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Part 1 - Statement on Quality by Chief Executive

This is the Trust’s fifth Quality Report (Quality Account) and over the last five years we have made some significant improvements to how we care for patients, their experience and their safety. This latest report is a review of how we have performed during 2015/16 and it looks forward to the year ahead, setting out the quality priorities we will be focusing on.

I am very clear that everything I do, and that all of our management and support staff do, must be geared towards supporting our clinical staff to deliver the best possible experience for our patients, their families and carers - Quality; first and foremost. 2015/16 was a very busy and challenging year for Bridgewater Community Healthcare NHS Foundation Trust. One of our significant achievements was being awarded the contract to deliver the Bolton’s five to 19 children’s services including school nursing, alcohol and substance misuse, sexual health and healthy schools services by Bolton Council. Oldham Council has also commissioned us to deliver key services to local children and young people including school nursing, health visiting, family nurse partnership and services in the borough’s 16 children’s centres from 1st April 2016.

However, the NHS nationally is currently operating within a very tough financial climate. With the support of our staff and partners we are addressing these financial challenges by adopting new ways of working, forging partnerships with other health and social care providers and continuing to engage our staff by actively pursuing a culture of innovation and involvement. Processes regarding the use of agency staff have been revised to ensure the effective use of resources.

The last year has seen the appointment of a new Chief Nurse, Medical Director, Strategy Director and Finance Director. The Board has also appointed two Area Directors. They are now non-voting members of the Board and their focus is to steer the future of the organisation, emphasising the move to being a more clinically-led trust. We commenced a re-structuring of clinical services to take into account our various boroughs and this will be implemented in 2016/17.

There has been a substantial amount of work undertaken to ensure our nursing/midwifery staff are fully prepared for the introduction of the Nursing and Midwifery Councils system of revalidation from April 2016. 2015 saw the advent of our Open Space meetings as a means of having honest, open and productive conversations with all of our staff. These meetings have proved to be a useful forum for discussing issues such as “how can we ensure that patients are receiving a quality service and what should it look like”?
An internal safeguarding review was commissioned by the Chief Nurse in year which identified strategic recommendations which were accepted by the Executive Team. The recommendations included the appointment of a strategic lead and Named Nurse for adults which have occurred in year. An operational re-design was also part of the review in line with the Trust borough facing arrangements during 2016/17. The Trust in year have worked in partnership with Local Authorities and CCGs to address concerns regarding training, staffing levels and partnership working which will form part of the redesign taking place in 2016/17.

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

**Insert CEO signature**
A bit more about us…

We provide high quality community and specialist services to 855,848 people living in:

- Runcorn & Widnes (Halton)
- St Helens
- Warrington
- Wigan Borough
- Community Dental (provides services in all of the above areas plus Bolton, Tameside, Trafford, Glossop, Stockport and western Cheshire)

The majority of our services are delivered in patients' homes or at locations close to where they live, such as clinics, health centres, GP practices, community centres and schools.

As a provider of both mainstream and specialist care our role is to focus on providing cost effective NHS care by keeping people out of hospital and supporting vulnerable people throughout their lives.

As a dedicated provider of community services our strategy is to bring more care closer to home – this means providing a wider range of services in community settings to keep people healthier for longer and developing more specialist services to support people to live independently at home.

We employ 3,400 staff and have an income of £140 million which comes from our commissioners, who include Clinical Commissioning Groups (CCGs), NHS England and local authorities.

- **NHS Warrington CCG** represents 26 GP practices, acting on behalf of over 212,901 patients living in Warrington
- **NHS Halton CCG** represents 17 GP practices, acting on behalf of over 125,892 patients living in Halton
- **NHS St Helens CCG** represents 37 GP practices, acting on behalf of over 194,758 patients living in St Helens
- **NHS Wigan CCG** represents 65 GP practices, acting on behalf of over 322,297 patients living in Wigan
- **LA as commissioners???

On an average day we care for:

- approximately 9500 patients
- 409 people in our walk in centres
- 27 people in our community hospital (Newton)
- 2190 supported by our district nurses
- 290 people in our community dental services
**Part 2**
**Review of progress against the 2015/16 Priorities for Improvement**

<table>
<thead>
<tr>
<th>Quality Priority</th>
<th>Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sign up to Safety</td>
<td>An extensive action plan with a work programme for 2015/16 was agreed. This has been updated on a quartile basis and reported to the Trust’s Quality and Safety Committee. In addition reports have also been received at the Clinical Quality Review Meetings with Commissioners. Significant progress has been made in year and any incomplete actions will be carried forward into 2016/17. A work programme for 2016/17 is being finalised and will include:- 1. Medication Safety - Continue to reduce internal Trust drug errors and effectively handle 3rd party incidents. 2. Pressure Ulcers - continue to reduce avoidable Bridgewater Pressure Ulcers and audit the use of the Trust's Pressure Ulcer reporting tool. 3. Evaluate the&quot; fallsafe “data and identify key priorities for the reduction of falls in Newton Community Hospital and Padgate House. 4. Implement the Bridgewater Food and Drink Strategy. 5. Improve rates of training compliance with both children and adult safeguarding.</td>
</tr>
<tr>
<td>Improvement in the handling of serious and untoward incidents</td>
<td>In order to maintain investigation quality, staff who received formal investigation training at the end of 2014/15 assisted experienced investigators during 2015/16 to gain practical experience before leading on investigations. This additional support has produced more rounded investigations and supported staff in balancing time undertaking an investigation with their daily duties. It has also meant that initial investigations have been completed earlier and offered more time for review by senior managers and revision before completion. A Case Note Review checklist has been developed for pressure ulcer Serious Incidents (SIs) during 2015/16, based on the findings of previous investigation findings, to more consistently identify any lapses in care, quality, or service delivery that might progress to an Root Cause Analysis (RCA) investigation. Used as a documented review within 72 hours of identifying an SI, it provides a defensible and transparent document on which to base an investigation and required improvements for local teams. It has reduced the time to decide on whether an RCA is required, the volume of RCAs and the people and resources needed to undertake these. If an SI does</td>
</tr>
</tbody>
</table>
proceed to RCA, it provides an accurate terms of reference. These
are reviewed and signed off by the newly established Incident
Review Panel that considers all SIs and investigations. As a
standard ‘checklist’ they also provide a means of monitoring themes
and the success (or not) of implemented service change. Although
the volume of RCAs is reduced, it was agreed with some of our key
commissioners that we would routinely review the areas of
improvement identified by the Case Note Reviews.

<table>
<thead>
<tr>
<th>NHS Safety Thermometer improvements in care</th>
<th>General narrative regarding safety thermometer to be added. Please see sections on pressure ulcers, falls and medication safety for further detail.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newton Hospital Vision and Strategy</td>
<td>The Commissioners are yet to set clear commissioning intentions for the service therefore this work has not been progressed. It is hoped that the results of the CCG review of intermediate care services in St Helens will be published within the next few months. This will then give the organisation direction as to what the future intentions for the service are and provide direction and structure for any future strategy/operational plan.</td>
</tr>
</tbody>
</table>

**Priorities for Improvement in 2016/17**

Bridgewater’s priorities for improvement are articulated in a number of Trust documents e.g. the Health and Wellbeing Strategy, the Operating Plan and the Quality Strategy action plan.

It is clearly important that there is a synergy between these corporate documents and the priorities for improvement for 2016/17 included in this Quality Report.

Through the monitoring of data relating to the quality of our services the following are seen as priorities and are consistent themes in the above mentioned documents:

- Improve the quality of record keeping - legally defensible documentation as this is a recurring matter in complaints and investigations.
- Reduce medication errors – continue to reduce internal drug errors and effectively handle 3rd party incidents. Medication errors are consistently in the top 3 of reported incidents.
- Reducing harm from pressure ulcers – continue to reduce Bridgewater Pressure Ulcers. Reducing the number of grade 3 and 4 pressure ulcers and increase the use of the trusts pressure ulcer reporting tool.
Statements of Assurance from the Board

Review of Services
During 2015/16 the Bridgewater Community Healthcare NHS Foundation Trust provided and/or sub-contracted 129 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 2015/16 represents 98% of the total income generated from the provision of relevant health services by the Bridgewater Community Healthcare NHS Foundation Trust for 2015/16.

Audit

Participation in clinical audits
During 2015/16 three national clinical audits and no national confidential enquiries covered NHS 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 which it was eligible to participate in.

The national clinical audits that Bridgewater Community Healthcare NHS Foundation Trust was eligible to participate in during 2015/16 are as follows:

- The National Audit of Intermediate Care. (NAIC)
- National Audit of Chronic Obstructive Pulmonary Disease (COPD) - Pulmonary Rehabilitation
- National Audit of Parkinsons

The national clinical audits and national confidential enquiries that Bridgewater Community Healthcare NHS Foundation Trust participated in, and for which data collection was completed during 2015-16, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

<table>
<thead>
<tr>
<th>Title</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>The National Audit of Intermediate Care. (NAIC)</td>
<td>100%</td>
</tr>
<tr>
<td>National Audit of Chronic Obstructive Pulmonary Disease (COPD) - Pulmonary Rehabilitation</td>
<td>86%</td>
</tr>
<tr>
<td>National Audit of Parkinsons</td>
<td>100%</td>
</tr>
</tbody>
</table>
The reports of three national clinical audits were reviewed by the provider in 2015-16 and Bridgewater Community Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

<table>
<thead>
<tr>
<th>Title</th>
<th>Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 The National Audit of Intermediate Care. (NAIC)</td>
<td>Recommendations of the audit were commissioner focussed. However, Bridgewater had identified that we can actively participate in commissioner led reviews of intermediate care provision in areas that Bridgewater covers.</td>
</tr>
<tr>
<td>2 National Audit of Chronic Obstructive Pulmonary Disease (COPD) - Pulmonary Rehabilitation</td>
<td>Add Medical Research Council score (this is a respiratory measure) at discharge in addition to the other measures already in place.</td>
</tr>
<tr>
<td>3 National Audit of Falls</td>
<td>This audit was undertaken within acute hospitals only and not within community healthcare providers such as Bridgewater. As a provider of non-acute bed based services, the Trust has mapped our existing FallSafe initiative to the standards in this audit and confirmed that all areas highlighted in this report are included in the initiative.</td>
</tr>
</tbody>
</table>

The reports of 20 local clinical audits were reviewed by the provider in 2015/16 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.

The reports from all clinical audits completed across Bridgewater are detailed in the Trust’s clinical audit annual report (anticipated completion date July 2016). To request a copy of the report please contact clinical.audit@bridgewater.nhs.uk

**Participation in Clinical Research**

The number of patients receiving relevant health services provided or subcontracted by Bridgewater Community Healthcare NHS Foundation Trust in 2015/16 that were recruited during that period to participate in research approved by a research ethics committee was 126.

In addition, 50 patients with diabetes living in the Wigan borough have signed up to the Help DiaBEATes (pronounced ‘Help Beat Diabetes’) research register, which aims to encourage people with diabetes 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.
Goals agreed with Commissioners - Use of the CQUIN Payment Framework

A proportion of Bridgewater Community Healthcare NHS Foundation Trust income in 2015/16 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.

Further details regarding the agreed goals for 2015/16 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 £2.873m subject to final confirmation from commissioners regarding quarter 4 data.

The monetary total for the associated payment in 2014/15 was £2.907m.

What others say about the Provider - Statements from the CQC

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

The Care Quality Commission has not taken enforcement action against Bridgewater Community Healthcare NHS Foundation Trust during 2015/16.

Bridgewater Community Healthcare NHS Foundation Trust has not participated in any special reviews or investigations by the CQC during the reporting period.

Bridgewater View on CQC Five Key Questions

CQC inspected the organisation in February 2014 as part of its piloting of the new inspection process. As the inspection was part of the pilot no rating was provided.

Below is the organisations view on whether the care we provide is safe, effective, caring, responsive and well-led.

Are we safe?

Are we effective?

Are we caring?

Are we responsive to people's needs?
Are we well-led?

NHS Number and General Medical Practice Code Validity
Bridgewater Community Healthcare NHS Foundation Trust submitted records during 2015/16 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:
- Xx% for outpatient care; and
- xx% for accident and emergency care

The percentage of records in the published data which included the patient’s valid General Medical Practice Code was:
- xx% for outpatient care; and
- xx% for accident and emergency care

Information Governance Assessment Report
Bridgewater Community Healthcare NHS Foundation Trust Information Governance Assessment Report overall score for 2015/16 was 74% and was 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 January/February 2016 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 (SIs) during 2015/16:
- Patient notes were left in a supermarket in error
- Patient information contained within a hidden pivot table was sent to a CCG and acute hospital in error.

Both incidents were investigated by the Information Commissioner’s Office and closed with no further action. Root Cause Analysis were completed and a number of lessons learnt resulted from these incidents.
Clinical Coding Error Rate
Bridgewater Community Healthcare NHS Foundation Trust was subject to the payment by results clinical coding audit during 2015/16 by the Audit Commission.

(DA - Maternity data Halton)

Only applicable if PBR is applic –
NHS foundation trusts should include an explanatory note for clinical coding stating:
☑ that the results should not be extrapolated further than the actual sample audited; and
☑ which services were reviewed within the sample.

Statement on Relevance of Data Quality and your actions to improve your Data Quality
Bridgewater Community Health 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 has used MIAA to audit performance reporting since May 2011. The overall objective of the audits is to provide assurance that the Trust has an effective process-controlled system for performance reporting.

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

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

The Trust has continued to be proactive in improving data quality by providing:
➢ System Training (and refresher training available on request)
➢ Drop-in sessions for assistance with system use for data recording
➢ Guidance and frequently asked questions (available on the Trust intranet).
➢ Activity and data quality are to be standing items on clinical team meeting agendas
➢ Activity recording and data quality will be referenced in KSFs and PDRs.
➢ Patient Access Policy reminders are being distributed to staff via the monthly Bulletin and Team Brief.
Reporting against Core Indicators

In accordance with NHS England requirements Bridgewater 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).

<table>
<thead>
<tr>
<th>Core Indicator</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>3%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>There were 295 discharges and 8 readmissions within 28 days.</td>
<td>There were 343 discharges and 7 readmissions within 28 days</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Reason</th>
<th>Days to readmission back into Newton Community Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 x Fall</td>
<td>4, 8 and 14</td>
</tr>
<tr>
<td>Cellulitis</td>
<td>8</td>
</tr>
<tr>
<td>Pain Management</td>
<td>4</td>
</tr>
<tr>
<td>Carer breakdown</td>
<td>15</td>
</tr>
<tr>
<td>Community acquired pneumonia</td>
<td>24</td>
</tr>
<tr>
<td>UTI off legs</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Core Indicator</th>
<th>Bridgewater 2015</th>
<th>Bridgewater 2014</th>
<th>National Average for Community Trusts</th>
<th>Highest Community Trust</th>
<th>Lowest Community Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a friend or relative needed treatment I would be happy with the standard of care provided by the organisation (Q21d NHS Staff Survey)</td>
<td>79%</td>
<td>70%</td>
<td>73%</td>
<td>82%</td>
<td>68%</td>
</tr>
<tr>
<td>% of staff that would recommend the Trust to friends and family as a place to work. (Q21c NHS Staff Survey)</td>
<td>49%</td>
<td>49%</td>
<td>57%</td>
<td>66%</td>
<td>48%</td>
</tr>
</tbody>
</table>
The Bridgewater Community Healthcare NHS Foundation Trust considers that this data is as described for the following reasons;
- There has been a period of major organisational changes affecting staff during 2013 and 2014 and there is due to be another period of change in 2016. It is recognised that change of this nature and scale can affect staff morale and their perceptions of the organisation. Work has been on-going during 2015 to try to improve this and whilst there has been no change with regards to the Trust as a place of work there has been in improvement in recommending the Trust as a place to receive treatment.

The Bridgewater Community Healthcare NHS Foundation Trust intends to take the following actions to improve this score, and so the quality of its services by;
- Recognising that there is a slight improvement in this result and continuing to work towards improving this score by proactively monitoring the staff survey action plans that will be developed with staff involvement and focusing on the results of the quarterly family and friends survey results.
- Various initiatives have been put into place to work further on staff engagement and these include: updating the intranet site, Director Quality Visits, Open Space Events, Professional Forums, Chief Executives Blog, Team Brief and Trust Bulletin, Star of the Month, Annual Staff Awards and “you said, we did…..are doing” cascades and Listening in Action groups.

<table>
<thead>
<tr>
<th>Core Indicator</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who were admitted to hospital (Newton Hospital only) and who were risk assessed for venous thromboembolism during the reporting period.</td>
<td>99.19%</td>
<td>98.75%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VTE Screening Performance</th>
<th>Average % of VTE Patients Screened</th>
<th>Lowest Performance %</th>
<th>Highest Performance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgewater Average Full Year</td>
<td>99.64%</td>
<td>93.40%</td>
<td>100%</td>
</tr>
<tr>
<td>National Average All Trust (April 2014 - Jan 2015)</td>
<td>96.09%</td>
<td>87.42%</td>
<td>100%</td>
</tr>
<tr>
<td>Greater Area Manchester Team (April 2014 - Jan 2015)</td>
<td>96.17%</td>
<td>93.68%</td>
<td>100%</td>
</tr>
<tr>
<td>Community Trust All (April 2014 - Jan 2015)</td>
<td>98.53%</td>
<td>95.14%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

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

- Five patients were not risk assessed
- Five patients were readmitted into the acute hospital within 24 hours.

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

<table>
<thead>
<tr>
<th>Core Indicator</th>
<th>2015/16</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>The number and, where available, rate of patient safety incidents reported within the trust during 2015/16, and the number and percentage of such patient safety incidents that resulted in severe harm or death</td>
<td>3986 incidents reported of which 1293 (32%) were submitted to the NRLS as patient safety incidents</td>
<td>3999 incidents reported of which 1321 (33%) were submitted to the NRLS as patient safety incidents</td>
</tr>
<tr>
<td>The number and percentage of such patient safety incidents that resulted in severe harm or death</td>
<td>There were 20 incidents resulting in severe harm or death, 3 of which met the criteria for a patient safety incident</td>
<td>There were 24 incidents resulting in severe harm or death, 11 of which met the criteria for a patient safety incident</td>
</tr>
</tbody>
</table>

The Bridgewater Community Healthcare NHS Foundation Trust considers that this data is as described for the following reasons, compared to 2014/15: -

During 2015/16, 3986 incidents were reported; 1293 (32%) of which were submitted to the National Reporting and Learning Service (NRLS) as Patient Safety Incidents. There were 20 incidents resulting in severe harm or death, three of which met the criteria for a Patient Safety Incident.

The Trust considers that this data is as described for the following reasons, compared to 2014/15:

- the volume of Patient Safety Incidents has decreased by 28 (2%) and is a negligible difference due to maintaining closer scrutiny and more accurate reporting, of these,
  - as well as the overall volume of Patient Safety Incidents slightly decreasing, the ratio of No Harm incidents (Near Miss, Insignificant
outcomes) decreased by 13% through better scrutiny and more accurate recording

- there was a decrease of 32 (42%) Serious Incidents identified.

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:

- maintained monthly training of investigators and managers in completing investigation documentation, incident management, risk assessment, and risk register maintenance
- routine scrutiny of incidents on a daily, weekly, and monthly basis by the Risk Team and senior clinicians that increases data quality and accuracy
- establishing weekly and monthly automated aggregate reports to assist monitoring by managers.

Part 3 – Quality of Care in 2015/16

Trust Quality Measures
In 2013/14 Bridgewater agreed the following Quality Measures.

The measures 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.

<table>
<thead>
<tr>
<th>Indicator to be measured</th>
<th>Change compared to previous year</th>
<th>2015/16 full year position</th>
<th>2014/15 full year position</th>
<th>2013/14 full year position</th>
<th>2012/13 full year position</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of pressure ulcers which developed whilst patients were under our care</td>
<td>↑</td>
<td>42%</td>
<td>38%</td>
<td>33%</td>
<td>34%</td>
<td>The overall number of reported incidents decreased, but the % ratio of reported pressure ulcers increased</td>
</tr>
<tr>
<td>Number of serious untoward incidents (SUIs)</td>
<td>↓</td>
<td>45</td>
<td>80</td>
<td>54</td>
<td>57</td>
<td>The volume of reported SIs decreased by 35 (44%)</td>
</tr>
<tr>
<td>Proportion of incidents with outcome of &quot;No Harm &quot;</td>
<td>↓</td>
<td>40%</td>
<td>45%</td>
<td>34%</td>
<td>51%</td>
<td>Reported patient safety incidents decreased by 2%, and &quot;No Harm&quot; (near miss, insignificant) outcomes decreased by 5%</td>
</tr>
<tr>
<td>Number of reported cases of Clostridium difficile</td>
<td>↓</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>For further information please see Clostridium difficile section</td>
</tr>
<tr>
<td>Number of reported cases of MRSA</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ratio of patient falls (in-patient facilities)</td>
<td>↑</td>
<td>6%</td>
<td>5%</td>
<td>3%</td>
<td>The number of reported falls incidents increased, and the ratio of falls to overall incidents increased by 1%</td>
<td></td>
</tr>
<tr>
<td>Percentage of admitted patients that have been risk assessed for VTE (Newton Hospital)</td>
<td>↑</td>
<td>99.19%</td>
<td>98.75%</td>
<td>99.46%</td>
<td>Figures not collected in 2012/13</td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Effectiveness

<table>
<thead>
<tr>
<th>Percentage of patient facing staff that have been vaccinated against flu</th>
<th>ALW ↓</th>
<th>Warrington ↓</th>
<th>Halton ↓</th>
<th>St Helens ↓</th>
<th>Dental ↓</th>
<th>Total ↓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria</td>
<td>49%</td>
<td>60%</td>
<td>56%</td>
<td>51%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td>50%</td>
<td>48%</td>
<td>46%</td>
<td>59%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Whooping cough</td>
<td>41%</td>
<td>45%</td>
<td>36%</td>
<td>58%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>Hib</td>
<td>38%</td>
<td>36%</td>
<td>32%</td>
<td>32%</td>
<td>38%</td>
<td></td>
</tr>
<tr>
<td>Meningitis C</td>
<td>52%</td>
<td>47%</td>
<td>36%</td>
<td>32%</td>
<td>52%</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal</td>
<td>46%</td>
<td>53%</td>
<td>45%</td>
<td>52%</td>
<td>46%</td>
<td></td>
</tr>
</tbody>
</table>

### Percentage of immunisations delivered on schedule for children reaching their 2nd birthday

<table>
<thead>
<tr>
<th>Diphtheria</th>
<th>Tetanus</th>
<th>Whooping cough</th>
<th>Hib</th>
<th>Meningitis C</th>
<th>Pneumococcal</th>
<th>MMR</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALW ↓</td>
<td>49%</td>
<td>60%</td>
<td>56%</td>
<td>51%</td>
<td>49%</td>
<td></td>
</tr>
<tr>
<td>Warrington ↓</td>
<td>50%</td>
<td>48%</td>
<td>46%</td>
<td>59%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Halton ↓</td>
<td>41%</td>
<td>45%</td>
<td>36%</td>
<td>58%</td>
<td>41%</td>
<td></td>
</tr>
<tr>
<td>St Helens ↓</td>
<td>38%</td>
<td>36%</td>
<td>32%</td>
<td>32%</td>
<td>38%</td>
<td></td>
</tr>
</tbody>
</table>

### Number of patients readmitted to the service within 30 days (Newton Hospital only)

<table>
<thead>
<tr>
<th>ALW ↓</th>
<th>Warrington ↓</th>
<th>Halton ↓</th>
<th>St Helens ↓</th>
<th>Total ↓</th>
</tr>
</thead>
<tbody>
<tr>
<td>97%</td>
<td>89%</td>
<td>85%</td>
<td>82%</td>
<td>Figures not collected in 2012/13</td>
</tr>
</tbody>
</table>

### Patient Experience

| Staff who would recommend our services to friends and family | 3.63 | 3.55 | 3.48 (reported as 3.47) | 3.58 | The minimum score is 1 and the maximum score is 5. For further information please see section on Statutory Quality Indicators and Statements |

### End of life – Percentage of patients being cared for in their Preferred Place of Care (PPC)

<table>
<thead>
<tr>
<th>ALW ↑</th>
<th>Warrington ↩</th>
<th>Halton ↑</th>
<th>St Helens ↓</th>
</tr>
</thead>
<tbody>
<tr>
<td>97%</td>
<td>97%</td>
<td>95%</td>
<td>97%</td>
</tr>
<tr>
<td>89%</td>
<td>87%</td>
<td>86%</td>
<td>Not available</td>
</tr>
<tr>
<td>85%</td>
<td>81%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 82%   | 95%          |          |             | In 2015/16 Halton and ALW have demonstrated an increase in the number of patients supported to achieve their PPC by District Nursing teams. Warrington has remained
In St Helens borough X patients experienced admission during the last days of life due to a palliative care emergency/care break down (data and exceptions need finalising at close of quarter).

<table>
<thead>
<tr>
<th>Percentage of patients indicating they had a good overall experience</th>
<th>99%</th>
<th>99%</th>
<th>98%</th>
<th>Figure not collected in 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of complaints</td>
<td>88</td>
<td>91</td>
<td>88</td>
<td>125</td>
</tr>
</tbody>
</table>

For further information please refer to patient survey and Friends and Family Test results sections of this account.

**Patient Safety**

**Safety Thermometer**

The survey is based on a point prevalence methodology; this means that all patients who are seen by nursing services in their homes and or bed based units on the specified day will be surveyed.

Data tables to be inserted on receipt of final end of year data to include:

- Percentage of Harm Free Care
- Percentage of Harms (New)

In 2015/16 we identified some areas where our data was above the national average of harms. As a result of this the Trust has looked closely at this data and how we collect it. This has identified areas where we could improve this process to ensure our data is accurate. We have, therefore, now updated our reporting process and shared this along with guidance documents to staff responsible for collecting the data. Part of this process sets out that when a harm is identified this is shared with the senior nurse on duty for the team and a discussion is undertaken to ensure care standards are being achieved.

In 2016/17 we intend to develop the ability to compare our data with other providers of community healthcare in addition to undertaking further work on our data submission process to assure us that this is effective. Working with like organisations offers an opportunity for us to develop and share improvement initiatives. To further enhance this the safety thermometer data will form part of our Quality and Safety sub-group agenda which will enable us to evaluate this data as part of our suite of quality initiatives.
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 rate 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.

<table>
<thead>
<tr>
<th>Total Falls Rates</th>
<th>Padgate House</th>
<th>Newton Community Hospital</th>
<th>Maple Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15 = 193</td>
<td>71</td>
<td>122</td>
<td>0</td>
</tr>
<tr>
<td>2015/16 = 215</td>
<td>92</td>
<td>111</td>
<td>12</td>
</tr>
</tbody>
</table>

In 2015/16 there appears to have been an 11% increase in falls rates from 2014/15 figures across all three units. Falls rates appear to have risen within two units (Padgate House and Maple Unit). The reporting of falls within both of these units has improved following staff awareness raising during the 2015/16 period, therefore it is possible that the increase is as a consequence of this. Newton Community Hospital has seen a 13% reduction in falls reported. Falls rates across all three units will continue to be monitored.

Over the past 12 months the inpatient units have been developing a FallSafe care bundle to help support the reduction of falls and harms from falls within all the inpatient units. FallSafe was a project funded by the Health Foundation and aimed to “close the gap” between the evidence base for effective care and the care that patients actually receive. It involved educating, inspiring and supporting registered nurses from acute, rehabilitation and mental health wards to lead their local multi-disciplinary teams in reliably delivering these assessments and interventions through a care bundle approach. Service leads across the intermediate care bed based unit's benchmarked current practice against this guidance. They identified gaps and developed tools which formulated the care bundle for use within the units. The care bundle was implemented from the 1st March 2016 and the impact of the tool will monitored over the next 12 months.

Care Bundles (Halton Borough)
The Adult Community Nursing Service in conjunction with the CCG have developed care bundles within District Nurses, Community Matrons, Treatment Room Nursing
and Specialist Nurses in palliative care, Stroke, Heart Failure, Continence, Intravenous Therapy and Tissue Viability services.

The introduction of the care bundles aims to;

- support frail older people and individuals with long term conditions, through early interventions and evidence based care to maintain their health, wellbeing and independence
- provide care which is personalised and adapted to individual need
- ensure patients are regularly reviewed to anticipate changing care needs in order to manage deterioration and reduce exacerbations
- prevent avoidable hospital attendance or admission
- provide care and support for people (and their carers) at the end of their life in all settings and at all times of the day or night.

Care is delivered using evidence based clinical pathways which have been developed in collaboration with primary, community and secondary care. All pathways of care incorporate high quality clinical care, education and signposting to other services.

The service is delivered to patients who are registered with a GP Practice in Halton. District Nursing, Treatment Room Nursing, Community Matron, and Macmillan services work closely with specific GP practices. Stroke, Heart Failure, Continence, IV Therapy and Tissue Viability teams are organised on a town or borough footprint. All teams are developing strong relationships with Primary Care.

Pressure Ulcers
Pressure ulcers are areas of damaged skin and underlying tissue which develop when a source of pressure reduces or cuts off the blood supply. They range in severity from redness of the skin, to a cavity and are graded 1-4 with grade 4 being the most severe. Pressure ulcers can be seen as a complication of illness however a significant number can be avoided with good care.

It is a national requirement to report all Grade 2 and above pressure ulcers as a clinical incident. Reporting in this way ensures that all patients who develop a pressure ulcer in our care have their care evaluated; this supports us to identify areas where we can continue to improve our practice.

More serious pressure ulcers, grade 3 and 4, which develop within our care, are reported to the Clinical Commissioning Groups (CCGs) through a national reporting system. For these we are required to carry out an investigation which must be submitted to the CCGs within 60 days. We also have a legal requirement to inform the patient and where appropriate those involved in their care in writing that a patient safety incident has occurred that has resulted in a level of moderate or severe harm. This is known as the Duty of Candour, adherence to the duty ensures we are
open and transparent and part of this is to provide patients with an opportunity to be involved in our investigations and share in the findings. On completion these findings along with recommendations and lessons learned are then presented to our Incident Review Panel, attended by senior nurses and led by our Medical Director, prior to submission to the relevant CCG.

During 2015/16 a total of 1198 pressure ulcer incidents were reported by staff 507 (42%) developed or deteriorated whilst the patient was under the care of the Trust and 691 (58%) developed before our involvement in the care of the patient. The graph below compares this with our data for 2014/15

Figure 1.1

![Graph comparing 2014/15 vs 2015/16
Developed in Bridgewater
Developed external to Bridgewater]

Figure 1.1 illustrates that in 2015/16 the number of pressure ulcers reported reduced however the proportion of pressure ulcers reported under the care of the Trust increased.

Figure 1.2 looks at this further comparing the number of reports by grade of pressure ulcer.

![Graph comparing 2014/15 vs 2015/16
Grade 2
Grade 3
Grade 4]

2014/15
2015/16
Figure 1.2 illustrates that although there was an increase in the number of grade 2 pressure ulcers reported there was a significant decrease in the number of more serious pressure ulcers (grade 3 and 4).

The number of pressure ulcers can be highly dependent on the case mix of nursing caseloads and the health and needs of those on the caseloads can vary widely and fluctuate. Within the Trust our pressure ulcer care therefore focuses on ensuring all patients with a pressure ulcer irrespective of where this was developed receive evidence based care. To support us to achieve this we have a Trust policy which is based on national guidance from the National Institute of Health and Clinical Excellence (NICE) and the European Pressure Ulcer Advisory Panel.

To ensure we are meeting these standards we utilise a monitoring tool that presents data in a visual way through a dashboard. This measures key standards from the Pressure Ulcer Policy e.g. ensuring that a skin integrity risk assessment (waterlow score) and a nutritional assessment have been completed, a pressure ulcer assessment chart has been completed, the patient has a care plan in place and the progress of the wound. For any pressure ulcer that has deteriorated we also evaluate why this has occurred. In 2015/16 we developed this further to include senior nurse review and the provision of patient information. The presentation of this information in the dashboard format supports nursing teams to see clearly where they are achieving well and areas where they can make improvements. In 2016/17 we plan to make further updates to ensure the type of pressure relieving equipment provided was consistent with the NICE standard.

In addition to this in 2015 we completed an annual audit of our compliance with the Pressure Ulcer Policy standards. Areas where we performed well in the audit were on skin integrity risk assessment, senior nurse review and use of appropriate equipment. We also identified areas where we could improve; provision of written patient information and photographing wounds as part of our assessments. We have planned to repeat this audit in 2016/17.

Other ways which we ensure we maintain the high profile of pressure ulcer care is through awareness raising sessions for example Stop the Pressure days. This is a national initiative and is part of the Stop the Pressure Campaign. During 2015/16 events were held in each of our boroughs led by our Tissue Viability Specialist Nurses.

During 2016/17 we will:
- Continue to monitor standards of care delivery using our care indicator tool
- Undertake an annual clinical audit of our care delivery
- Develop mechanisms to evaluate our care for those patients assessed as having a high waterlow score who have not developed a pressure ulcer. By
doing this we will ensure our approach to preventative care is also meeting national standards.

Achievement against these objectives will be monitored throughout the year as part of our Quality and Safety Sub Group.

For further information on the ‘Care Indicator Tool for Pressure Ulcers’ please see Patient Safety / Incident Reporting section.

**Medication Safety**

The Trust continues to support an open culture encouraging the reporting of medication incidents and learning lessons to avoid possible future errors. A new Medicines Management structure has been implemented to allow greater focus and support to all staff around medication safety incidents, and the further development of these systems and processes is planned for the coming year.

Medicine incidents are reported on the Trust incident reporting system (Ulysses), and are reviewed in detail by a member of the Medicines Management Team, who provide on-going advice and support on any action and investigation which may be needed. The Risk Management Team also identifies further incidents which may involve medicines and have been classified with an alternative “main cause”. These incidents are also reviewed by the Medicines Management Team and those which are identified as medicine incidents are added to the figures reported. Quarterly figures for all medicines incidents are reported to the Quality & Safety Committee and the Medicine Management Interface Group. The focus for 2015/16 has been to refine the reporting system and the classification of the most frequent types of medicine incident, to allow thematic reporting and trends to be identified and addressed.

In 2015/16, ??%, medication related incidents (an average of ??% of the total incidents reported over this period) were reported by the Trust staff including ?? involving controlled drugs. Around ??% of these continue to be classified as third party incidents ie 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.
- Systems process where patient visits are missed because staff members were not aware they had been discharged from hospital or the patient information was not transferred to work sheets.
Development and implementation of electronic patient records and software systems is on-going to help to reduce this.

Links continue to be developed between the Trust’s Medicines Management Team, local trusts, local Clinical Commissioning Groups and other relevant local agencies to report relevant third party incidents for appropriate investigation and to facilitate lessons learnt being put into practice and shared across the health economy.

Near miss review and reporting continued over 2015/16 with a total of ?? near misses (an average of approximately ?? per month) reported for 2015/16. Although there was an initial reduction in near miss reporting from April 2015 to May 2015 the rate has remained consistent for the remaining months.

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

**Non-Medical Prescribing**

Non-Medical Prescribing is the term used to describe registered professionals who have successfully undertaken a recognised prescribing course and have their qualification annotated on their professional register. There are several different types of health professional who can become Non- Medical Prescribers (NMPs), for example nurses, pharmacists, physiotherapists, podiatrists, optometrists, dieticians and radiographers. Recently Bridgewater NMPs have provided evidence which contributed to a report produced by i5 Health on behalf of Health Education North West, called “Non-Medical Prescribing, An Economic Evaluation”.

The following information is extracted from the latest report:

"The North West of England has a longstanding history in the use of nurses, pharmacists and other professionals who are not doctors or dentists to prescribe and manage medicines for the benefit of patients and organisations. The qualitative and quantitative impacts on patient outcomes are tested through the use of an annual audit in the North West of NMP practitioners (Clinicians Audit). Based on the latest Clinicians Audit*, i5 Health has calculated that each of the 1,566 participants contributed an average added value of nearly £1,500 during the month of the audit i.e. together a total of £2.7m for that month and, in all probability, over £32.8m during 12 months. Applying the results to England as a whole, i5 Health’s Big Data analytical capabilities show a value of circa £777m in a twelve month period]." *2014 Audit data used.

All active Bridgewater NMPs are eligible to take part in the Clinician’s Audit. Results build year on year to contribute to one of the largest pieces of evidence highlighting the impact that clinicians have on patient care, when using their non-medical prescribing skills and knowledge.
Results - 1051 audits from care provided by NMPs completed in November 2015

- Bridgewater was 10th highest out of 50 organisation's participating
- Potentially there were 402 active NMP participants in 2015
- 196 NMPs took part in the audit (49%)
- The split between Community Formulary Prescribers, Independent and Supplementary

The % split between Community Formulary Prescribers, Independent and Supplementary

- 25% contacts prevented a GP surgery appointment
- 27% contacts prevented a GP home visit
- 11% contacts prevented an Accident & Emergency attendance
- 8% contacts prevented attendance by another healthcare professional
- 93% were seen in primary care settings
- 58% needed a prescription
- 100% of the patients who required a prescription received one
- 64% received a medication review of some or all of their medicines
- 95% had access to information on current medications
- 97% had access to patient's allergy status
This highly useful evidence can be used to help shape the future of prescribing in Bridgewater and the North West and help inform commissioners and providers.

**Safeguarding**

The Safeguarding Service provides the following across the Trust:

- Advice, support and training to all Trust staff in relation to all aspects of Safeguarding
- Safeguarding supervision for staff within the Trust
- Supports the services for Children in Care to ensure health needs are identified and care plans monitored
- Supports teams in multiagency work for serious case reviews, local case reviews, domestic homicides reviews.

During this year the safeguarding teams across the boroughs have worked together in a co-ordinated manner building on best practice from all boroughs. All safeguarding adult and safeguarding children policies and guidelines have been reviewed.

During 2015/16 a number of changes took place in the leadership of Safeguarding across the Trust as follows;

- The Chief Nurse (Executive Lead for Safeguarding) came in to post April 2015.
- Associate Director of Safeguarding came in to post January 2016.
- Named Nurse for Adults came in to post February 2016.

These posts have provided further resource to the delivery of safeguarding across the Trust.

The Chief Nurse commissioned an internal review in year which identified strategic recommendations which were accepted by the Executive Team. The recommendations included the appointment of a strategic lead and named nurse for adults which have occurred in year. An operational re-design was also part of the review in line with the Trust borough facing arrangements during 2016/17.

Safeguarding services across the country have had challenges this last year with high profile cases both for children and adults. The safeguarding teams have continued to work in multi-agency partnership with our local authority partners to address the growing challenges that safeguarding teams are facing such as modern day slavery, human trafficking and Child sexual exploration. We have developed new posts in child sexual exploration to work in specialist team and realigned teams to work in multi-agency front door referral units to provide stream lined services to address the growing vulnerability of children and adults.
The Trust is represented on each of the local safeguarding boards and the staff involved in safeguarding issues have a good working relationship with local authorities, social services, police and safeguarding teams. The organisation participates in multi-agency safeguarding inspections working with services within local authority boundaries e.g. St Helens, Halton, Warrington, Wigan Trafford and Bolton.

Our Dental Network also work and adhere to reporting of safeguarding concerns in accordance with the local safeguarding areas they operate in East Cheshire, West Cheshire, Thameside and Glossop and Stockport.

Safeguarding assurance is provided to commissioners through the safeguarding audit tool which is completed annually with quarterly reviews of performance by the commissioners.

Internally the Trust safeguarding assurance is provided through the Safeguarding Assurance Group which reports to the Trust’s Quality and Safety Committee. The Safeguarding Assurance Group monitors training, incidents, risks and supports the partnership working in relation to safeguarding children and vulnerable adults. The group provides challenge to internal and external processes.

The Trust follows national and local recommended practice and statutory guidance.

This last year the Trust has participated in the following:-

- 4 Serious Case Reviews for children identified and ongoing
- 4 Serious Case Reviews for children published in year
- 6 Local case review for Children
- 4 Local case review for Adults
- 4 Domestic Homicide Review

The reviews provide learning which continually inform best practice in the organisation and in partnership working.

Some of the Learning this year which has been implemented includes:-

- Local escalation procedure training has taken place by locality briefings to ensure all staff are aware of the procedure.
- Specialist training took place in one locality in relation to BRAVER training which allows staff to address professional challenge regarding cases and escalation.
- One locality had additional training as part of level 3 safeguarding training to equip practitioners with skills to recognise risk taking behaviours amongst adolescents and in particular when being involved with the police as perpetrators of crime.
It has been emphasised in briefings and as part of safeguarding training that the approach to and management of injuries in non-mobile children needs to come from the standpoint of suspicion and not just accept what we are being told by employing professional curiosity and challenge.

Information sharing has also been reviewed between acute providers, GPs and community providers. This has resulted in the information sharing agreements being reviewed in some boroughs and we are also part of a pilot for electronic flagging of electronic notes re child protection.

Infection Prevention and Control

Hygiene Code

The Trust is responsible for meeting the standards within Hygiene Code (Health and Social Care Act 2008). We therefore believe that we are able to assure the Care Quality Commission (CQC) that we can supply evidence of best practice which indicates how we are maintaining a reduction in Health Care Acquired Infection’s (HCAI) and supporting measures to improve environmental hygiene.

Dental health care and practice is monitored by ensuring care is monitored against the standards within ‘HTM 01-05: Decontamination in Primary Care Dental Practices Guidance’, and again the Trust is able to indicate that best practice is maintained. As a Trust, we will continue to support a philosophy of a ‘zero tolerance’ to avoidable HCAI.

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, which outlines the structures required to share information across the Trust from the Chief Executive to staff in the community and vice versa.

All actions set within the work programme are developed to support the Trust in providing evidence of meeting the criteria within the Health and Social care Act 2008. All actions set this year have been completed.

Internal Reporting Arrangements

The Trust Quality and Safety Committee have in the past always received quarterly Infection Prevention and Control (IPC) reports and verbal updates from the Lead IPC Nurse and Director of Infection Prevention and Control (DIPC). To strengthen the quality of the information presented at the Quality and Safety Committee, the IPC team now present these reports to the Trust Clinical Governance Committee for scrutiny; this allows frank discussions and improvement of the information being reported (see below for a diagram of information flow).
Reporting to Clinical Commissioning Groups
The Trust reports its compliance against the Health and Social Care Act to a number of Clinical Commission Groups. The annual IPC work programme forms the basis of this reporting mechanism, and any findings from outbreaks or single cases of infection are discussed at these groups. Action plans are scrutinised and clear dates for response and completion of actions are set and monitored.

Healthcare Associated Infection (HCAI)
The risk of obtaining a HCAI will always be a concern for patients receiving treatment across the NHS. We have worked closely with our commissioners to monitor HCAI, and where we provided services to a patient diagnosed with a HCAI a full root cause analysis (RCA) for Clostridium Difficile infection and Post Infection Review (PIR) of Metthicillin-sensitive Staphylococcus aureus (MSSA) and Methicillin-resistant Staphylococcus aureus (MRSA) infections are always undertaken. These RCA and PIRs’ are often complicated as the patients who receive these infections are almost always receiving care from a number of care providers.

The Trust can report that we have had no MRSA/MSSA or Clostridium Difficile Infections apportioned to us. This said through the process of undertaking either RCA or PIR (noted above), where antibiotic use has not been appropriate feedback to these prescribers is given to improve practice.

Outbreaks
Outbreaks of infection usually occur when people and patients come together. The Trust is responsible for one inpatient facility and we have had one significant outbreak of diarrhoea and vomiting this year. This outbreak was found to be caused by Norovirus which affects all ages and all care settings. The outbreak took less than two weeks to bring under control which was a testament to the staff at the unit who were themselves affected. In total 18 patients and 19 staff were unwell, with seven confirmed cases. Whilst these outbreaks are an unwelcome event they offer the
opportunity to test outbreak plans and where necessary update current policy and
guidance. No updates were required to policies or guidance.

Environmental Cleanliness
All premises that Trust staff work in are subject to audit via the cleaning service,
these audit results are scrutinised at the Trust IPC Group and action taken where
standards are not being met. The audits however do indicate that environmental
hygiene is of a good standard. The Trust cleaning services all work to the National
Cleaning Colour Coding standards and all clinics are asked to display notices asking
service users to feedback where they feel standards can improve.

Quality Walk rounds and where appropriate PLACE (Patient-led assessments of the
care environment) are undertaken in clinics at least annually and following each
audit an action plan is written with recommendations for implementation. Overall the
audits indicate that the majority of our clinics demonstrate very good compliance with
national standards. Where issues are found action plans are set to improve
standards. The challenge from IPC is often supporting staff to better manage the
shared environment where there is a shared responsibility for maintaining a clean
work area.

Influenza Vaccination for staff
As a Trust we always communicate the need for frontline staff to be vaccinated
against seasonal influenza. This year flu vaccination was delivered via some
occupational health provider sessions, supported by other drop in clinics.
The target set by the Department of Health is for 75% of frontline staff to base
vaccinated.

The uptake for the whole Trust this year was 46% (n=891 frontline staff) however this
was below the expected target. We will be asking staff their opinion about the
campaign and look to improve flu vaccination next year.

Improvements to the IPC service
As we go forward into 2016-17 the IPC team have outlined through the annual IPC
programme a number of key improvement areas that will receive extra attention.

These are to:
- Work with medicines management to improve Antibiotic stewardship (this
  means stopping unnecessary antibiotic prescribing and improving education
to staff and public about the use and abuse of antibiotics)
- Improve patient information about infection risk, making it better, clearer and
  more accessible.
- Improve compliance and re-invigorate hand hygiene practice by staff
delivering hands on care.
Patient Safety / Incident Reporting
The Trust utilised the web-based Ulysses Safeguard Risk Management System for reporting all actual incidents and near misses, where clinical service delivery or patient safety may have been compromised.

There was a decrease in 2015/16 reporting compared to 2014/15 due to more accurate reporting. Increasing accuracy of incident reporting is a positive indication of an open and honest culture that encourages staff to report incidents.

<table>
<thead>
<tr>
<th>Commissioner</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALW</td>
<td>1185</td>
<td>1127</td>
<td>-58</td>
</tr>
<tr>
<td>Bolton*</td>
<td>11</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>Cheshire</td>
<td>8</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>Halton</td>
<td>774</td>
<td>823</td>
<td>49</td>
</tr>
<tr>
<td>Knowsley*</td>
<td>3</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>St Helens</td>
<td>1033</td>
<td>872</td>
<td>-161</td>
</tr>
<tr>
<td>Trafford</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Warrington</td>
<td>773</td>
<td>950</td>
<td>177</td>
</tr>
<tr>
<td>Health for Justice</td>
<td>79</td>
<td>42</td>
<td>-37</td>
</tr>
<tr>
<td>Dental</td>
<td>139</td>
<td>141</td>
<td>2</td>
</tr>
<tr>
<td>Corporate</td>
<td>7</td>
<td>6</td>
<td>-1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3999</td>
<td>3986</td>
<td>-13</td>
</tr>
</tbody>
</table>

*Bolton and Knowsley Commissioners came online during 2015/16.
Due to weekly and monthly incident data reviews by senior clinicians and managers introduced during 2014/15, and maintained during 2015/16, the quality and accuracy of data has continued to improve. Along with daily checks undertaken by members of the risk team, this process also ensures that any serious incidents are identified early and escalated as quickly as possible for management attention.

The ‘Care Indicator Tool for Pressure Ulcers’ demonstrated quarterly improvements in pressure ulcer management by clinicians and continues to be utilised during 2015/16 to the benefit of patient outcomes. The added value of this data resulted in improved investigations and identified gaps for service change, notably, the frequency of review of patients’ pressure ulcers.

There were three patient safety incidents reported that resulted in major or catastrophic outcomes. Staff reported 3986 incidents during 2015/16, 1293 (32%) of which were categorised as incidents or near misses effecting patient safety. These are submitted to the National Reporting and Learning Service (NRLS), from which the CQC nationally monitors all Trusts’ patient safety incidents. The following table represents the number of patient safety incidents reported to the NRLS by level of actual impact.

<table>
<thead>
<tr>
<th>Patient Safety Incidents by Actual Impact</th>
<th>2014/15</th>
<th>2015/16</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>%</td>
<td>Total</td>
</tr>
<tr>
<td>Near Miss</td>
<td>203</td>
<td>15%</td>
<td>112</td>
</tr>
<tr>
<td>Insignificant</td>
<td>391</td>
<td>30%</td>
<td>405</td>
</tr>
<tr>
<td>Minor</td>
<td>546</td>
<td>41%</td>
<td>722</td>
</tr>
<tr>
<td>Moderate</td>
<td>170</td>
<td>13%</td>
<td>51</td>
</tr>
<tr>
<td>Major</td>
<td>4</td>
<td>0.30%</td>
<td></td>
</tr>
<tr>
<td>Catastrophic</td>
<td>9</td>
<td>0.68%</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1323</td>
<td></td>
<td>1293</td>
</tr>
</tbody>
</table>
The overall volume of reported incidents (3986) has decreased compared to last year by 13 (0.3%), the volume of Patient Safety Incidents (1293) has correspondingly decreased by 30 (2%) compared to 2014/15. The ratio of ‘No Harm’ Patient Safety Incidents decreased by 77 (13%); Minor incidents increased by 176 (32%) and Moderate to Catastrophic incidents decreased by 129 (70%).
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 Trust maintained a pool of over 63 staff (clinical and non-clinical) specifically trained and experienced in root cause analysis techniques thus ensuring that incidents are thoroughly investigated and lessons are learned to prevent recurrence.

<table>
<thead>
<tr>
<th>Patient Safety Incidents reported to the National Reporting and Learning Service (NRLS) April 15 to September 15 by NRLS Degree of Harm</th>
<th>Ave from similar organisations*</th>
<th>Reported from similar organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>%</td>
</tr>
<tr>
<td>None</td>
<td>277</td>
<td>44%</td>
</tr>
<tr>
<td>Low</td>
<td>316</td>
<td>50%</td>
</tr>
<tr>
<td>Moderate</td>
<td>40</td>
<td>6%</td>
</tr>
<tr>
<td>Severe</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Death</td>
<td>1</td>
<td>0.16%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>634</strong></td>
<td><strong>1352</strong></td>
</tr>
</tbody>
</table>

* These are national figures obtained from the NRLS April 2016 report. Please note that:

- the averages include Bridgewater data,
- this national data covers patient safety incidents reported from April 2015 to September 2015 (October 2015 to March 2016 data is available later in 2016), however,
- the NRLS advises that not all organisations apply the national coding of Degree of Harm in a consistent way, which can make comparison of harm profiles of organisations difficult, also
- most other providers are not solely Community Trusts as Bridgewater is i.e. they have some mental health or acute functions; as a result, of the 18 other trusts that the NRLS has compared Bridgewater to, 10 of these possess a service profile similar to Bridgewater and against which the Trust remains comparable and only these have been used as comparators above.

The following initiatives were undertaken during 2015/16 to improve our management of incidents;

- all ‘cause groups’ (used to aggregate and monitor incident trends) were reviewed and updated to be more accurate and representative, and also to enable direct comparison with risks on the operational risk register
- the directorates established Quality and Safety sub-Groups to analyse and escalate significant incidents, complaints, or risks for support from the directorate team meetings and to direct service change in response
- newly established Incident Review Group that monitors and considers all Serious Incidents and investigations
- automated monthly incident reports to senior managers at the beginning of each month
- pairing up experienced RCA investigators with newly-trained investigators (those trained in quarter 4 in 2014/15) to gain practical knowledge
- ongoing improvements to the submission of pressure ulcer photographs attached electronically to incidents in order that Tissue Viability Nurses can provide early advice remotely
- established a consistent documented ‘case note review’ checklist (with commissioner input) of serious pressure wounds within 72 hours to identify any learning points or lapses in care at an early stage, any identified lapses progressing to an RCA investigation if required
- the Incident Reporting Policy was reviewed and updated during 2015/16 and takes into account some new guidelines from NHS England, including an extension of the RCA investigation period from 45 working days to 60 working days

**Freedom to Speak Up – Raising Concerns**

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

One of the actions was “All NHS organisations that are obliged to publish quality accounts should include in them quantitative and qualitative data describing the number of formally reported concerns in addition to incident reports, the actions taken in respect of them and feedback on the outcome”.

Bridgewater had one concern raised in September 2015. The concern was raised directly by the employee under the Trusts Whistleblowing Policy. It related to one of the Trust’s services and the competencies of staff working therein. An independent, external investigation was undertaken and the resulting report determined that the service was safe. The report was considered by the Board and an action plan was developed to pick up areas of improvement. The action plan was monitored by the Directorate Management Team.

**Never Events**

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

Central Alerting System
Using incident data from across England, the NHS develops national initiatives and training programmes to reduce incidents and encourage safer practice. Alerts are released through a single “Central Alerting System” (CAS) to NHS organisations which are then required to indicate their compliance with these safe practice alerts. They cover urgent regional or national matters concerning faulty medical devices, medication, estates issues and other patient safety issues. The Trust received 38 clinical alerts, and 55 non-clinical alerts, the Patient Safety Advisor then cascaded to each directorate and onto service leads to assess the action required for each alert. All alerts relevant to patient safety were assessed and responded to where they were applicable to community healthcare.

At the end of 2015/16 the Trust was assessing the relevance of three alerts to meet any recommendations within the expected completion dates set later in 2016/17.

Mortality reviews
Bridgewater has recently reviewed its position with regard to Mortality Governance, following receipt of guidance from NHS England and most specifically the Trust Development Agency, in the form of the Mortality Governance Guide. This document calls for a new approach and culture in order to address Avoidable Mortality. Whilst this guidance is aimed chiefly at acute trusts, community providers are not exempt. Options that the Trust may consider during 2016/17 are to establish a group to look specifically at avoidable deaths (Mortality Governance Group) or possibly to undertake some joint working with a partner organisation. Mortality Governance could also be addressed via the existing Trust structures. An update will be included in the 2016/17 Quality Report.

Sign up to Safety
Some key aspects of our Sign Up to Safety Campaign included:–
- NHS Safety Thermometer - Improvement actions identified in relation to data quality. Actions completed in year include; data reporting process and guidance recirculated to all clinical managers for cascade to services. We are undertaking a full review of data submission and reporting process.
- HCAI – Nil each quarter.
- Pressure Ulcers – we are piloting Pressure Ulcer Checklists as part of a documented early review to reduce the number of required RCAs which will allow us to focus on more significant lapses in care or service delivery.
- Falls – piloting “FallSafe” project in our community hospital.
- Open and Honest Care Reporting – we report monthly on the Trust website data on safety, infections, pressure ulcers, patient experience, staff experience, a patient’s story and a synopsis of an area where we have improved care.
- Competency framework for all clinical disciplines – the care certificate is available for all new clinical staff in Band’s 1-4. Generic competency frameworks have been developed for staff in Band’s 5, 6, 7 & 8a. The next step is to work with individual services to look at specific specialised roles.

**Quality Impact Assessments**

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

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

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

The QIA panel reports on a quarterly basis to the Quality and Safety Committee. The report includes/highlights the following details;
- The number of QIAs completed
- The assigned level of risk to quality for each QIA undertaken
- The outcome for each QIA, i.e. approved, further clarification required or not approved.
- Situations where the panel has accepted a QIA, but has requested further mitigating action to be undertaken
- Arrangements for on-going monitoring of the quality impact of CIP/Service Developments approved by the panel and in accordance with the panel risk rating process.
- A Risk Log.

The outcomes of the QIA are reported to CCGs, via the quarterly CCG Quality Reviews and contract management meetings.
Clinical Effectiveness

Clinical Audit

Clinical Audit is a quality improvement process that seeks to improve patient care. This means the care that patients receive is reviewed against standards which are proven to be best practice (evidence based care). This is carefully evaluated and where required, changes are made to improve care.

We believe that it is our responsibility to provide our patients with good quality, safe and effective care in order to achieve the best outcomes.

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

The table below shows summary information relating to a sample of clinical audits undertaken during 2015-16, shows some of the improvement achieved and where necessary shows that Bridgewater Community Healthcare NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

<table>
<thead>
<tr>
<th>Audit of Management of Pressure Ulcers – Community Nursing services (across all boroughs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The audit results show good level of care overall with some room for improvement. There were 14 standards in the audit, nine were met to a compliance level of 90% or more. The remaining five standards are shown below.</td>
</tr>
<tr>
<td>What we found</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>In 20% of cases photographs were not being taken within a seven day period of first visit. Some reasons identified for this are; 1. Patient did not want photograph taken but it was not documented in their record. 2. Staff member did not have access to a camera.</td>
</tr>
<tr>
<td>In a significant number of cases (30%) there was no evidence that leaflets were provided to patients.</td>
</tr>
<tr>
<td>Referral to the specialist tissue viability nurses was consistent overall except in one area where there was a staff vacancy.</td>
</tr>
<tr>
<td>Comprehensive documentation of assessment – most but not all elements were included. 71% had all elements included.</td>
</tr>
</tbody>
</table>
Comprehensive documentation of care plan - most but not all elements were included. 67% had all elements included. documentation of all elements of both assessment and care plans to be included in the design of the templates.

It should be noted that standards relating to clinical care were adhered to and patients were treated appropriately. All areas should show improvement on re-audit planned for 2016-17.

Audit of in-patient Falls (cycle 2) Newton Hospital (St Helen’s borough)

The FallSafe Care Bundles initiative is in the process of being rolled out and is already having a positive impact as evidenced by improved results in this audit based on NICE standards.

Improvement achieved:
- evidence of a multifactorial assessment improved from 21% to 100%
- care plans based on the assessment improved from 40% to 100%
- 100% of patient records had evidence that that the patient received information on reducing falls discussed with them compared to 88% previously.
- 100% of patients had a discharge plan compared to 81% previously.

Areas for improvement:
- The taking of lying and standing blood pressure had not improved. It was noted that this is not prompted on the paperwork. The paperwork currently being used is a nationally recognised observation chart set by the Resus Council UK. The National Audit of Falls that was released in October 2015 highlighted the importance of taking both lying and standing blood pressures.

Actions:
- the FallSafe Care Bundles initiative will continue to be rolled out.
- Taking lying and standing blood pressure will be implemented as part of FallSafe.

Audit of the Appropriateness of Referrals to the Vascular Podiatry Service (cycle 2) (Wigan borough)

The previous audit led to the introduction of Doppler Ultrasound (high frequency sound waves that measure the blood flow) to measure pulses as part of the revised referral criteria. Training was provided in the use of Doppler which has reduced the inappropriate referrals and streamlined the care provided.

The average waiting time has been reduced by 57 weeks to an average of 8 weeks.

No need to re-audit but continue to monitor waiting times.

Audit of NICE CG47 Feverish Illness in Children – Out of Hours Services (Warrington and Wigan boroughs)

Overall NICE recommendations in both Wigan and Warrington Out of Hours services are being met.
Wigan now on cycle 3 of the audit and has shown improvements in all areas, 100% of records now show the use of the traffic light system compared to 54% in 2012.

100% of patients and/or carers received advice and information needed to manage their feverish child in both boroughs. In Wigan this is an increase of 47% in compliance.

Temperature is always recorded; but respiratory rate, heart rate and capillary refill are only recorded in 60% of cases in both boroughs. Despite this, evidence shows that all patients were managed appropriately.

There was no unnecessary prescribing of antibiotics.

Actions: Update electronic systems to Read code temperature, capillary refill, heart rate and respiratory rate as a minimum; this will enable electronic data analysis.

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 2016). To request a copy of the 2015-16 clinical audit annual report please contact clinicalaudit@bridgewater.nhs.uk

Research and Development

During 2015/16, Bridgewater has expanded its research portfolio which has brought increased opportunities for eligible Trust patients to participate in a number of important national studies such as musculoskeletal and stroke rehabilitation, paediatric speech and language therapy and health service research. It is extremely rewarding to see how clinical practice has directly benefitted from our involvement in research, with findings being put back into practice to inform both local and national clinical guidelines and standards.

The Trust has received important recognition from the National Institute for Health Research (NIHR) for the contribution we have made to promote clinical research in the Trust through our involvement in their studies. These NIHR studies are held as the gold standard of health research, and often Bridgewater is the only Community Healthcare Trust invited to participate, with researchers from internationally renowned institutions returning to the Trust because of our track record of delivering studies.

Bridgewater's Community Neurosciences Team, based in Warrington, was this year's runners up in the Best Community Research Contribution category at the National Institute for Health Research (NIHR) Greater Manchester Clinical Research Awards. The team of experienced health professionals offer Physiotherapy, Occupational Therapy, Specialist Nursing and Neuropsychology services in the community including people’s homes to those affected by Stroke, Acquired Brain Injuries and other neurological conditions.
The team were shortlisted in this category for successfully recruiting Stroke patients in Warrington to participate in two innovative research projects funded by the NIHR. The research focused on the rehabilitation approaches post Stroke, and the team made a positive contribution to enhancing evidenced based practice whilst maintaining their busy clinical work. Moreover, these studies allowed the Trust to act as a research site, a first for us.

Bridgewater's workforce continues to be our greatest asset in achieving our priority of providing evidence-based quality care through research. Despite continuing pressures to service delivery, our workforce has demonstrated a commitment and enthusiasm for research. During 2015/16, Trust staff have published their work in books, journals, and presented at conferences. Examples of these publications involve trialling prostate awareness information amongst men with learning disabilities, improving the referral of patients with learning disabilities for bowel screening, the Health Visitor’s role in the identification of child neglect, and infection control in the home care setting. Additionally, a number of staff have successfully completed doctorates and other postgraduate study with a research component.

**National Institute for Health and Care Excellence (NICE) Guidance**

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

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

All newly published NICE guidance is distributed to services throughout the Trust to ensure that services are compliant with NICE recommendations. Services evaluate each piece of guidance and determine whether it is relevant to their service and if so, the service is required to undertake a baseline assessment to state whether they are fully compliant, partially compliant or non-compliant.

Services are given four weeks to undertake baseline assessments following publication of guidance and a further four weeks if compliance is partial and an action plan needs to be developed. Partial compliance means that there is one or more 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 2015 to March 2016, NICE published 130 pieces of guidance, excluding NICE Quality Standards, most of which relates to care provided in acute hospitals. There were 22 pieces of guidance applicable to services that the Trust provides. We are fully compliant with 14 and action plans are underway to bring us into full compliance with the remaining 8.
Compliance with NICE guidance is reported through the Quality & Safety Committee of the Trust Board. Clinical audits of NICE guidance are included in the annual clinical audit plan. Below is an example of an audit that was completed to check compliance with NICE guidance.

### Audit of NICE CG176 Head Injury – Walk in Centres (Halton, Warrington & Wigan boroughs)

This audit was undertaken to monitor compliance with NICE guidance on head injuries in a community setting. The results showed that
- Compliance with NICE guidance is evident.
- All patients were managed appropriately.
- All patients got verbal advice; written advice was also given if deemed necessary.
- Recording of the actual Glasgow Coma Scale needs to be improved, the score is typed in manually not coded electronically.

Improvements could be made to the electronic systems to allow for electronic monitoring of NICE guidance. For example, our existing coding system (Read Codes) should be used for the following:

- Glasgow Coma Scale (GCS)
- Any previous brain surgery.
- Any history of bleeding or clotting disorders.
- Current anticoagulant therapy such as warfarin.
- Current drug or alcohol intoxication.

This audit is for assurance of compliance against NICE declaration.

### NICE Quality Standards

NICE Quality Standards are a different type of publication to be used by providers and commissioners in the design and delivery of services.
are to be used to engender quality improvements and, unlike other NICE guidance, are not for compliance purposes although they are underpinned by NICE guidance and other sources of evidence based practice.

In the year April 2015 to March 2016 NICE published 32 Quality Standards. They have been reviewed within the Trust, 7 are applicable only to the GP service that we provide and 21 are applicable to various services across Bridgewater making a total of 28/32.

Where a NICE Quality Standard exists in relation to a clinical audit topic, the statements contained within the Quality Standard are included in the audit. The example below references NICE Quality Standard End of Life Care for Adults (QS13). The results showed that:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Overall %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The patient’s preferred place of care at the end of life is documented.</td>
</tr>
<tr>
<td>2</td>
<td>The patient died in the documented/stated preferred place.</td>
</tr>
<tr>
<td>3</td>
<td>There is clear evidence that patients who are initiated on the pathway had a multidisciplinary team (multi-professional) assessment prior to commencement and in agreement with the patient</td>
</tr>
<tr>
<td>4</td>
<td>People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.</td>
</tr>
<tr>
<td>5</td>
<td>All patients to have a complete and accurate assessment which includes all of the following: - symptoms - nutrition &amp; hydration - personal care - spiritual &amp; religious - support needs</td>
</tr>
<tr>
<td>6</td>
<td>All patients are to have individualized plan based on needs identified and ongoing needs were acted upon in accordance with evidence based practice.</td>
</tr>
<tr>
<td>7</td>
<td>Clear evidence that communication and on and ongoing basis with family members</td>
</tr>
<tr>
<td>8</td>
<td>Evidence of care and support following patient death.</td>
</tr>
<tr>
<td>9</td>
<td>Evidence that the family or other nominated person were given the support and advice that they needed following the patient’s death “verbal and written”</td>
</tr>
</tbody>
</table>
Observations from the audit results;

The individual plan of care clearly demonstrates quality of care given for the dying person. There are a few areas of focus for improvement such as:

- GPs are not recording in the records, any evidence of a GP review is being documented by the district nursing teams.
- Standard 5: Recording spiritual and religious needs to be improved as 35% of records had no evidence of any discussions.
- Standards 8 and 9: 77% of families had evidence of verbal support following death, of these only 35% also received a bereavement leaflet.

**Delirium**

During 2015/16 as part of the FallSafe care bundle and CQUIN the intermediate care bed based units developed and introduced a process for risk assessing and identifying patients that may be at risk or be suffering from Delirium. Delirium is characterised by a disturbance of consciousness (i.e. reduced clarity of awareness of the environment) and a change in cognition (such as memory deficit, disorientation, language disturbance) that develop over a short period of time (usually hours to days). Delirium is a very common symptom affecting up to 30% of older medical inpatients. The hospital environment often precipitates or exacerbates episodes of delirium.

Delirium is associated with:

- Increased length of stay
- Increased mortality
- Increased risk of institutional placement
- Increased risk of development of dementia

By identifying patients who may be at risk of or are displaying signs of delirium the staff within the units are able to investigate the cause and provide timely interventions to treat or prevent the condition. Newton Community Hospital implemented the risk assessment tool from 1st January 2016. To date ???% of patients have been risk assessed on admission for delirium on admission. Padgate House implemented the tool in July 2015. To date 99.5% of patients have been risk assessed within 24 hours of admission. One patient was unable to be assessed as they returned to hospital within 24 hours of admission.

**Library and Knowledge Services**

In 2015, as part of the Trust’s Learning and Development Agreement (LDA) with Health Education North West the Bridgewater library and knowledge service (LKS) submitted its annual self-assessment against the national standards contained in the NHS Library Quality Assurance Framework (LQAF). The Service scored 90% (87% in 2014) and is now rated as a ‘green’ service. Bridgewater LKS were commended by the assessors for the improvements made in the last 12 months resulting in a change from an amber rating in 2014.
**Patient Experience**

The Trust recognises that eliciting, measuring and acting upon patient feedback is a key driver of quality and service improvement. The Trust has a Patient Charter outlining what people should expect from Bridgewater services and who to contact if they do not meet those standards. The Trust uses a range of methods to seek patient feedback including the use of patient stories, patient surveys, which include the Friends and Family Test and the use of Patient Partners, as a way of involving the people who actually use the services. All feedback is closely monitored with any lessons learned identified and cascaded across the organisation. The Trust also has a Being Open/Duty of Candour Policy and is implementing training for all staff to ensure openness and transparency for all patients and carers regarding their care and treatment.

**Halton Patient Experience Matrix**

*Text to be added*

**Complaints**

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

During 2015/16 we received **88** complaints compared to **91** during the previous year. These are summarised on a Borough/Service basis below:

<table>
<thead>
<tr>
<th>Number of Complaints</th>
<th>Dental</th>
<th>Halton</th>
<th>St Helens</th>
<th>Warrington</th>
<th>Wigan</th>
<th>Willaston</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>12</td>
<td>18</td>
<td>25</td>
<td>29</td>
<td>1</td>
<td>88</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Theme of complaint</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspects of clinical treatment</td>
<td>61</td>
</tr>
<tr>
<td>Attitude of staff</td>
<td>7</td>
</tr>
<tr>
<td>Aids and appliances, equipment, premises</td>
<td>2</td>
</tr>
<tr>
<td>Appointments, delay/cancellation (outpatient)</td>
<td>2</td>
</tr>
<tr>
<td>Failure to follow agreed procedures</td>
<td>6</td>
</tr>
<tr>
<td>Admissions, discharge and transfer arrangements</td>
<td>5</td>
</tr>
</tbody>
</table>
Patients’ privacy and dignity | 2
---|---
Other | 3
Total | 88

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

Some examples of lessons learned include:

- **Oxygen Therapy** - complaint about the decision to stop oxygen therapy for a patient after assessment.
  - Two leaflets are being produced, one for patients who are being weaned off home oxygen and one for patients where home oxygen is no longer required/recommended and is being withdrawn.

- **Dental** - complaint received from a patient who has been accessing a service since 1998. The patient, who requires wheelchair access, received an appointment letter which only stated the date and time of the next appointment and not the fact that the clinic had been relocated to a different town and the parking facilities at the new location were not adequate for the patient. The patient had not been informed of the relocation of the service.
  - Services should ensure effective communication to patients when services are relocated, including updating standard template letters to include location and using posters to keep patients updated.
  - Services should develop a communication plan when relocation is occurring detailing how patients/carers will be informed of changes.

- **Health Visiting** - complainant was unhappy that the Health Visitor had shared personal information within a report submitted to Social Care without sharing the information with the complainant.
  - Health Visitors will ensure that, where reports are to be shared with other agencies, the information will be shared with parents beforehand.
  - All Clinicians should consider the sharing of information with families prior to forwarding to other agencies.

- **Community Paediatric Medicine** - complaint which relates to the alleged lack of diagnosis for a child from the Paediatric Community Medicine Service.
  - Review the literature given to parents about the role of the community paediatrician, and also a conversation with parents at the outset about expectations and roles.
Patient Survey and 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 35,700 people responded to the friends and family question and 97.2% indicated that they would recommend Bridgewater services.

<table>
<thead>
<tr>
<th>Borough/Service</th>
<th>FFT results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>FFT returns</td>
</tr>
<tr>
<td>Halton</td>
<td>4732</td>
</tr>
<tr>
<td>St Helens</td>
<td>14,117</td>
</tr>
<tr>
<td>Warrington</td>
<td>3414</td>
</tr>
<tr>
<td>Wigan</td>
<td>10,281</td>
</tr>
<tr>
<td>Dental</td>
<td>2690</td>
</tr>
<tr>
<td>Willaston</td>
<td>57</td>
</tr>
<tr>
<td>Antenatal</td>
<td>104</td>
</tr>
<tr>
<td>Postnatal</td>
<td>305</td>
</tr>
<tr>
<td>Bridgewater</td>
<td>35,700</td>
</tr>
</tbody>
</table>

Borough/Service Talk to Us… form also asks further questions about patients and carers experiences of Bridgewater services. A total of 37,109 responses were received during the year and 99% indicated overall satisfaction with their care and treatment.

<table>
<thead>
<tr>
<th>Satisfaction Domains</th>
<th>Dental</th>
<th>Halton</th>
<th>St Helens</th>
<th>Warrington</th>
<th>Wigan</th>
<th>Willaston</th>
<th>Bridgewater</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do you feel about the time you waited to be seen?</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
<td>97%</td>
<td>96%</td>
<td>97%</td>
<td>97%</td>
</tr>
<tr>
<td>How do you feel about the</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>93%</td>
<td>100%</td>
</tr>
</tbody>
</table>
information you were given (verbal or written)?

How do you feel about the privacy, dignity and respect given to you?

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>100%</th>
<th>85%</th>
<th>100%</th>
</tr>
</thead>
</table>

How do you feel about the overall experience of your care or treatment?

<table>
<thead>
<tr>
<th></th>
<th>99%</th>
<th>99%</th>
<th>100%</th>
<th>99%</th>
<th>99%</th>
<th>92%</th>
<th>99%</th>
</tr>
</thead>
</table>

Number of responses

<table>
<thead>
<tr>
<th></th>
<th>2821</th>
<th>5283</th>
<th>14,551</th>
<th>3547</th>
<th>10,864</th>
<th>58</th>
<th>37,109</th>
</tr>
</thead>
</table>

**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:

**Wheelchair Service**

A patient raised concerns around the poor communication between the service, the GP and the family during assessment process and the length of time taken to provide a powered wheelchair. As a result of the family sharing their story the service has reviewed and changed the assessment process to ensure carers needs and preferences are also taken into account. The patient was very happy with his chair and the family appreciated the opportunity given to tell their story.

**Adult Learning Disability Service**

A patient wanted to share their story about how the service has helped him to access a range of health services which they were not able to do previously. This was done with the use of pictures and careful explanations, which in turn helped to reduce his anxiety levels to ensure he was able to undertake the tests required.

**Adult Continence Service**

The patient reported that the service provided had given them the confidence to live their life, including going on holidays abroad, using trains and going to the theatre.

**Health Visiting – Parent Partners**

A Parent Partner has shared her story of how and where Parent Partners were making a difference. How they are actively involved in the service and how the service is continually listening and improving as a result of their input.
Patient Partners
Patient Partners is a Bridgewater initiative to showcase how to actively involve patients and carers to work with staff to identify areas for improvement in quality of care and service delivery.

The services working with Patient Partners include:

Health Visiting Service St Helens
Staff are using a variety of initiatives to engage with parents and continuing to roll out Parent Partners across the organisation. The initiative was introduced by the service in St Helens. One to one interviews with parents have taken place with recommendations presently being put into place within teams. Some of the changes include:

- Photo recognition laminated sheets displayed within clinics of who the staff are/what they do.
- Recording child’s likes/dislikes when attending home visits, to help reduce anxiety levels.
- Case studies being prepared of parents’ experiences of services.

Integrated Children’s Therapy Service Wigan
Children attending the ‘Summer Group’ therapy session were asked for their views on, ‘what they liked’ and ‘what the service did well’. They were also asked, ‘what they didn’t like and what things the service could improve on’. To make it fun, they were given word stars to stick on an information board. Some of the outcomes from the event were to:

- produce pre-group information sheets
- explore options for sessions in other areas
- provide age appropriate music during the group sessions
- explore opportunities for children to develop friendships with other children with similar needs
- ensure that the therapy services have strong links with local community services to enable signposting to various social participation groups including Wigan Youth Zone, and Wigan Leisure and Cultural Trust sessions.

Adult Learning Disability Service Wigan
The service has a strong track record of continually involving service users in improving the services. Some of the outcomes include:

- The development of user friendly literature, including posters and leaflets.
- Service users participation in health and wellbeing initiatives.
- A number of service users have shared their story about the experience of being supported by the Learning Disability Service, including accessing the cervical screening programme.
- A number of service users have shared their story at Bridgewater Board meetings.
Adult Speech and Language Therapy Halton
Patient Partners was initially developed within this service. It has a strong record in continually involving patients. Some of the outcomes this year include:
- Involving Patient Partners in the recruitment process of two new members of staff, including their active involvement in the interview process.
- Working in partnership with two care homes to support staff around their competencies in dealing with residents' nutrition and hydration.

Long Term Conditions (COPD Wigan)
The service carried out a number of semi-structured interviews with patients to elicit their views about the service they receive. One of the main outcomes was that the patients felt that singing helps their breathing control and the idea for a singing group was developed. A number of users have joined the group which accessed some funding from the Bridgebuilder fund and formed a choir. The sessions have been well attended and apart from the obvious benefits for breathing problems it has also been a source of companionship for patients who live on their own and are often isolated from their community.

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 2015/16 we received 2105 contacts across Bridgewater. These are summarised below.

<table>
<thead>
<tr>
<th></th>
<th>Corporate</th>
<th>Dental</th>
<th>Halton</th>
<th>St Helens</th>
<th>Warrington</th>
<th>Wigan</th>
<th>Willaston</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qtr. 1</td>
<td>5</td>
<td>4</td>
<td>47</td>
<td>54</td>
<td>97</td>
<td>142</td>
<td>2</td>
<td>351</td>
</tr>
<tr>
<td>Qtr. 2</td>
<td>0</td>
<td>8</td>
<td>46</td>
<td>57</td>
<td>122</td>
<td>177</td>
<td>4</td>
<td>414</td>
</tr>
<tr>
<td>Qtr. 3</td>
<td>8</td>
<td>4</td>
<td>53</td>
<td>412</td>
<td>125</td>
<td>173</td>
<td>0</td>
<td>775</td>
</tr>
<tr>
<td>Qtr. 4</td>
<td>0</td>
<td>3</td>
<td>52</td>
<td>285</td>
<td>90</td>
<td>128</td>
<td>7</td>
<td>565</td>
</tr>
<tr>
<td>Total</td>
<td>13</td>
<td>19</td>
<td>198</td>
<td>808</td>
<td>434</td>
<td>620</td>
<td>13</td>
<td>2105</td>
</tr>
</tbody>
</table>

Around 20% of the contacts were requests for advice and information, including signposting to other organisations.

Almost 46% 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.
The reason for the sharp increase in the numbers of contacts in St Helens in quarter 3 was largely due to the transfer of the Community Paediatric Services from Alder Hey hospital to Bridgewater for patients living in the St Helens Borough and related to requests for appointments and medication.

Only seven of the 2105 contacts went on to become formal complaints.

**Patient Led Assessments of the Care Environment 2015**

NHS England recommends that all hospitals providing NHS funded care undertake an annual assessment of the quality of non-clinical services and the condition of their buildings. These assessments are referred to as Patient Led Assessments of the Care Environment (PLACE). Our assessment team consisted of both internal and external assessors.

Bridgewater has only one hospital i.e. Newton Community Hospital. The percentage summary scores for each category below have been awarded by the Health and Social Care Information Centre (HSCIC) based on the information returned by us for the 2015 assessment.

<table>
<thead>
<tr>
<th>Category</th>
<th>Newton Community Hospital</th>
<th>National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cleanliness</td>
<td>99.43%</td>
<td>97.6%</td>
</tr>
<tr>
<td>Food</td>
<td>81.87%</td>
<td>88.5%</td>
</tr>
<tr>
<td>Organisation Food</td>
<td>73.75%</td>
<td>87.2%</td>
</tr>
<tr>
<td>Ward Food</td>
<td>89.96%</td>
<td>89.3%</td>
</tr>
<tr>
<td>Privacy, Dignity, and Wellbeing</td>
<td>90.48%</td>
<td>86%</td>
</tr>
<tr>
<td>Condition, Appearance and</td>
<td>96.88%</td>
<td>90.1%</td>
</tr>
<tr>
<td>Maintenance</td>
<td>82.89%</td>
<td>74.51%</td>
</tr>
</tbody>
</table>

Since the assessment in 2015 the trust has drafted a Food and Strategy which will be implemented in 2016/17.

**Further Information Regarding Quality in 2015/16**

**Equality and Diversity and Inclusion**

The communities we serve are diverse and we know that many of the people in our boroughs are suffering inequalities that mean ill health from an early age and for many a lower life expectancy when compared to the average for England. The Trust’s new Strategy for Health and Wellbeing 2015/16 – 2020/21 seeks to reduce these inequalities by addressing the wider determinates of health and working with communities to provide care that meets their needs and supports their independence.
At Board level, responsibility for equality, diversity and inclusion sits with the Director of People and Organisational Development. On a day-to-day basis equality, diversity and inclusion is managed by the Health Inequalities and Inclusion Team. They work with staff and services to:

- ensure that the services we provide are accessible to all
- develop services which best meet the needs of our diverse communities
- employ, develop and retain a workforce which at all levels reflects the diversity and make-up of the population we serve
- ensure that staff have information on equality, diversity and health inclusion
- eliminate from our services, polices and decision making any adverse impact on the promotion of equality or potential adverse effect on any particular groups or communities.

To demonstrate compliance with the legal frameworks of the Equality Act and in particular the requirements of the Public Sector Equality Duty the Trust produces an annual report that analyses staff and patient data by protected characteristic. We also use the mandatory NHS Equality Delivery System (EDS2) to assess experience and outcome of patients and staff against 18 outcomes. Further information on these annually produced reports can be found on our webpages.

The Trust has a set of SMART Equality Objectives that were originally set in 2012 and have been reviewed and updated yearly following the Public Sector Equality Duty and EDS2 reporting, these objectives support compliance with the second of the Specific Duties of the Public Sector Equality Duty. The Objectives are also amended to reflect new national policy and commissioner requirements. The current Equality Objectives (2012 – 2016) can be viewed on our webpage and new objectives are due to be set in summer 2016.

As a health care provider the Trust requires all services to have a completed equality analysis, these are undergoing a planned review in early 2016 and updated forms can be viewed on the Trust webpage. All service redesigns and new service mobilisation are subject to an equality analysis before being implemented.

Two major pieces of work in 2015/16 have been on the new NHS Workforce Race Equality Standard and the NHS Accessible Information Standard for patients. Work will continue on these into 2016/17 and the Health Inequalities and Inclusion Team are meeting with other local E&D leads to review and provide feedback on the proposed Workforce Disability Equality Standard planned to be mandated in 2016/17 by NHS England.

Other work planned for 2016/17 includes development work with the Trust’s new staff wellbeing lead on mental health and the Mindful Employer Charter, submission to the Navajo Charter and the signing of the British Deaf Association BSL Charter following some engagement work with Wigan CCG and local Deaf clubs.
Detailed Trust equality information such as our Public Sector Equality Duty reports, our EDS (and EDS2) grading results, our Equality Statement and service equality analysis are published on our website.

**Monitor Compliance / Monitor Risk Assessment Framework**
Monitor expects NHS Foundation Trusts to establish and effectively implement systems and processes to ensure that they can meet national standards for access to health care services. Monitor incorporated performance against a number of these standards in their assessment of the overall governance of Bridgewater going forward as a Foundation Trust.

Performance against the relevant indicators and performance thresholds is set out on next page. **Data table to be added**

**Waiting Times**
The Trust monitors and reports on the length of time between a patient’s referral to one of our services and when the treatment is received by the patient.

**Waiting Times Consultant Led**
Consultant-led services are those where a consultant retains overall responsibility for the clinical care of the patient.
The completed referral to Treatment (RTT) Pathway is a true indicator of the length of time between referral and the start of treatment.

At the end of 2015/16 the Trust had a total of xxx patient waiting for consultant led services.

**Waiting Times All Services**
The Trust measures the time that has elapsed between receipt of referral 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 (2015/16).

**(insert graph of all services waiting)**

At the end of 2015/16 the Trust had a total of xx,xxx patients waiting for all services. Of these x,xxx (xx%) 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 that the Trust has been meeting and overachieving against the Referral to Treatment and cancer targets throughout 2015/16:
Compliance against Targets
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.

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
- The Trust also aspires to meeting the 18 week pledge for all other services
- 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 achieved all its quarterly monitored national targets for waiting times during 2015/16. Performance against Referral to Treatment (RTT) waiting time targets as part of the national requirements 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 following table demonstrates our compliance against the 18 week RTT target of 95% for completed pathways.  

Telehealth
During 2015 the post holder with responsibility for the roll out of telehealth left the organisation. The Medical Director determined that the use of telehealth within clinical services was not the responsibility of one individual but rested with all clinical staff and should be driven by service need, as advised by the clinical leads. During 2015 the main area of development in the use of telehealth continued to be the use of Florence. Florence is an NHS system developed to use mobile phone technology to allow patients to submit their own vital signs information to their health professionals in a simple manner. The system also allows health promotion and motivational messages to be sent to patients, increasing compliance with treatment regimes and improving awareness and understanding around lifestyle choice.

Delivering Same Sex Accommodation
Every patient has the right to receive high quality care that is safe, effective and respects their privacy and dignity. We are committed to providing every patient with same sex accommodation as it helps to safeguard their privacy and dignity when they are often at their most vulnerable.
Newton Community Hospital
Other than in exceptional circumstances, patients admitted to Newton Community Hospital can expect to find the following standards for the provision of same sex accommodation:

- The room where their bed is will only have patients of the same sex.
- The toilet and bathroom will be just for one gender and will be close to the bed area.
- Patients may share some communal space, such as day rooms or dining rooms.

Occasionally, it may not be possible to care for patients in a same sex environment, e.g. in the case of an emergency or specialist care situation. The clinical (medical) need will take priority over keeping the patient apart from other patients of the opposite sex. During the period of April 2015 – March 2016 there were two occasions when this was required. On both occasions the consideration was given to the clinical and best interest requirements of the individuals and a decision was made in conjunction with the individuals to allow a husband and wife to share the same bed area and bathroom facilities. This was reported via the appropriate reporting systems and was not considered to be a breach of the same sex accommodation standard.

We can confirm for the period of April 2015 until March 2016 there were no breaches to the same sex accommodation.

Padgate House
Padgate House is a 35 bedded intermediate care unit based in Warrington. The building is owned and managed by Warrington Borough Council. The Trust is responsible for the provision of clinical services. The same standards are applied to this unit, however the home has 35 single bedded rooms which are not en-suite. This ensures that patients never share a bedded area. The building has 14 bathrooms which are shared by all residents meaning that males and females will share the same facilities however there are clear engaged signs on doors and doors 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.

Commissioning for Quality and Innovation (CQUIN)
For 2015 /16, Bridgewater agreed in total 35 CQUIN schemes;

- 25 CQUIN measures with our commissioners in Wigan, Warrington, Halton and St Helens
- Four with our children’s commissioned services from Public Health England
- Six primary care CQUINs for Willaston practice in partnership with Western Cheshire CCG.
This demonstrates our continuous commitment to improving services in terms of quality outcomes for patients, carers and service users.

These quality indicators support and ensure ongoing innovation and improvement across all of our services and in defined areas of clinical care. There are six national CQUINS, six regional ones and 23 local improvement areas.

The national CQUINS relate to the development of electronic patient records in adult services. The public health CQUINS are looking to improve child safety, increase breastfeeding rates and improving integrating care between maternity and health visiting services and between education and health visiting services for 2 year olds.

The six regional relate to primary care at the Willaston practice and the outcomes are focused on;
- keeping frail, vulnerable patients within the community to reduce avoidable admissions
- improving access to primary care
- proactively managing the supported discharge of patients back into the community following unplanned admission into hospital.

Local CQUINS by Borough

**Wigan**
Seven local CQUINS which focused on effective antibiotic prescribing in the Out of Hours service, improving services in podiatry, and better outcomes of care for the frail and elderly.

The two CQUINS in podiatry have been very successful. The first was the introduction of out of hours Diabetic annual review appointments at two locations (Boston House and Leigh Health Centre.) We had long known that most type 2 diabetic patients just coming for an annual foot review are of working age and find 9 to 5 appointments not always helpful. After scoping the best locations (opening times and access), we have been running early evening appointments at these sites since June 2015 and have seen the did not attend (DNA) rate drop from 16.75% to 9.4%.

This is very favourable as nationally most screening programs have a DNA rate of between 20-40%. Patient feedback by way of a satisfaction questionnaire has been very positive with 94% (from last cohort) stating that they would choose early evening appointments in the future.

The second CQUIN was called an Off Loading CQUIN - We decided to see if by off-loading plantar foot ulcers by way of Darco boots would see a reduction in healing times and positive outcomes for patients. Normally we would have to get these
devices through the GP, but this CQUIN enabled us to purchase them directly, and fit earlier. Not all the final data is currently in, as many patients come to the service with chronic wounds, however early indications show patients find these devices easy to wear and feel they are helping in their treatment.

In children’s services they have concentrated on improving child therapy services by developing enhanced data sets to inform planning of services and getting views of families and children about their care

**Warrington**
Nine local CQUIN schemes. Their focus was on improving services for patients with dementia and their carers, diabetic foot screening, the development of a tissue viability post and supporting patients at end of life. They have also improved the intravenous therapy services in the community. Within children’s services, community nursing, neurology, Intravenous therapy and unscheduled care have improved their quality data collection to help inform service developments.

In recognition that our model of Tissue Viability Specialist Nurse support in Warrington differed from our other boroughs, we have worked closely with our CCG colleagues to design a revised community model to be delivered through a CQUIN Scheme.

The key components of the model included;
- Identification of a lead specialist nurse
- Working collaboratively across the health care economy to ensure access to the specialist resource from all sectors
- Deliver a standardised education programme
- Focus on pressure ulcer care

**St Helens**
Five CQUIN schemes. Their focus was on developing services for the frail and elderly working closely with primary care, integrating services for patients with long term conditions, improving care for patients with dementia and also developing a pathway for patients with delirium in Newton hospital. They have also undertaken a review of the services providing pressure relieving equipment in patients’ homes to ensure they receive the right equipment. In children’s services they have also improved services for children with complex needs.

**Halton**
Six CQUIN schemes focusing on the development of services for the frail and elderly working closely with primary care, integrating services for patients with long term conditions, improving care for patients with dementia. They have also undertaken a review of the services providing pressure relieving equipment in patient’s homes to ensure they receive the right equipment. In children’s services they have had two
CQUINs, one is improving services for children with complex needs and the other has focused on finding out about families views when accessing children’s services.

**Quality Improvement Programmes**

The Innovation & Improvement team continue to provide service improvement sessions, using lean methodology to teams who request assistance. In 2015/16 over 60 separate improvement programmes were delivered including bespoke capacity and demand planning, team building, problem solving methodology, process mapping, process flowcharting, force field analysis, pareto analysis. The team also supported the Quality events and several Open Space sessions.

The Trust has been part of an Academic Health Science Network (AHSN) supported roll out of an innovative new device to enable patients with neurological deficit to remain hydrated. The Hydrate for Health bottle has been rolled out via Bridgewater’s Wheelchair services during 2015/16 with excellent feedback from participants. The project is being evaluated by the North West AHSN.

Bridgewater’s Quality Improvement Programme, developed and delivered by the Innovation & Improvement team has been further developed at the request of the Adult and Children’s 0 – 19 Service Managers to provide all their Band 7 team leaders with a bespoke leadership development programme. The programme will enhance leadership skills based upon the current required competencies of a Band 7 team leader with additional units that reflect the emerging leadership models deriving from NHS Litigation Authority and the Kings Fund. These models specifically relate to integration, partnership models, social asset and self-care approaches to health care for the future. The programme will support the Trust to deliver an asset based approach and acknowledge the changing leadership requirements for the integration agenda. The values and behaviours taught on the programme align with our strategy for health and well-being and support the Listening into Action framework to deliver continuous quality improvement.

**Quality walk-rounds**

Quality Visits have been undertaken within the Trust for some time. In October 2015 the process and documentation was revised.

The documentation and visits are now structured around the CQC five questions;

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people’s needs?
- Are they well-led?
Training for the people involved in the visits e.g. Governors, NEDs and Executives was delivered prior to the re-instatement of the visits.

The visits have been welcomed by staff and it is very apparent that they are committed to delivering safe and effective care. The visits have mainly identified estates and facilities type issues. A report is written up for each visit which includes an action plan that is monitored through to completion.

**Widnes Urgent Care Centre (Halton Borough)**
This centre opened officially in October 2015 on the site of the old Widnes Walk in Centre at the Health Care Resource Centre although some of the new facilities were already in place and being used from July.

It is staffed by nurses but there is also a doctor on site during opening hours and all staff are trained in the clinical pathways agreed with nursing and medical staff and the local hospitals so that patients receive consistent quality care.

There are now x-ray facilities which are mainly used for identifying fractured limbs but GPs can also refer for chest x-rays so patients do not have to attend hospital.

The centre can now see more poorly patients and is kite-marked by North West Ambulance service so that patients who call an ambulance maybe taken there to be treated rather than going to hospital. The number of patients being seen is increasing.

There is an ultra-sound scanner which helps to identify DVTs (blood clots) which can then be treated without the patient attending or being admitted to hospital. There is also a paediatric cooling room for children who have high temperatures which is in line with NICE guidelines.

**Midwifery (Halton)**
Halton midwifery service continues to be the only midwifery service nationally that is based within a community trust. The service delivers the full remit of pregnancy care across Halton ante and post natal care and a home birth facility. The birth rate in Halton remains static at approximately 1,600 women per year. In the past 12 months there were 12 successful planned home births and the service responded and provided care to nine un-booked home births. The service provides care 365 days per year and has an on call facility from 5pm-9am across the 365 days.

The National Screening Committee (NSC) embarked on a series of quality assurance visits across all maternity services nationally just under two years ago. Bridgewater midwifery services had their visit on the 3rd and 4th November 2015. Whilst some of the findings were good and areas of good practice were highlighted by the assurance team, the audit also identified that our systems and processes
relating to screening need to be strengthened. Following the report an action plan was devised and submitted to the NSC. An internal group which meets monthly was set up to address the audit findings and monitor the action plan and will report progress to the Trust’s Clinical Governance Committee and the NSC.

**Local Supervising Midwifery Report (Halton and St Helens)**

The Local Supervising Authority (LSA) carry out an annual audit visit on all maternity services in the UK as part of the statutory requirement.

The aims of the audit are to:

- ensure that there are relevant systems and processes in place for the safety of mothers and babies;
- ensure that midwifery practice is evidence based and responsive to the needs of women;
- review the evidence presented to ensure standards for supervision are being met;
- review the impact on supervision on midwifery practice.

Bridgewater’s annual LSA audit was carried out in November 2015. The team interviewed supervisors, midwives, and student midwives on duty on the day.

Service users were also invited and of the 65 women invited, five women and one partner attended and participated in a focus group with the audit team. Feedback from the all the stakeholders was positive and the team commented on the value of this model of care for women and their families. Once again the national standards were met. Recommendations from the visit were generic rather than local and have been incorporated into an action plan which is reviewed at the six weekly supervisor of midwifery meetings and both the plan and the progress will be presented at the next audit visit in September 2016.

**Collaborative Working in Warrington**

The community nursing workforce in Warrington has been remodelled to reflect the primary care GP clusters to deliver the ‘Collaborative Clusters’ model. The aim is to develop closer working relationships across primary care, community and social care within a cluster. Cluster meetings have been held to identify ways of improving communication, preventing duplication, and how to ensure individuals and their families get the right care at the right time by the right person. The need for multi-disciplinary team meetings has been identified and work is on-going as to the best way to deliver this.

Bridgewater has been a key partner alongside Warrington Health Plus in the delivery of an enhanced care home model. The model includes an element of proactive weekly visits by a named GP and nurse as well as a pharmacist. Patients have a full assessment and plans put in place to ensure their needs can be met within the home
and also the home feel supported to care for the individual. There is an emphasis on end of life patients to ensure the individual and their family are included in discussions relating to advanced care planning. Homes continue to be supported through a central contact point for urgent in day requests for visits and advice. The aim of the enhanced care model is to improve care and prevent unnecessary admissions to hospital for frail elderly individuals.

**Dermatology Service in Warrington**

In July 2015 Warrington CCG raised concerns that patients referred under the cancer two week (suspected cancer) rule were not being managed as per the national cancer waiting time guidance.

Subsequently a letter was received on the 8/10/15 stating that in line with the General Condition 16.1.1 of the NHS Standard Contract, NHS Warrington CCG considered that a suspension event had occurred within the Dermatology Skin Cancer Service.

An investigation was carried out in order to;
- establish whether patient safety, clinical effectiveness or patient experience had been adversely affected as a result of the Trusts Patient Access Policy
- understand why the Trusts Patient Access Policy failed to take account of the NHSE cancer guidance,
- identify learning in order to mitigate against a re-occurrence.

The investigation concluded that there had been no negative impact on patient care.

Subsequently the Trusts Patient Access Policy was amended and the service was resumed on 26th October 2015.

**Community Dental**

**Text to be added**

**Stakeholder Involvement in the Development of our Quality Report**

**Opportunity to Shape the Content of our Quality Account**

Prior to our quality report being drafted our Chief Nurse wrote to our stakeholders requesting their input into the content of the report. A number of suggestions were received regarding content and our 2016/17 quality improvement priorities which have been addressed 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.

Appendix A – Workforce Information

Our key priorities for 2015 were:
- 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 for Staff recommending the Trust as a place to work and receive treatment
- To increase the Personal Development Review rate (Staff appraisal)
- To reduce sickness absence rates against a Trust target of 3.78%
- To achieve Trust target of a rolling 8% for staff turnover.

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

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

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

We have various information and communication channels, engagement systems, programmes and initiatives which include, but are not limited to:
A monthly Team Brief cascade led by the Chief Executive and Executive Team. The Brief is cascaded by managers across the whole organisation within seven days.

Regular Open Space events which gives all staff the opportunity to bring forward ideas or suggestions. The most ones agreed by the group to be the most viable are worked into a proposal for consideration for implementation.

A weekly Trust Bulletin which provides staff with information as to what is happening within the Trust, patient stories, the events that they can attend, seminars, workshops and forums they can engage in. Staff are able to contribute to the content of the Bulletin, put questions to the Trust’s communications team and partake in research programmes and promote the good work of their services as per its regular ‘Spotlight on Services’ feature.

A “Star of the Month Award” whereby staff can nominate colleagues who have gone over and above their role, living up to the Trust’s values and demonstrating ‘star’ qualities. Awards are presented by the Chief Executive and publicised in the Bridgewater Bulletin, Trust Intranet and website.

Trust wide Staff Awards will be held in March 2016. There were six Awards 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.

Director Quality Visits enable staff to meet members the executive team to discuss the quality of services they delivery and listen to their views, ideas and what it is like to work for the Trust.

Professional Forums, which are made up of clinical staff, include presentations and workshops on national, regional and local issues and initiatives, best practice and networking opportunities.

The Productive Community Services Programme enables staff to share their experiences of service improvements and developments. Staff have and are adjusting to new ways of working. Staff who have undergone modules have reported much improved working environments, increased face-to-face contact time with patients and less time spent on administration tasks due to system and process improvements, enabling more time to deliver patient care.
NHS Staff Survey 2015 - Working with staff to understand key messages from the staff survey

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 2015 score slightly improved in comparison to 2014 from 3.67 to 3.75. The scoring system is a scale of 1 to 5 with 1 being 'strongly disagree' and 5 'strongly agree'.

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, this has resulted in changes to the walk in centre process which has been trialled and is now being rolled out to all our walk in centres. We are also undertaking a full review of our PDR process, starting by surveying staff on their views of our current system. A Listening in Action group has also been established to look at the Trusts communication methods, again starting with a survey of staff opinions and ideas. Year on year we ensure that we measure the changes identified in the staff survey as it provides structured, evidence based way for us to engage with staff and respond to their feedback.

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** - The five areas for which the Trust compares most favourably with other Community Trusts in England are:
- KF20: Percentage of staff experiencing discrimination at work in the last 12 months
- KF7: Percentage of staff able to contribute towards improvements at work
- KF13: Quality of non-mandatory training, learning or development
- KF22: Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months
- KF9: Effective team work

**Bottom 5 Ranking Scores** - The five areas for which the Trust compares least favourably with other Community Trusts in England are:

- KF17: Percentage of staff suffering work related stress in the last 12 months
- KF6: Percentage of staff reporting good communication between senior management and staff
- KF12: Quality of appraisals
- KF29: Percentage of staff reporting errors, near misses or incidents witnessed in the last month
- KF5: Recognition and value of staff by managers and the organisation

Although we saw a deterioration in 14 of our ‘Key Findings’ in comparison to the 2014 with the exception of KF21: Percentage believing the organisation of staff appraised in the last 12 months, and KF 26: Percentage of experiencing harassment, bullying or abuse for staff in the past 12 months the staff survey results were not statistically significant. There has also been an improvement in scores on 4 of the Key Findings from 2014 to 2015. None of the scores in which there has been an improvement are statistically significant.

Improving on the staff survey results will remain a key priority through our action plans and focus groups.

The NHS Staff Survey results for 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;

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2014</th>
<th>Median Community Trust</th>
<th>Lowest Community Trust Score</th>
<th>Highest Community Trust Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of staff experiencing harassment, bullying or abuse from staff in the last 12 months (<em>The higher the score the better</em>)</td>
<td>83%</td>
<td>94%</td>
<td>90%</td>
<td>83%</td>
<td>95%</td>
</tr>
<tr>
<td>% of staff believing that the trust provides equal opportunities for</td>
<td>23%</td>
<td>16%</td>
<td>21%</td>
<td>13%</td>
<td>25%</td>
</tr>
</tbody>
</table>
Both scores have declined from the 2014 scores. This has been identified in our staff survey results and actions will be put in place to address this in the NHS Staff Survey action plan.

**Staff Health & Wellbeing**

We continue in our commitment to reduce sickness absence through effective management and support from occupational health and the Trust’s human resources team. A healthy motivated workforce is integral to achieving better care for our patients. We have an occupational health service which provides staff with:

- Telephone and face to face counselling services
- Physiotherapy services
- Occupational health referral and assessment services, including speedy referrals for mental health and muscular-skeletal disorders

Our occupational health service provides us with information that helps us identify areas of staff health and wellbeing that may require more attention, such as issues of personal and workplace stress. The introduction of on-line occupational health referrals has enabled more timely referrals and feedback on medical assessments/opinions.

The Trust recognises that any adverse impact on staff that affects their ability to function at their best in the workplace needs active steps to provide support and take a preventative stance where possible. The Trust will be recruiting a member of staff to support the managing and handing of staff health and wellbeing.

The Trust’s sickness absence target is 3.78%. The absence rate at the end of March 2016 was 5.02% in comparison to 5.68% at the end of March 2015. 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 monthly by the Trust Board.

**Personal Development Reviews (PDRs)**

We continue to provide opportunities for our staff to develop via a ‘values’ driven personal development review to ensure they can continue to meet the needs of our aims and objectives and patients.
The Trust’s focus on PDRs has been captured within the 2015 NHS Staff Survey in which 85% of respondents confirmed that they had been appraised in the last 12 months.

<table>
<thead>
<tr>
<th>Directorate</th>
<th>Percentage of Staff Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Services</td>
<td>89.28%</td>
</tr>
<tr>
<td>Children’s Services</td>
<td>91.67%</td>
</tr>
<tr>
<td>Corporate Service</td>
<td>34.17%</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>95.81%</td>
</tr>
<tr>
<td>BRIDGEWATER</td>
<td>84.39%</td>
</tr>
</tbody>
</table>

The PDR policy is now under review and staff have been surveyed for their opinions on the current PDR process. 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. To ensure PDRs are meaningful, we will be focussing on improving our bottom five ranking staff survey scores.

**Staff Turnover**

The rolling staff turnover for the Trust as at 31 March 2016 was 16.60%. 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 into and out of the organisation during the last year which impacts significantly on the staff turnover rates. Work is on-going 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 2015/16 plan was developed with input from each of our clinical services. The Clinical Services Strategies set out the intentions for the delivery and development of Services over the next five years. They include what we do, why and how to ensure that our Services are in the strongest position to deliver high quality care and promote health and wellbeing in our communities.

The composition of the workforce has remained relatively stable over recent years but it will need to change to reflect and respond to national and local changes. This will impact on the productivity levels and the ways of working. Implementing new roles, new ways of working and skill mix changes will be essential to meet costs and increase outputs. New ways of working are being developed as part of redesign and
in conjunction with new technologies and IT strategies i.e. patient systems and mobile working.

This includes the implementation of the Trust’s mobile electronic patient records system, which is now underway and expected to increase productivity by around 10% for each service on the roll-out schedule.

In line with the competitive commercial environment, one of the Trust’s key strategic priorities is retaining existing business and development of new business. This will be regularly reviewed will be reflected in future workforce plans.

As part of its commitment to improving quality and efficiency, the Trust has undertaken capacity and demand modelling with key services e.g. District Nursing, School Nursing and Health Visiting. A clinically led approach, which was informed by patients’ needs and supported by the service improvement team, has enabled staff to redesign the workforce profile. This has resulted in a greater congruence between skill mix and case mix.

As part of the planning process our workforce profile factors in the Cost Improvement Programmes - The Trust’s activity remains fairly constant and the emphasis is upon increasing productivity, via skill mix and service redesign to support the CIP programme and ensure maximum service efficiency, whilst maintaining quality. CIP plans have been reviewed through the Trust’s Quality Assurance Process and key workforce indicators are reported on a monthly basis.

Work is progressing with our local CCG’s on response to the Five Year Forward Plan and supporting relationships with patients and the communities. The Workforce plan focuses on new models of care with dementia, mental health, cancer/palliative care and integrated working models. The priority for 2016/2017 is the integrated Care models and the relationships between primary and secondary care and ‘out of hospital’ care. Our future plans will include the developments of the public health agenda and the greater support for community organisations and also integration with social care.

As a Trust we are aligned to two Local Education and Training Boards to meet our geographical needs. As an organisation we are committed to offering high quality and diverse placements to both pre and post-registration health care professionals and to be the placement provider of choice. We also aim to continue to develop a Learning Environment that not only consistently delivers the Inter-Professional Learning agenda and the Placement Charter but that also provides a rich learning experience for all staff that we employ or host on placement. There is a robust education governance structure in place with clearly defined work-streams, accountabilities and reporting arrangements.
**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. 90% of our doctors have received an appraisal in the last 12 months. The remaining 10% all have an appraisal scheduled within the accepted 15 months cycle.

The Annual RO report for 2014/15 was accepted by the Board in September 2015 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 health care staff within Bridgewater to have up to date, evidence based knowledge, skills and abilities in order to ensure that they can provide safe, effective and compassionate care.

**Mandatory Training**

Statutory and mandatory training is an essential requirement to ensure that we adequately protect patients, staff, and members of the public and to support the quality and clinical effectiveness of services.

The Trust statutory and mandatory training offer was reviewed in 2015. As a consequence the programme content of both of the mandatory and clinical
programmes has been revised and aligned to the National Core Skills Framework and Care Quality Commission (CQC) Standards with the aim of enhancing the offer and the quality of provision in 2016.

Compliance of 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.

**Care Certificate**
The Care Certificate covers 15 standards that set out the learning outcomes, competences and standards of behaviour expected of all healthcare support workers to ensure that they are caring, compassionate and provide quality care. 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.
The workbook is given to eligible staff as part of the Induction process and there are now processes in place to support both the candidate and their Assessor throughout the programme.

**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). The EPD Service has continued to support all staff to further develop their knowledge, skills, practical experience and competencies. This is achieved by completion of an annual Training Needs Analysis which is based on both individual learning and development needs, identified through Personal Development Review, and the Commissioned Service delivery. This ensures that staff have the right skills to deliver a high quality service to meet the identified needs of the population they serve. During 2015/16 training has been provided on a variety of topics including:
- Clinical skills for all Services
- Coaching and Mentorship
- Leadership and management

In addition we continue to support and fund staff to attend external learning and development opportunities and to access academic modules on a wide range of subjects for example:
- Advanced Clinical Skills
- Apprenticeship frameworks, vocational qualifications and cadet programmes
- Clinical assessment and diagnostics
- Non-medical Prescribing
- Prevention and early intervention
- Research and development
Educational Governance and internal Quality Assurance process are in place aligned to the Education Outcomes Framework (DH 2013). This guarantees continual improvement of the training provided and that it matches the expectations of the public, staff, employers, healthcare professional bodies and, if appropriate, statutory requirements.

**Pre-Registration**
A dedicated team of Practice Education Facilitators work in partnership with our clinical staff, Services and local Universities to ensure the maintenance of high quality educational placements and positive learning experiences for all pre-registration students. During 2015/16 this has included a new initiative of developing placements to support undergraduate medical students. The team also supports practice education through the on-going 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 2016/17 we plan to further develop our mandatory training offer as we move over to the National Learning Management System and to review the Training Needs Analysis for Services to ensure that it is more closely related to competencies and high quality Service delivery.

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:
- Pre-degree year of care experience
- Pre-employment programmes
- Skills club programmes for Year 9 students

**Appendix B – Children's Immunisation Data**
Appendix C- 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 2015/16 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 2015 to [the date of this statement]
  - papers relating to quality reported to the board over the period April 2015 to [the date of this statement]
  - feedback from commissioners dated XX/XX/20XX
  - feedback from governors dated XX/XX/20XX
  - feedback from local Healthwatch organisations dated XX/XX/20XX
  - feedback from Overview and Scrutiny Committee dated XX/XX/20XX
  - the trust’s complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated XX/XX/20XX;
  - the [latest] national patient survey XX/XX/20XX
  - the [latest] national staff survey XX/XX/20XX
  - the Head of Internal Audit’s annual opinion over the trust’s control environment dated XX/XX/20XX
  - CQC Intelligent Monitoring Report dated XX/XX/20XX
- 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 Monitor’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
Appendix D Independent Auditors Report