is not referenced within the QR, we are one of many local partners who have continued to engage with the Trust throughout 2017/18, and have supported development of the Trust's Patient Experience through public engagement through promotion and attendance of events and activities e.g. The Big Conversation.

The report format appears clear and thought out, though some data in the Appendix e.g. NHS Staff Survey data, could benefit from being included in the body of the report, especially given the challenges that the Trust has experiences, especially with a staff turnover 6% higher than the target, and consistent staff sickness ratios higher than the Trust's target (of 3.78%). Inclusion of a Glossary within the QR is also welcomed, but could benefit from reference throughout the document to ensure reader comprehension. There are still some terms, however, that could benefit from inclusion within the Glossary e.g. DoLs, MCA, to make it more meaningful for readers, as this is a public document.

Healthwatch Warrington
Charitable Incorporated Organisation
Registered Charity Number 1172704

In regards to Quality of Care and Patient Safety, the QR indicates that there is a significant focus on falls prevention and understanding, especially within inpatient settings e.g. Padgate House, Warrington. The Falls Audit has shown evidence that Bridgewater perform well in comparison to national targets re: call bells, footwear, reductions in environmental hazards and an ongoing focus on patient independence by ensuring walking aids/sticks are in easy reach through hourly and ongoing round checks. This is a positive ongoing focus which is evident in its success by the Trust's performance. There is potentially promotion of good practice to be encouraged here, which could be shared with other services working alongside the Trust e.g. hospitals, care homes and domiciliary care. Falls prevention has also been addressed through the Trust's involvement in the National Audit of Inpatient Falls, where there has been the move away from the FRAT as a result of feedback from the audit, and a focus on MDT working and Safety Huddles (which has been noted in many Trust Quality Accounts this year), to address and manage patient needs. There is also reference here to regular falls presentations with staff, patients and carers. It would be useful to know what this entails e.g. prevention advice, awareness raising of risk, signposting of local support services, to understand how this is addressing the falls prevention agenda, and feedback from those attending would better help quantify the benefits though qualitative data. Patient assessments upon admission and daily ongoing reviews help ensure patient needs are also central to care plans, and also best ensures that changing patient needs can be effectively monitored, while supporting independence. Falls have reduced in Padgate House, which highlights the effect of this approach, falling from 96 to 92. It would be useful to see what the trends are here across the 3 facilities of inpatient units, to better understand and interrogate this data further.

Sepsis ID and screening to support management of sepsis has continued, as is seen in many Trusts both locally and nationally, while the Trust's focus on End of Life Care co-ordination and focus on patient need is positive and an essential approach to ensure patient care is effective and suitable, and that patient choice is recognised and acted upon effectively. Pressure ulcers have increased by 14% since 2016/17 (to 604 incidents), which is concerning, especially given that the severity of ulcers in Grade 3 and 4 have also increased. The evidence shows an ongoing increase in pressure ulcers developed within the Trust, while those developed outside the Trust have decreased by 105 incidents, in total. In total, however, the data suggests that pressure ulcers developed outside of the Trust have been higher in number than those developed within the Trust. Within the Trust, the majority of ulcers (around 425) appear to be Grade 2, while a further 60 (approx.) are Grades 3 and 4. Unfortunately, as the Grading breakdown does not provide specific figures or specific detail in the chart legend, we are unable to interrogate this in detail. Practice improvements and learning in response to this, with enhanced use of assessments, documentation, reporting, and information sharing will hopefully impact on this and can be commented upon next year. RCAs are also bring undertaken to address the causes of these incidents of harm, and to focus on improving education, adherence to policies and a focus on a District Nursing pilot project. We look forward to hearing further progress on this in the 2018/19 Quality Report.

Healthwatch Warrington
Charitable Incorporated Organisation
Registered Charity Number 1172704

Medication Safety is the next area of reflection, including a strengthened Medicines Management Team and the appointment of a Medication Safety Officer in 2017, which is a beneficial step in co-ordinating this approach and supporting management of incidents. 2017/18 recorded 606 Medication related incidents, 120 of which related to controlled drugs. 26% were identified as relating to third parties, including omitted doses and missed visits due to hospital discharge and lack of communication and lack of paperwork co-ordination. It would be beneficial to understand within the QR how this is to be addressed in partnership, with clear information on how this will be measured and monitored to reduce these errors and ensure a joined up approach. The QR also reports 173 near misses and zero Never Events, which indicates a strong reporting culture within the Trust and is the strongest way to address the zero harm agenda. The QR shows a clear focus on Safeguarding and involvement in the Making Safeguarding Personal agenda, which again is a positive Trust approach and will develop support for those patients who are most at risk or vulnerable. There is also a strong theme around involvement of the "voice" of children and adults in Safeguarding, which is central to a successful approach. Infection control and prevention remains a clear area of focus and development, though Warrington is the 3rd lowest in vaccination rates of patient facing staff, at 52.5%, and is significantly lower than the target of 75%. There is work to do here to raise this standard and ensure that those patients most at risk (as well as staff) are not subjected to unnecessary risk.

The QR highlights that in 2017 - 2018 in Clinical Effectiveness the Trust has continued to work on patient outcomes and Shared Decision Making, which we have looked to promote and encourage as a Healthwatch, to enhance better care conversations, better informed decision making about care options and enhanced outcomes. The process of measuring these aims upon admission and on discharge from the service shows a clear commitment to measuring the impact of care and patient involvement. Detail of the collected data would be beneficial here, as well as specifics of any tools of processes used e.g. AQuA Ask 3 Questions resources, decision support tools etc, which will help ensure this is an approach that can be shared across the Trust, to ensure equity of service. The Trust also demonstrated a drive to comply with National guidance from NICE through Trust policy and approach, which is to be encouraged and built upon in future.

Patient Experience highlights that the Trust is working to better collect patient feedback through a variety of methods, including the Friends and Family Test, Patient Stories, surveys and social media. Complaints are welcomed by the Trust to review and develop, and data shows that there has been a slight reduction (of 2) in complaints since 2016/17. Borough specific data here (as in other areas of the QR) is positive and helpful for readers to make the data more meaningful. Warrington is ranked 4th of the 7 areas covered here, with 11 complaints in total. Though this is a small figure, it is important that these issues are acted upon and the top 3 areas highlighted as trends within complaints overall include clinical treatment, staff attitude and communication, which is similar to the overall trends that we, as Healthwatch Warrington, see across most services. With over 27,000 Friend and Family responses, there is a high percentage of service recommendations (96.7%) though Warrington

specific data satisfaction with waiting times is the lowest, at 92%. We appreciate that waiting times continue to be a challenge across all NHS services, and clear and timely communication with patients is a key way to ensure patients are aware of this. PALS calls continue to be an area of essential support within the Trust, with 1950 contacts in 2017/18, with the highest percentage (55%) being for information, advice and sign posting, and only the development of 5 of the contacts into formal complaints, suggesting that PALS continues to be a valued and essential form of support for patients. Data to compare use of this service with 2016/17 would be beneficial here, to enable better understanding of it and how use has increased or decreased in relation to previous years.

The report continually references values, compassion and care, which is highlighted both in the care delivered and staff satisfaction/workload management. Staff appraisals are also highlighted as an area requiring focus, which should be addressed moving forwards. The QR unfortunately makes no reference to public rating systems used by Healthwatch Warrington or neighbouring Healthwatch, or the data collected by these partners, which in future could also be used to inform the report.

A key area for understanding and measuring safety is also to be found in lessons learned from deaths and serious incidents. The QR (27.1) quantifies that 1,035 total patient deaths occurred within the Trust, a number of which were within custodial settings. The Trust QR reports that zero of these deaths were as a result of care within the Trust, but no further detail is given in regards to any trends or issues arising as a result of these deaths across the Trust footprint. Further information here would enable understanding of gaps in provision and would further enhance reader knowledge about how the Trust is learning from these incidents. Patient safety incidents and reporting remains high, with Warrington being the second highest (a 110 increase on 2016/17). Again, the data suggests a strong culture of reporting, learning, and development within the Trust, which is positive to see. Some of the Mortality Review Data is yet to be provided within the Report, and as such, we are unable to comment in relation to Serious Case Reviews re: child's death data, and the Coroner's Investigations.

Moving forwards into 2018 - 2019, it's positive to see that the Trust will continue to focus on work around pressure ulcers and reduction in medication errors, alongside ongoing quality development through senior nursing leadership. The Trust will also be developing the framework for responding and learning from deaths, all of which as discussed above and is key to enhancing the Trust and supporting patients to have the best possible care. The QR also makes reference to Warrington's Accountable Care System (now known as Warrington Together) which in future will work across services, providers and commissioners to support integrated care and again, work towards better outcomes for patients.

Overall the QR shows a willingness to learn and develop though there are some areas which require more in-depth information and detail to quantify this and understand how the Trust will measure progress and improvements. In the forthcoming year, we look forward to supporting public engagement and strengthening the voice of

patients, carers and relatives by encouraging public participation in events both by and including the Trust, including our annual Healthwatch Quality Accounts Involvement Day. We look forward to hearing from the Trust and being involved in future developments.

Yours faithfully,

Lydia Thompson
Chief Executive Officer
Healthwatch Warrington

Appendix C – School Aged Immunisation Programmes End of Academic Year

End of Academic Year 2016/17 (reported to NHSE in August 2017)

In the academic year 2016/17 Bridgewater was commissioned to deliver immunisations in:-

- Halton
- Warrington
- Wigan
- Bolton
- Oldham

Percentage Uptake Per Borough

Borough	HPV Dose 1 Year 8	HPV Dose 2 Year 8	Td/IPV (Year 9/10)	MenACWY (Year 9/10)
England Uptake	87.2	Not Published	Year 9 = 83.6 Year 10 = 82.5	Not Published
Bolton	89.9	85.9	83.2 (year 10)	82.5 (year 10)
Oldham *	88.5	77.44	68.3 (year 9)	68.6 (year 9)
Warrington	89.8	82.7	89.3 (year 9)	89.63 (year 9)
Halton	88.5	77.3	76.29 (year 9)	76.5 (year 9)
Wigan	88.4	84.1	80.7 (year 10)	80.5 (year 10)

HPV Year 9 Percentage Uptake (reportable on immform each year)

Borough	HPV Dose 1 Year 9	HPV Dose 2 Year 9
England Uptake	88.8	83.1
Bolton	94.2	93.4
Oldham *	91.1	88.9
Warrington	88.9	83.9
Halton	87.7	77.1
Wigan	90.2	85.8

School aged Childhood Flu Vaccination Programme – 2017/18

Bridgewater was also commissioned to deliver the school aged childhood flu vaccination programme in the boroughs of Halton and Warrington in 2017/18.

Delivery of this programme was completed Oct 2017 – Dec 2017. Both boroughs were commissioned to deliver to an acceptable target of 40% of the population with an achievable target of 65%.

Halton

	Cohort size	Administered by Bridgewater	Percentage Uptake by Bridgewater	Administered by GP	Percentage Total uptake
Reception	1543	873	56.58	12	57.36
Y1	1565	902	57.64	11	58.34
Y2	1539	814	52.89	11	53.60
Y3	1645	877	53.31	14	54.16
Y4	1496	744	49.73	8	50.27
TOTAL	7788	4210	54.06	56	54.78

Warrington

	Cohort size	Administered by Bridgewater	Percentage Uptake by Bridgewater	Administered by GP	Percentage Total uptake
Reception	2499	1724	68.99	45	70.79
Year 1	2610	1733	66.40	36	67.78
Year2	2654	1731	65.22	27	66.24
Year 3	2650	1643	62.38	33	63.25
Year 4	2571	1563	60.79	42	62.43
TOTAL	12984	8394	64.65	183	66.06

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 2017/18 and supporting guidance;
- the content of the Quality Report is not inconsistent with internal and external sources of information including:
    - board minutes and papers for the period April 2017 to the date of this statement
    - papers relating to quality reported to the board over the period April 2017 to the date of this statement
    - feedback from commissioners dated 23rd May 2018
    - feedback from governors dated 18th May 2018
    - feedback from local Healthwatch organisations dated – 23rd May 2018
    - No feedback from Overview and Scrutiny Committee
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009; June 2018
    - the national patient survey – not applicable to community healthcare providers
    - the 2017 national staff survey March 2018
    - the Head of Internal Audit's annual opinion over the trust's control environment received at Audit Committee on the 23rd May 2018
    - 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

Date: 25 May 2018 Chairman 

Date: 25 May 2018 Chief Executive 

Appendix E Independent Auditors Report

Independent Auditors' Limited Assurance Report to the Council of Governors 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 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 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 NHS Improvement:

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period	Page 198
Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.	Page 198

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 2017/18" 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 2017/18";
- 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 2017/18".

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 2017/18"; 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, April 2017 and up to 31 March (the period);

- Papers relating to quality report reported to the Board over the period April 2017 to the date of signing this limited assurance report;
- Feedback from Wigan Borough Clinical Commissioning group dated 15 May 2018;
- Feedback from Governors dated 18 May 2018;
- Feedback from Healthwatch Warrington dated 18 May 2018;
- Feedback from Halton Borough Council dated 30 April 2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for 2017/18;
- The 2017 national staff survey dated March 2018;
- 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 2018 dated 23 May 2018.

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) 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 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and 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 2017/18";
- 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 2017/18"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 2018:

- 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 2017/18";
- 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 2017/18".

PricewaterhouseCoopers LLP

PricewaterhouseCoopers LLP
Date: 27 May 2018

The maintenance and integrity of the Bridgewater Community Healthcare NHS Foundation Trust 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.

Appendix F - Glossary

A-EQUIP	Advocating for Education and Quality Improvement - A model of clinical midwifery supervision
AHP	Allied Health Professional
ANTT	Aseptic Non-Touch Technique - used globally as the foundation for effective infection prevention
AQuA	Advancing Quality Alliance – NHS health and care quality improvement organisation
BABAH	Bridgewater Community Healthcare Foundation Trust anti-bullying and harassment campaign
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group – play a major role in achieving good health outcomes for the communities they serve
CDOP	Child Death Overview Panel
CIC/LAC Teams	Children in Care and Looked After Children Teams - Teams provided by Bridgewater Community Healthcare Foundation Trust Safeguarding Team
CP-IS	Child Protection - Information Sharing - within the Safeguarding teams
CQC	Care Quality Commission – An independent regulator of all health and social care services in England
CQUIN	Commissioning for Quality & Innovation - The key aim of the CQUIN framework is to secure improvements in the quality of services and better outcomes for patients
CSE	Child Sexual Exploitation
CYP IAPT	Children & Young People Increasing Access to Psychological Therapies Programme – primary function to improve the psychological wellbeing of children and

	young people
CRES	Cash Releasing Efficiency Saving Scheme.
EOL	End of Life Services - service provided by Bridgewater Community Healthcare Foundation Trust
FFT	Friends and Family Test – introduced to help service providers and commissioners understand whether their patients are happy with the service provided.
GDPR	General Data Protection Regulation - Data protection
GP	General Practitioner
HCAI	Health Care Acquired Infections
HEE	Health Education England - supports the delivery of excellent healthcare and health improvement to the patients and public of England
HMP	Her Majesty's Prison
HSCIC	NHS Digital – the national provider of information, data and IT systems for commissioners, analysts and clinicians in health and social care
ICO	Information Commissioners Office - The UK's independent authority set up to uphold information rights in the public interest
IHAs	Initial Health Assessments - provided for children by the Safeguarding Team
IHI	Institute for Healthcare Improvement (IHI) – IHI works with health systems to improve quality, safety and value in healthcare
JTAI	Joint Targeted Area Inspection - Multi-agency team consisting of Ofsted, Care Quality Commission (CQC, Her Majesty's Inspectorate of Constabulary (HMIC and Her Majesty's Inspectorate of Probation (HMIP), who inspect particular themes within safeguarding children's services
KPMG	Management Consultants – a team of expert practitioners supporting Lancashire Care NHS Foundation Trust in the development of this year's Quality Account

LADO	Local Authority Designated Officer - Investigates allegations against staff towards children
LeDeR	Learning Disability Mortality Review - aims to make improvements to the lives of people with learning disabilities. It clarifies any potentially modifiable factors associated with a person's death, and works to ensure that these are not repeated elsewhere.
LiA	Listening in Action - Service for the staff of Bridgewater Community Healthcare Foundation Trust
LSCB	Local Children Safeguarding Board
MARAC	Multi Agency Risk Assessment Conference - associated with the Safeguarding team
MASH	Multi-Agency Safeguarding Hub - multi-agency team consisting of health, local authority and the police within Safeguarding Services
MDT	Multi-Disciplinary Team - is a group of health care workers and social care professionals who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions.
NCISH	National Confidential Inquiry into Suicide and Homicide – the Inquiry produces a wide range of national reports, projects and papers providing health professionals evidence and practical suggestions to effectively implement change
NHS England	NHS England authorises the new clinical commissioning groups, which are the drivers of the new, clinically-led commissioning system introduced by the Health and Social Care Act
NHSBSA	National Health Services Business Services Authority
NHSI	NHS Improvement - Helps the NHS to meet short-term challenges

NICE	National Institute for Health and Care Excellence (NICE) – provides national guidance and advice to improve health and social care
NMP	Non-Medical Prescriber - prescribing of medicines, dressings and appliances by health professionals who are not doctors
NRLS	National Reporting and Learning Services - A central database of patient safety incident reports
Ofsted	Office for Standards in Education, Children's Services and skills - inspects and regulates services that care for young children
PALS	Patient Advisory Liaison Service - offers confidential advice, support and information on health-related matters.
PDSA	Plan-Do-Study-Act methodology – is a systematic series of steps for gaining valuable learning and knowledge for the continual improvement of a process
PHE	Public Health England - executive agency of the Department of Health
PREMS	Patient Reported Experience Measures - capturing the experiences of people using healthcare services
QI	Quality Improvement - systematic and continuous actions that lead to measurable improvements
QIA	Quality Impact Assessment – a tool used to identify a potential impact of our policies, services and functions on our patients and staff
QIF	Quality Improvement Framework – a framework for delivery of initiatives that will ultimately result in quality improvements for our patients and staff
R & D	Research and Development
BRAG	**Blue,** Red Amber Green rating – a simple colour coding of the status of an action or step in a process.
RHAs	Risk Health Assessments - provided for children by the Safeguarding Team

RTT	Referral to Treatment – your waiting time starts from the point the hospital or service receives your referral letter
SAB	Safeguarding Adult Board
SOP	Standard Operating Procedure – is a documented process in place to ensure services are delivered consistently every time
SPOA	Single Point of Access
STEIS	Strategic Executive Information System - for the reporting and monitoring of serious incidents
SUS	Secondary Uses Service – supplies accurate and consistent data to enable the NHS to plan, analyse and enhance performance
SystmOne	Electronic patient record database
Ulysses	Bridgewater Community Healthcare Foundation Trust's IT risk management and patient safety system
VTE	Venous Thromboembolism – a blood clot that forms within a vein
YOI	Youth Offenders Institute

5. Annual Accounts for year ended 31 March 2018

FOREWORD TO THE ACCOUNTS

These accounts, for the period ended 31 March 2018, 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.

Signed 

Name: Colin Scales
Job title: Chief Executive
Date: 25 May 2018

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 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 NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health Group Accounting Manual*) have been followed, and disclose and explain any material departures in the annual accounts
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance, and
- Prepare the annual accounts 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.

Signed  Chief Executive

Date: 25 May 2018

Statement of Comprehensive Income for year ended 31 March 2018

	Note	2018 £000	2017 £000
Operating income from patient care activities	3	**146,682**	157,974
Other operating income	4	**5,122**	6,164
Total operating income from continuing activities		**151,804**	**164,138**
Operating expenses	6,7	**(154,940)**	(161,694)
Operating (deficit)/surplus from continuing operations		**(3,136)**	**2,444**
Finance income	10	**20**	17
Finance expenses	11	**(20)**	-
PDC dividends payable		**(414)**	(371)
Net finance costs		**(414)**	**(354)**
(Deficit)/surplus for the year from continuing operations		**(3,550)**	**2,090**
(Deficit)/surplus for the year		**(3,550)**	**2,090**
Other Comprehensive Income			
Will not be reclassified to income and expenditure:			
Revaluations	13	**1,157**	890
Total comprehensive (expenditure)/ income for the year		**(2,393)**	**2,980**

Statement of Financial Position as at 31 March 2018

	NOTE	**30 March 2018** **£000**	31 March 2017 £000
Non-current assets:			
Intangible assets	12	**1,779**	1,924
Property, plant and equipment	13	**23,127**	21,251
Trade and other receivables	16	**604**	846
Total non-current assets		**25,510**	**24,021**
Current assets:			
Inventories	15	**40**	44
Trade and other receivables	16	**14,032**	14,344
Cash and cash equivalents	17	**2,945**	4,357
Total current assets		**17,017**	**18,745**
Current liabilities			
Trade and other payables	18	**(13,326)**	(20,469)
Borrowings	19	**(392)**	-
Provisions	20	**(39)**	(65)
Total current liabilities		**(13,756)**	**(20,534)**
Net current assets / (liabilities)		**3,260**	**(1,789)**
Total assets less current liabilities		**28,770**	**22,232**
Non-current liabilities			
Borrowings	19	**(8,221)**	**-**
Total non-current liabilities		**(8,221)**	**-**
Total assets employed		**20,549**	**22,232**
Financed by:			
Public dividend capital		**5,671**	4,961
Revaluation reserve		**7,161**	6,004
Income and expenditure reserve		**7,717**	11,267
Total taxpayers' equity		**20,549**	**22,232**

The notes on pages 250 to 288 form part of this account

The annual accounts on pages 246 to 249 were approved by the Audit Committee on behalf of the Board on 23 May 2018 and signed on its behalf by:

Chief Executive: Date: 25 May 2018

Statement of Changes in Equity for the year ended 31 March 2018

	Public Dividend Capital	Revaluation Reserve	Income and expenditure reserve	Total tax-payers' equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 – brought forward	4,961	6,004	11,267	**22,232**
Deficit for the year	-	-	(3,550)	**(3,550)**
Revaluations	-	1,157	-	**1,157**
Public dividend capital received	710	-	-	**710**
Taxpayers' and others' equity at 31 March 2018	**5,671**	**7,161**	**7,717**	**20,549**
Taxpayers' 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**

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 trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the 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 trust.

Statement of Cash Flows for the year ended 31 March 2018

	NOTE	2018 £000	2017 £000
Cash flows from operating activities			
Operating (deficit)/surplus		**(3,136)**	2,444
Non-cash income and expense:			
Depreciation and amortisation	6	**2,975**	3,491
Decrease/(increase) in receivables and other assets		**640**	(5,545)
Decrease/(increase) in Inventories		**4**	(5)
(Decrease)/increase in payables and other liabilities		**(7,692)**	4,486
(Decrease)/increase in provisions		**(26)**	11
Net cash (used in)/generated from operating activities		**(7,235)**	**4,882**
Cash flows from investing activities			
Interest received		**20**	17
Purchase of intangible assets		**(175)**	(304)
Purchase of property, plant, equipment and investment property		**(2,845)**	(2,213)
Net cash used in investing activities		**(3,000)**	**(2,500)**
Cash flows from financing activities			
Public dividend capital received		**710**	-
Movement on loans from Department of Health and Social Care		**8,613**	-
PDC dividend paid		**(500)**	(371)
Net cash generated from/(used in) financing activities		**8,823**	**(371)**
(Decrease)/increase in cash and cash equivalents		**(1,412)**	**2,011**
Cash and cash equivalents at 1 April		**4,357**	2,346
Cash and cash equivalents at 31 March	17	**2,945**	**4,357**

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, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts. The period covered by these annual accounts is the year ended 31 March 2018.

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

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trusts' Annual Reporting Manual the financial statements have been prepared on a going concern basis as the Trust does not either intend to apply to the Secretary of State for the dissolution of the Trust without the transfer of the services to another entity, or consider that this course of action will be necessary. The Trust is also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the Trust and these are disclosed below.

The Trust has delivered a financial outturn for 2017/18 of £3.6m deficit against a planned deficit of £0.5m, showing an adverse variance £3.1m, the performance in the year required interim revenue support to be provided of £8.6m.

The Board of Directors has approved a deficit financial plan of £7.6m for 2018/19.This will require further financial support to be provided to enable the Trust to meet its debts as they fall due over the foreseeable future, which is defined as the period of 12 months from the date the accounts are signed. Plans are in place to draw down additional funding, although these are agreed on a monthly basis and at the year-end there is no formal agreement in place.

As with any financial plan, there are potential risks and opportunities to its delivery. The Board is confident that any risks can be successfully mitigated through focused scrutiny on the output of the service line reporting programme implemented by the Trust in 2017/18 and in conjunction with our commissioners.

In the current climate the Trust does not see itself as an outlier in the NHS financial framework and has aspirations to get back to a break-even position on its income and expenditure account within the next five years as a maximum. Having considered the material uncertainties and the Trust's financial plans, together with the likelihood of securing additional financial funding to support the financial operations, the directors have determined that it remains appropriate to prepare these accounts on a going concern basis.

The accounts do not include any adjustments that would result if the Trust was unable to continue as a going concern.

Note 1.2 - 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 trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

- assessment of the classification for estates rental charges, between operating and finance leases;
- non-consolidation of the Trust's element of the registered charity North West Boroughs Partnership NHS Foundation Trust Charitable Fund (charity number 1061651). In making this judgement the Trust has made reference to the DH GAM 2017/18. The Trust's element of this fund is managed under a Service-level agreement with North West 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 North West 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, 31 March 2017 and 31 March 2018 and this has been the basis for the valuation as at 31 March 2016, 31 March 2017 and 31 March 2018 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.

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 1.3 - 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.

Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training

service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4 - 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 1.5 - 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 1.6 - 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	7
Furniture and fittings	1	7
Wheelchairs/home loan equipment	1	5

Note 1.7 - 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, eg 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, eg 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	12

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 - Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.10 - 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, ie, 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 1.11 - Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

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

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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 1.12 - 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

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried by NHS resolution on behalf of the trust is disclosed at note 21 but is not recognised in the trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 - Contingencies

Contingent liabilities are not recognised, but are disclosed, 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 1.14 - 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 organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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 trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for

- donated assets (including lottery funded assets),
- average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
- any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.15 - 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 1.16 - 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 1.17 - 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 1.18 - 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 2017/18.

Note 1.21 - Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2017/18. These standards have not yet been adopted within the FReM and are therefore not applicable to DH group accounts in 2017/18.

- 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.
- 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:

	17/18	16/17
	£'000	£'000
CCGs and NHS England	**107,532**	114,825
Local authorities	**30,960**	36,595

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)

	2018	2017
	£000	£000
Acute services		
A&E income	**6,600**	6,631
Community services		
Community services income from CCGs and NHS England	**100,932**	108,194
Income from other sources (e.g. local authorities)	**37,895**	40,923
All services		
Other clinical income	**1,255**	2,226
Total income from activities	**146,682**	**157,974**

Note 3.2 Income from patient care activities (by source)

	17/18	16/17
	£000	£000
NHS England	**16,725**	13,768
Clinical commissioning groups	**90,807**	101,057
Other NHS providers	**6,080**	2,891
NHS other	**855**	1,437
Local authorities	**30,960**	36,595
NHS injury scheme	**525**	904
Non-NHS: other	**730**	1,322
	146,682	**157,974**
Of which:		
Related to continuing operations	**146,682**	**157,974**
Related to discontinued operations	**-**	**-**

Revenue from patient care services includes income accrued for activity where data is not available at 31 March 2018. 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 22.84% (2016/17: 22.94%) to reflect expected rates of collection.

Note 4 Other operating income

	2018 £000	2017 £000
Education and training	**1,788**	2,074
Sustainability and Transformation Fund income	**1,277**	4,090
Other income	**2,057**	-
	5,122	**6,164**
Of which:		
Related to continuing operations	**5,122**	**6,164**
Related to discontinued operations	**-**	**-**

Other income includes the impact of the settlement of a commercial debt and Health Centre recharges.

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:

	2018 £000	2017 £000
Income from services not designated as commissioner requested services	**146,682**	157,974
	146,682	**157,974**

Note 5 Fees and charges

	2018 £000	2017 £000
Income	**-**	-
Full cost	**-**	-
Surplus/(deficit)	**-**	-

Note 6 Operating expenses

	2018 £000	2017 £000
Purchase of healthcare from NHS and DHSC bodies	**7,407**	6,636
Purchase of healthcare from non-NHS and non-DHSC bodies	**3,409**	2,523
Staff and executive directors costs	**104,081**	110,470
Remuneration of non-executive directors	**143**	137
Supplies and services – clinical (excluding drugs costs)	**7,813**	8,161
Supplies and services - general	**641**	810
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**2,777**	1,821
Consultancy	**1,893**	1,001
Establishment	**6,919**	7,039
Premises	**4,096**	5,511
Transport (including patient travel)	**223**	252
Depreciation on property, plant and equipment	**2,655**	2,926
Amortisation on intangible assets	**320**	565
Increase in provision for impairment of receivables	**67**	31
(Decrease)/increase in other provisions	**(26)**	11
Audit fees payable to the external auditors		
- audit services - statutory audit	**64**	65
- other auditors' remuneration (external auditors only)	**3**	3
Internal audit costs	**152**	131
Clinical negligence	**313**	256
Legal fees	**265**	322
Education and training	**317**	373
Rentals under operating leases	**10,913**	12,107
Hospitality	**5**	5
Other	**490**	538
	154,940	**161,694**
Of which:		
Related to continuing operations	**154,940**	**161,694**
Related to discontinued operations	**-**	**-**

Operating expenses includes expenditure accrued for which no invoice has been received by 31st March 2018. 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.

Note 6.1 Other auditors' remuneration

	2018 £000	2017 £000
Other auditors' remuneration paid to the external auditors:		
- Other assurance services	3	3
Total	**3**	**3**

Note 6.2 Limitation on auditors' liability

The limitation on auditors' liability for external audit work carried out for the financial years 2017/18 is £1 million. This is consistent with the principal terms of the agreement with the auditors dated 21 May 2018.

Note 7 Employee benefits

	2018	2017
	£000	£000
Salaries and wages	**81,147**	85,082
Social security costs	**7,145**	7,621
Apprenticeship levy	**385**	-
Employer's contributions to NHS pensions	**10,357**	11,126
Temporary staff (including agency)	**5,595**	7,083
Total gross staff costs	**104,629**	**110,912**
Recoveries in respect of seconded staff	**-**	**-**
Total staff costs	**104,629**	**110,912**
Of which:		
Costs capitalised as part of assets	**548**	**442**

Note 7.1 Retirements due to ill health

During 2017/18 there was five early retirements from the trust agreed on the grounds of ill-health (one in the year ended 31 March 2017). The estimated additional pension liabilities of this ill-health retirement is £344k (2016/17: £169k).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 8 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 financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to

recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

Note 9 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 below therefore only include our expected costs for these properties.

	2018	2017
	£000	£000
Operating lease expense	**10,913**	12,107
Minimum lease payments	**10,913**	**12,107**
Total		

	31 March 2018	31 March 2017
	£'000	£'000
Future minimum lease payments due:		
- not later than one year;	**10,758**	12,453
- later than one year and not later than five years;	**1,637**	1,709
- later than five years.	**2,914**	2,677
Total	**15,309**	**16,839**

Note 10 Finance Income

	2018	2017
	£000	£000
Interest on bank accounts	**20**	17
Total	**20**	**17**

Finance income represents interest received on assets and investments in the period.

Note 11 Finance Expenditure

	2018 £000	2017 £000
Interest expense:		
Loans from the Department of Health and Social Care	**20**	-
Total	**20**	**-**

Finance expenditure represents interest and other charges involved in the borrowing of money.

Note 12 Intangible assets

Note 12.1 Intangible assets – 2017/18

	Internally generated information technology £000
Gross cost at 1 April 2017	**3,142**
Additions	175
Gross cost at 31 March 2018	**3,317**
Amortisation at 1 April 2017	**1,218**
Provided during the year	320
Amortisation at 31 March 2018	**1,538**
Net book value at 31 March 2018	**1,779**
Net book value at 31 March 2017	1,924

Note 12.2 Intangible assets – 2016/17

	Internally generated information technology £000
Gross cost at 1 April 2016	**2,838**
Additions	304
Gross cost at 31 March 2017	**3,142**
Amortisation at 1 April 2016	**653**
Provided during the year	565
Amortisation at 31 March 2017	**1,218**
Net book value at 31 March 2017	**1,924**
Net book value at 31 March 2016	2,185

13 Property, plant and equipment

Note 13.1 Property, plant and equipment – 2017/18

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 – brought forward	**2,424**	**9,790**	**8,618**	**7,226**	**658**	**28,716**
Additions	-	65	1,938	1,371	-	**3,374**
Revaluations	-	859	-	-	-	**859**
Valuation/gross cost at 31 March 2018	**2,424**	**10,714**	**10,556**	**8,597**	**658**	**32,949**
Accumulated depreciation at 1 April 2017 – brought forward	**-**	**53**	**3,197**	**3,913**	**302**	**7,465**
Provided during the year	-	406	1,557	650	42	**2,655**
Revaluations	-	(298)	-	-	-	**(298)**
Accumulated depreciation at 31 March 2018	**-**	**161**	**4,754**	**4,563**	**344**	**9,822**
Net book value at 31 March 2018	**2,424**	**10,553**	**5,802**	**4,034**	**314**	**23,127**
Net book value at 31 March 2017	2,424	9,737	5,421	3,313	356	21,251

Note 13.2 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**	**1,891**	**2,699**	**233**	**4,876**

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 13.3 Property, plant and equipment financing – as at 31 March 2018

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Owned	2,424	10,553	5,802	4,034	314	23,127
Net book value at 31 March 2018	**2,424**	**10,553**	**5,802**	**4,034**	**314**	**23,127**

Note 13.4 Property, plant and equipment financing – as at 31 March 2017

	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 14 Revaluations of property, plant and equipment

All of the Trusts owned Land & Buildings have been revalued at 31 March 2018. 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 15 Inventories

	31 March 2018	31 March 2017
	£000	£000
Drugs	**40**	44

Inventories recognised in expenses for the year were £2,777k (2016/17: £427k). Write down of inventories recognised as expenses for the year was £nil (2016/17: £nil).

Note 16 Trade and other receivables

Note 16.1 Current and non-current trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	**9,226**	8,974
Accrued income	**2,999**	4,578
Provision for impaired receivables	**(372)**	(312)
Prepayments (non-PFI)	**1,534**	758
PDC dividend receivable	**86**	-
VAT receivable	**559**	346
Total current trade and other receivables	**14,032**	**14,344**
Non-current		
Provision for impaired receivables	**(171)**	(186)
Other receivables	**775**	1,032
Total non-current trade and other receivables	**604**	**846**

Note 16.2 Provision for impairment of receivables

	31 March 2018 £000	31 March 2017 £000
At 1 April	**498**	467
Increase in provision	**67**	31
Amounts utilised	**(22)**	-
At 31 March	**543**	498

Note 16.3 Analysis of impaired receivables – 31 March 2018

	Trade and other receivables £000
Aging of impaired financial assets	
0-30 days	**-**
30-60 days	**-**
60-90 days	**-**
90-180 days	**-**
Over 180 days	**371**
Total	**371**
Aging of non-impaired financial assets past their due date	
0-30 days	**522**
30-60 days	**910**
60-90 days	**373**

90-180 days	**935**
Over 180 days	**3,504**
Total	**6,244**

Note 16.4 Analysis of impaired receivables – 31 March 2017

	Trade and other receivables £000
Aging of impaired 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 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 17 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.

	17/18	16/17
	£000	£000
At 1 April	**4,357**	2,346
Net change in year	**(1,412)**	2,011
At 31 March	**2,945**	**4,357**
Broken down into:		
Cash at commercial banks and in hand	**23**	29
Cash with the Government Banking Service	**2,922**	4,327
Total cash and cash equivalents as in SoFP and SoCF	**2,945**	**4,357**

Note 18 Trade and other payables

	31 March 2018	31 March 2017
	£000	£000
Current		
Trade payables	**4,566**	11,978
Capital payables	**630**	101
Accruals	**4,856**	4,959
Social security costs	**1,853**	1,944
Accrued interest on loans	**20**	-
Other payables	**1,400**	1,487
Total current trade and other payables	**13,325**	**20,469**
Of which: payables to NHS and DHSC group bodies	3,602	9,505

Note 19 Borrowings

	31 March 2018	31 March 2017
	£000	£000
Current		
Loans from the Department of Health and Social Care	**392**	**-**
Total current borrowings	**392**	**-**
Non-current		
Loans from the Department of Health and Social Care	**8,221**	**-**
Total current borrowings	**8,221**	**-**

Note 20 Provisions

	legal claims
	£'000
At 1 April 2017	**65**
Arising during the year	46
Reversed unused	(72)
At 31 March 2018	**39**
Expected timing of cash flows:	
- not later than one year	**39**
Total	**39**

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 21 Clinical negligence liabilities

At 31 March 2018 £2,106k was included in the provisions of the NHSLA in respect of clinical negligence liabilities of Bridgewater Community Healthcare NHS Foundation Trust (2016/17: £1,375k).

Note 22 Contractual capital commitments

	31 March 2018	31 March 2017
	£000	£000
Property, plant and equipment	**99**	-

Note 23 Financial Instruments

Note 23.1 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 2018 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 23.2 Carrying Values of Financial assets

	Loans and receivables £000
Assets as per SoFP as at 31 March 2018	
Trade and other receivables excluding non-financial assets	**11,985**
Cash and cash equivalents at bank and in hand	**2,945**
Total at 31 March 2018	**14,930**
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**

Note 23.3 Carrying Values of Financial liabilities

	Other financial liabilities £000
Liabilities as per SoFP as at 31 March 2018	
Borrowings excluding finance leases and PFI liabilities	**8,613**
Trade and other payables excluding non-financial liabilities	**11,580**
Total at 31 March 2018	**20,193**
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**

Note 23.4 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	**11,972**	13,566
In more than one year but not more than two years	**-**	-
In more than two years but not more than five years	**8,221**	-
In more than five years	**-**	-
Total	**20,193**	**13,566**

Note 23.5 Fair values of financial assets at 31 March 2018

The fair value of financial assets is considered to be equivalent to the transaction value.

Note 23.6 Fair values of financial liabilities at 31 March 2018

The fair value of financial liabilities is considered to be equivalent to the transaction value.

Note 24 Losses and special payments

	2018		2017	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	£000	£000	£000	£000
Losses				
Bad debts and claims abandoned	14	1	10	-
Total losses	**14**	**1**	**10**	**-**
Total losses and special payments	**14**	**1**	**10**	**-**

Note 25 Related parties

The Trust considers the Department of Health and Social Care as its parent department and the following provides a list of the main entities within the public sector with which the body has had dealings:

- Department of Health ministers
- Board members of the NHS foundation trust
- The Department of Health and Social Care
- 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:

CCGs
NHS Halton CCG
NHS St Helens CCG
NHS Warrington CCG
NHS Wigan Borough CCG

NHS England
NHS Core
Cheshire and Merseyside
Greater Manchester Local Office
Lancashire and South Cumbria Local Office

NHS Trusts
St Helens and Knowsley NHS Trust

NHS Foundation Trusts
Greater Manchester Mental Health NHS Foundation Trust
Warrington and Halton Hospitals NHS Foundation Trust
Wrightington, Wigan and Leigh NHS Foundation Trust
Wirral Community Healthcare NHS Foundation Trust

Other NHS Bodies
NHS Pension Scheme
Health Education England
NHS Property Services
Community Health Partnerships

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 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Local Authorities				
Halton Borough Council	**1,163**	484	**122**	124
St Helens Metropolitan Borough Council	**252**	487	**2**	36
Warrington Borough Council	**157**	159	**-**	42
Wigan Borough Council	**77**	348	**110**	106
Bolton Metropolitan Borough Council	**395**	165	**29**	1
Oldham Metropolitan Borough Council	**387**	990	**70**	30
	2,431	**2,633**	**333**	**339**

	Income		Expenditure	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Local Authorities				
Halton Borough Council	**4,334**	5,247	**10**	39
St Helens Borough Council	**598**	2,525	**204**	219
Warrington Borough Council	**7,399**	7,919	**3**	13
Wigan Borough Council	**7,121**	8,155	**100**	93
Bolton Metropolitan Borough Council	**3,358**	3,408	**30**	17
Oldham Metropolitan Borough Council	**7,897**	8,473	**-**	17
	30,707	35,727	**347**	398

Independent auditors' report to the Council of Governors of Bridgewater Community NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Bridgewater Community NHS Foundation Trust's financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of the Trust's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts 2017/18 (the "Annual Report"), which comprise: the Statement of Financial Position as at 31 March 2018; the Statement of Comprehensive Income for the year then ended; the Statement of Cash Flows for the year then ended; the Statement of Changes in Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

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"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 (Accounting Policies) to the financial statements concerning the Trust's ability to continue as a going concern.

The Trust has produced a financial plan for 2018/19 which indicates a deficit of £7.6m. The Trust anticipates that it will receive external financial support to ensure that it is able to meet its liabilities as they fall due and provide ongoing healthcare services. However, the nature of any financial support, including whether such support will be forthcoming or sufficient is not yet known and will be agreed on a monthly basis.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust were unable to continue as a going concern.

Explanation of material uncertainty

The Trust's annual plan for 2018/19 is a planned deficit of £7.6m. We examined the Trust's cash flow forecast for 2018/19 and the subsequent period to May 2019 (inclusive). Throughout the period, the Trust expects to maintain positive cash balances, but this is contingent on the Trust requiring additional loan funding during the year which is not yet agreed.

Based on the financial plan for 2018/19, the Trust will require further financial support from the Department of Health and Social Care. At the time of approval of the financial statements the amount of and nature of the funding was unknown and will be agreed on a monthly basis.

What audit work we performed

In considering the financial performance of the Trust we:

- Understood the Trust's 2018/19 Annual Plan and cash flow forecasts, including their key assumptions, for example CIP and working capital requirements;
- Confirmed the agreement of 2018/19 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 / efficiencies target through consideration of historical delivery of CIP requirements; and
- Assessed the sensitivity of the 2018/19 Annual Plan to underperformance in this area; and
- Considered the reliance that the Trust has on external support to deliver its 2018/19 plan, which at the time of approval of the financial statements the nature and amount had not been agreed.

Our audit approach

Context

The 2017/18 financial year is the second year that PwC has audited the Trust. In the year the Trust experienced financial pressure delivering a £3.5m deficit for the year, which was higher than the original planned deficit of £0.5m. External borrowing from the Department of Health and Social Care has also risen from £nil to £8.6m during the year.

Within the prior year the Trust was subject to an inspection from the Care Quality Commission ("CQC") which, although acknowledging the Trust's progress and improvements made, gave a rating of 'requires improvement'. These matters have been considered within our audit approach.

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview

- Overall materiality: £3,036,080 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

As part of designing our audit, we determined materiality and assessed 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.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to financial sustainability and going concern, described in the Material Uncertainty relating to going concern section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	***How our audit addressed the Key audit matter***
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 planned outturns, 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. 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. 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. 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 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 2017/18 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 had a net impact on the Statement of Comprehensive Income, 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 posted in each month showed any unusual trends. *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. *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 2017/18 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*	We used our valuations expertise to confirm that management's decision to apply the BCIS indexation and the indexation applied to

Key audit matter	How our audit addressed the Key audit matter
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 2017/18. The carrying value of PPE is £23.1m (2017: £21.3m). 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 2018. The PPE balance also includes £4.4m (2017: £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.	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 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.

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 accounting processes and controls, and the environment in which the Trust operates.

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	£3,036,080 (2017: £3,276,000
How we determined it	2% of revenue (2017: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, 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 £151,000 (2017: £163,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 26, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

As part of an audit in accordance with ISAs (UK), we exercise professional judgement and maintain professional scepticism

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.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Bridgewater Community 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.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, 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 2017/18.

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 2018.

Basis of adverse conclusion

ii) Financial performance

In the year the Trust delivered a deficit of £3.5m, which was £3.0m adrift of the original deficit plan of £0.5m. Cash outflow from operations was £7.2m and external borrowing with Department of Health is at £8.6m (2017: £nil).

The above issue is evidence of a weakness in proper arrangements for planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions.

iii) CQC inspection results

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). We have also seen no evidence that the Trust had made sufficient improvements before the start of the year.

Adverse conclusion

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 2018.

Other matters on which we report by exception

We are required to report to you if:

- the statement given by the directors on page 27, 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 Trust's performance, business model and strategy is not materially consistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 39, 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 2017/18 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 not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

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.

Anna Blackman (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Date: 27 May 2018

7. 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.

8. Appendices

Appendix 1 Board and Committee Attendance Register

Board and Committee Attendance Register - April 2017 to March 2018

KEY AP – apologies A-absent (no apologies) *closed/extraordinary session **/*** two or three Board sessions in a month, some closed		April	May	June	July	August**	September**	October	November**	December	January	February	March	TOTAL
Board meetings (including both public and closed meetings)														
Harry Holden	Chairman	x		x	x	AP/x	x/x		x/x			x	x/x	11/12
Karen Bliss	Non – Executive Director	x		x	x	AP/AP	x/x		x/x			x	x/x	10/12
Steve Cash	Non – Executive Director	x		AP	x	x/x	AP/A		x/x			x	x/AP	8/12
Marian Carroll	Non – Executive Director	x		AP	x	x/x	x/AP		x/x			x	x/x	10/12
Maggie Pearson	Non – Executive Director	x		x	x	x/x	AP/AP		x/x			AP	x/x	9/12
Bob Saunders	Non – Executive Director	x		x	x	x/x	AP/x		x/AP			AP	x/x	9/12
Sally Yeoman	Non – Executive Director/Senior Independent Director	x		x	x	x/AP	x/x		x/x			x	x/x	11/12
Dorothy Whitaker	Non – Executive Director/Vice Chair	x		x	x	x/x	x/x		x/x			x	x/x	12/12
Christine Samosa	Director of People and Organisational Development/Deputy Chief Executive	x		x	x	AP/x	x/x		x/x			x		9/10
Colin Scales	Chief Executive	x		x	x	x/x	x/x		x/x			x	x/x	12/12
Esther Kirby	Chief Nurse and Director of Quality	x		x	AP	x/x	x/x		x/x			x	x/x	11/12
Gareth Davies	Director of Finance	x		x	AP	x/x	x/x		x/x					8/9
Mike Barker	Director of Strategic Development	x		x	x	x/AP	x/x		x/x			x	x/x	11/12
Karen Slade	Medical Director	x		x	x	x/AP	AP/AP							4/7
David Lewis	Interim Medical Director								N/A/x			AP	AP/x	2/4
Wendy Hull	Interim Finance Director											x		1/1
Sue Hill	Director of Finance												x/x	2/2
Lynne Carter	Interim Chief Nurse												NA/x	1/1
Sharon Barber*	Director of Adult Services Wigan						NA /AP		x/x			AP	AP/AP	2/6
Caroline Williams*	Interim Director of Operations	x		x	x	x/x	AP/AP		AP/AP			x	x/x	8/12

*Non-voting members

KEY AP – apologies		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Nominations and Remuneration Committee (held on ad – hoc basis)														
Harry Holden	**Chairman**			x	x					x		x	x	5/5
Karen Bliss	**Non – Executive Director**			x	x					x		x	x	5/5
Steve Cash	**Non – Executive Director**			AP	x					x		x	x	4/5
Marian Carroll	**Non – Executive Director**			AP	x					AP		x	x	3/5
Maggie Pearson	**Non – Executive Director**			x	x					x		AP	x	4/5
Bob Saunders	**Non – Executive Director**			x	x					x		AP	AP	3/5
Sally Yeoman	**Non – Executive Director**			x	AP					x		x	x	4/5
Dorothy Whitaker	**Non – Executive Director**			x	x					x		x	x	5/5

KEY AP – apologies *Extraordinary Audit Committee		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Audit Committee														
Karen Bliss	**Non – Executive Director (Chair)**		x		x			x			x			4/4
Steve Cash	**Non – Executive Director**		AP		x			x			x			3/4
Marian Carroll	**Non – Executive Director**		x		AP			x			x			3/4
Maggie Pearson	**Non – Executive Director (Chair from October 2017)**		x		x			x			x			4/4
Bob Saunders	**Non – Executive Director**		x		x			x			AP			3/4
Dorothy Whitaker	**Non – Executive Director**		x		AP			x			x			3/4

KEY AP – apologies *Extraordinary Audit Committee		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Quality and Safety Committee														
Bob Saunders	Non – Executive Director (Chair)	x	x	x	x	x	x	x	x	x	x	x	AP	11/12
Marian Carroll	Non – Executive Director	AP	x	AP	x	x	x	x	AP	x	x	x	x	9/12
Sally Yeoman	Non – Executive Director	AP	x	x	AP	x	x	x	x	x	x	x	x	10/12
Dorothy Whitaker	Non – Executive Director	x	x	x	x	x	AP	x	x	x	x	x	x	11/12
Esther Kirby	Executive Nurse and Director of Quality	x	x	x	x	AP	x	x	x	AP	x	x	x	10/12
Karen Slade	Medical Director	x	x	x	x	x	AP							5/6
David Lewis	Interim Medical Director								N/A	AP	x	x	x	3/4

KEY AP – apologies		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Workforce and Organisational Development Committee														
Marian Carroll	Non-Executive Director (Chair)			x			x		x		x		x	5/5
Dorothy Whitaker	Non-Executive Director			x			AP		x		x		x	4/5
Karen Bliss	Non – Executive Director			AP			x		x		x		x	4/5
Maggie Pearson	Non – Executive Director			AP			AP		x		AP		AP	1/5
Christine Samosa	Director of People and Organisational Development/Deputy Chief Executive			x			x		x		x			4/4
Esther Kirby	Chief Nurse			x			AP		x		AP		x	3/5
Karen Slade	Medical Director			x			x							
David Lewis	Interim Medical Director										x		AP	1/2

KEY AP – apologies		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Finance and Investment Committee														
Karen Bliss	Non – Executive Director (Chair)	AP	x	x	x	AP	x	AP	x	x	x	x	x	9/12
Steve Cash	Non – Executive Director	AP	x	x	x	x	AP	x	x	x	x	x	x	10/12
Maggie Pearson	Non – Executive Director	AP	x	x	x	x	AP	x	x	x	x	AP	x	9/12
Sally Yeoman	Non – Executive Director	x	x	x	x	x	x	x	x	x	x	x	x	12/12
Christine Samosa	Director of People and Organisational Development/Deputy Chief Executive	x	AP	x	AP	AP	x	AP	x	x	x			6/10
Gareth Davies	Director of Finance	x	AP	x	AP	x	x	x	x	x				7/9
Mike Barker	Director of Strategic Development	x	x	x	x	x	x	x	x	x	x	AP	x	11/12
Esther Kirby	Executive Nurse and Director of Quality	AP	x	x	x	AP	AP	x	AP	AP	AP	x	AP	5/12
Wendy Hull	Interim Director of Finance										x	x		2/2
Sue Hill	Director of Finance												x	1/1

KEY AP – apologies A – absent without apologies		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Council of Governors														
Harry Holden	Chairman	x		x		x				x		x		5/5
Dorothy Whitaker	Non – Executive Director/Vice Chair	x		x		x				x		x		5/5
Karen Bliss	Non – Executive Director	AP		x		x				x		x		4/5
Steve Cash	Non – Executive Director	AP		AP		AP				x		x		2/5
Marian Carroll	Non – Executive Director	x		AP		x				AP		x		3/5
Maggie Pearson	Non – Executive Director	AP		x		x				x		x		4/5
Bob Saunders	Non – Executive Director	x		x		x				x		x		5/5
Sally Yeoman	Non – Executive Director/Senior Independent Director	x		AP		x				x		x		4/5
Christine Samosa	Director of People and Organisational Development/Deputy Chief Executive	x		x		x				x				4/4
Colin Scales	Chief Executive	x		x		AP				x				3/4
Esther Kirby	Chief Nurse and Director of Quality	AP		AP		AP				AP				0/4
Gareth Davies	Director of Finance	x		x		AP				AP				2/4
Mike Barker	Director of Strategic Development	x		AP		x				x				3/4
Karen Slade	Medical Director	x		AP		x								2/3
David Lewis	Interim Medical Director									x				1/1
Wendy Hull	Interim Director of Finance													N/A
Sue Hill	Director of Finance													N/A

**Exec Directors attendance not required from February 2018 as directed by Governors, only if presenting an item*

KEY AP – apologies A – absent without apologies		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Council of Governors														
John Prince	Lead Governor and Public Governor – Wigan	x												1/1
Gary Young	Public Governor – Wigan	AP		AP		AP				AP		AP		0/5
William (Ken) Griffiths	Public Governor – Wigan	x		x		AP				x		AP		3/5
Susan Francis	Public Governor – Wigan	AP		x		AP				x		x		3/5
Rebecca Reece	Public Governor – Wigan	x		x		AP				x		x		4/5
Paul Mendeika	Public Governor – Warrington	x		x		x				x		x		5/5
Alan Guthrie	Public Governor – Warrington	AP		AP		AP				A		AP		0/5
Rita Chapman	Public Governor – St Helens	x		x		AP				x		x		4/5
Derek Maylor	Public Governor – St Helens	x		x		AP				x		AP		3/5
Canon Geoff Almond	Public Governor – St Helens	AP		AP		x				AP		AP		1/5
Marlene Quinn	Public Governor – St Helens	A		A		A				A		A		0/5
Bill Harrison	Public Governor – St Helens	x		x		x				x		x		5/5
Diane McCormick	Public Governor - Halton	x		x		x				x		x		5/5

KEY AP – apologies A – absent without apologies		April	May	June	July	August	Sept	October	Nov	Dec	Jan	Feb	March	Total
Council of Governors														
Steven Lowe	Staff Governor – AHP	x		AP		x				x		x		4/5
Heulwen Sheldrick	Staff Governor - AHP	x		x		AP								2/3
Corina Casey Hardman	Staff Governor – Nursing and Midwifery	AP		x		AP				AP		AP		1/5
Fiona Bremner	Staff Governor – Nursing and Midwifery	x		AP		AP				x		AP		2/5
Janet Rawlings	Staff Governor – Nursing and Midwifery	x		x		x				x		x		5/5
Dr Deb Mandal	Staff Governor – Doctors/Medical	AP		AP		x				x		x		3/5
Dave Smith	Staff Governor – Non-Clinical Support	x		x		x				AP		AP		3/5
Janette Grey	Partner Governor – Higher Education	x		x		x				x		x		5/5
Cllr Judith Guthrie	Partner Governor - Warrington	x		AP		AP				A		AP		1/5
Cllr Geoff Zygadlo	Partner Governor - Halton	AP		x		AP				x		x		3/5
Nigel Ash	Partner Governor – Wigan	AP		AP										0/2
Alison Cullen	Partner Governor – Voluntary Sector	A		A		A				A		A		0/5

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

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Quality first and foremost