NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

Thursday 7 April 2022, 10am
Virtual meeting via Microsoft Teams

A G E N D A

Item	Time	Item Title	BAF Reference	Action
14/22	**10.00**	**APOLOGIES FOR ABSENCE – Gail Briers** **DECLARATION OF INTEREST IN ITEMS ON THE AGENDA**		**Information** **Assurance**
15/22	**10.00**	**MINUTES OF THE LAST MEETING:** (i) **BOARD MEETING HELD ON 3 FEBRUARY 2022**		**Assurance/ Approval**
16/22	**10.05**	**MATTERS ARISING FROM THE ACTION LOG**		**Action/ Assurance**
17/22	**10.15**	**ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE CHAIR**		
18/22	**10.15**	**SPOTLIGHT ON SERVICES – AHP Workforce Strategy**		**Information**
19/22	**10.40**	**BOARD ASSURANCE FRAMEWORK - presented by Executive Leads and Board Committee Chairs:** BAF 1 Failure to implement and maintain sound systems of Corporate Governance BAF 2 Failure to deliver safe and effective patient care BAF 3 Managing capacity and demand BAF 4 Financial sustainability BAF 5 Staff engagement and morale BAF 6 Staffing levels BAF 7 Strategy and Organisational sustainability BAF 8 Digital Services which do not meet the demands of the organisation	**ALL**	**Assurance/ Approval**

20/22	**11.00**	**KEY CORPORATE MESSAGES**	**BAF1**	**Information**
21/22	**11.20**	**QUALITY - To deliver high quality, safe and effective care which meets both individual and community needs**		
		(i) IQPR presented by Executive Leads	**ALL**	**Assurance**
		(ii) Covid-19 Update Report presented by the Chief Operating Officer	**BAF2,3,6**	**Assurance**
		(iii) Report from the Quality and Safety Committee held on 17 February 2022 presented by the Deputy Committee Chair	**BAF2,3,6**	**Assurance**
10 minute break				
22/22	**12.15**	**SUSTAINABILITY – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability.**		
		(i) Finance report presented by the Director of Finance	**BAF4**	**Assurance**
		(ii) Report from the Finance and Performance Committee held on 24 March 2022 presented by the Committee Chair	**BAF4, 8**	**Assurance**
23/22	**12.35**	**INNOVATION AND COLLABORATION – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living**		
		(i) Integration and collaboration update presented by the Programme Director of Integration and Collaboration	**BAF7**	**Assurance**
24/22	**12.50**	**PEOPLE – to be a highly effective organisation with empowered, highly skilled and competent staff and; EQUALITY, DIVERSITY AND INCLUSION – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.**		
		(i) Report from the People and Organisational Development Committee held on 16 March 2022 presented by the Committee Chair	**BAF5, 6**	**Assurance**
		(ii) Staff Survey Report presented by the Director of People (verbal report)	**BAF5, 6**	**Information**
		(iii) North West Anti-Racist Framework presented by the Director of People	**BAF5,6**	**Information**

25/22	**1.20**	**OVERARCHING CORPORATE GOVERNANCE ITEMS** (i) Russian / Belarussian Interests presented by the Trust Secretary (ii) Board Terms of Reference presented by the Trust Secretary (iii) Board Annual Effectiveness Review presented by the Trust Secretary (iv) Trust Register of Seals Report presented by the Trust Secretary	**BAF1**	**Assurance** **Approval** **Assurance** **Assurance**
26/22	**1.45**	**REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK**	**ALL**	**Information**
27/22	**1.50**	**OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE CHAIR**		**Information**
28/22	**1.55**	**DATE AND TIME OF NEXT MEETING** **Thursday 9 June 2022, 10am, in person meeting – venue details to be provided.**		**Information**
29/22	**1.55**	**MOTION TO EXCLUDE** **(Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960)** **The Trust Board reserves the right to exclude, by its resolution, the press and public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the resolution**		

Bridgewater Community Healthcare NHS Foundation Trust

Unapproved Minutes from a Public Board Meeting
Held on Thursday 3 February 2022, 10am

Meeting held virtually via Microsoft Teams

Present
Karen Bliss, Chair
Colin Scales, Chief Executive
Gail Briers, Non-Executive Director
Linda Chivers, Non-Executive Director
Nick Gallagher, Director of Finance
Aruna Hodgson, Medical Director
Abdul Siddique, Non-Executive Director
Martyn Taylor, Non-Executive Director
Tina Wilkins, Non-Executive Director
Paula Woods, Director of People and Organisational Development
Sally Yeoman, Non-Executive Director

In Attendance
Rob Foster, Programme Director of Integration and Collaboration
Jeanette Hogan, Deputy Chief Nurse
Eugene Lavan, Deputy Chief Operating Officer
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

Observers/members of the Public
Rita Chapman, Lead Governor
Diane McCormick, Public Governor, Halton
Sam Scholes, Head of Corporate Governance

01/22 (i) APOLOGIES FOR ABSENCE
Ted Adams, Medical Director
Lynne Carter, Chief Nurse
Sarah Quinn, Chief Operating Officer

The Chair welcomed all to the meeting.

ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

There were no declarations of interest made.

02/22 MINUTES OF THE LAST MEETING:

2 December 2021

The following corrections were noted:

Page four, final sentence concerning dental waiting lists to be revised. The Board agreed that whilst statement was made, the paragraph should refer to the Trust taking assurance that General Dental Practitioners were picking up the consequences of waiting lists.

Page six, final sentence to read: The Board agreed that the Green Plan, Winter Plan, EPRR and wellbeing pledges to be added to the *Board Assurance Framework* as assurances.

Page seven, item 84/21 to include statement made by member of the public concerning services.

The remainder of the minutes were approved as an accurate record.

03/22 MATTERS ARISING FROM THE ACTION LOG

The Board noted the updates provided against the actions recorded in the log.

It was agreed that the following items were completed and could be removed from the action log:

37/21 Review of meeting (board meeting invites to partners)
66/21i Warrington New Town Deal
80/21iv Green Plan
83/21 Review of meeting/items to be added to the Board Assurance Framework

04/22 ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR

The Chair confirmed that she had not been made aware of any urgent items of business to be taken.

05/22 BOARD ASSURANCE FRAMEWORK

The Trust Secretary reported that due to the increase in pressures of the pandemic within the Trust during December, a decision was taken to stand down the Quality and Safety Committee that month. The Trust then received correspondence on the 24 December 2021 from Sir David Sloman, the Chief Operating Officer of NHS Improvement/England, who advocated Trusts taking a streamlined approach to reporting, meetings and workstreams over the period. The Trust Secretary advised that the remainder of the Board Committees had met with significantly reduced agendas, with a focus on business-critical items only. She confirmed that a review of the Board Assurance Framework would take place during the next cycle of Board Committees.

The Trust Secretary reported that since the circulated report was written, it had been agreed that fortnightly meetings with Staff Side colleagues would be added to the prevent controls for BAF5 and 6 overseen by the People Committee.

Non-Executive Director, Gail Briers advised the Board that although the Quality and Safety Committee had been stood down in December 2021, this happened the day before the meeting was to take place. She had subsequently reviewed the agenda items in December along with the Chief Nurse, with a thorough consideration of the agenda items, risks and any quality impacts with notes taken of the meeting that would be taken through to the next Committee meeting in February 2022.

The Board received the report and acknowledged that thorough review of the Board Assurance Framework would occur as part of the next cycle of committees and updates would be reported back to the April Board meeting.

06/22 KEY CORPORATE MESSAGES

The Chief Executive presented the report which set out Non-Executive and Executive Director activity from December 2021 to February 2022. The Chief Executive advised that the executive team would meet again following their December away day on 1 March to begin to forward plan in the context of recovery from the pandemic and strategic planning. The Chief Executive advised that the Board would today discuss how it could focus on being strategically proactive in effecting change during the creation of the ICB and the clinical focus groups, with an expected hiatus in commissioning arrangements during the coming months. He noted that the establishment of the ICB had been paused until 1 July 2022 with appointments to be made to nine place director roles. The Chief Executive reported that he would be taking part on the interview panel for the Halton Place Director role on 28 February 2022. Appointments had been made to some executive ICB roles, however announcements had not yet been made publicly.

Non-Executive Director, Linda Chivers referred to the hiatus in commissioning arrangements due to the transition to and the delay in the establishment of the ICB to 1 July. She commented that it would be important to ensure that there would be an understanding in the change in activity levels and challenges for the Trust as a community provider as contracts would be rolled over, clarity would be beneficial recognising that there would be an effect on the IQPR where the Trust measured itself against targets. She noted that the Trust could be measuring itself against unsuitable targets including some that may not be achievable in areas that may not be the right focus for the Trust. The Chief Executive provided some reassurance concerning the targets and their validity; whilst the Trust would expect to receive information from the new commissioning body for 2022/23 to add depth and detail to performance standards, he advised that an event had taken place with the Chief Executives involved in the provider collaborative. This discussed the setting of stretch targets for community health services which was something that did not currently exist. This would involve self-determined targets that the Trust could hold itself accountable for the delivery of which would differ from the contractual standards that had been worked to over many years. This would be something more qualitative and reflective of the acuity, case mix and volume of care that the Trust had been providing outside of hospitals. The Chair acknowledged that this presented an opportunity for the Trust to influence metrics and measure meaningful outcomes in the new phase of commissioning.

The Director of Finance advised that regarding contracting, the planning guidance was open for local contracts for 2022/23. He explained that there were weekly workshops being held including Directors of HR and Chief Operating Officers to ensure triangulation and including agreement on planning assumptions. He noted that there had been acute focussed discussions and that there was a need to highlight community providers and the acuity of patients. He added that ERF was focussed on acute settings, however recovery related to all organisations and there was a need for recognition around this and the related complexities. The Director of Finance informed the Board that the Trust was inputting into the weekly discussions with other organisations involved in the provider collaborative including mental health organisations and other community organisations. The Trust was also meeting with commissioners to discuss the baseline for the next year.

The Chief Executive updated Non-Executive Director, Sally Yeoman on the working arrangements between the provider collaborative and the hospital provider collaborative. He confirmed that both met bi-weekly as a pair of collaboratives with independent updates being shared on the work being undertaken and that there had been discussion regarding engagement on a number of workstreams, the most prominent of those being discharges. It was expected that there would be further opportunities as workplans were formulated for the two collaboratives to engage on further work. The Chief Executive added there was a shared view that the collaboratives working together would present benefits to level up standards in community health care, working with the third sector, other community organisations and primary care colleagues and addressing health inequalities and connecting at the interface for supporting hospital discharges and interventions for people waiting for out-patient follow

up appointments could then receive support via community integrated teams. He recognised that work was currently at an early stage and this was expected to develop further over the next months.

07/22 QUALITY - To deliver high quality, safe and effective care which meets both individual and community needs

(i) IQPR

The Chief Executive reflected that it had been an atypical period between board meetings in terms of the work that had been undertaken. He commented that the Board would gain a sense of the pressures and demand for services and acuity and the significant challenges that the Trust had faced concerning sickness absences with similar levels having been experienced nationally. He advised that there was now an improvement in those levels and there were statistics within the report to demonstrate how the organisation had been affected by sickness and the redeployment of staff into priority one services or other parts of the system where there had been significant pressures. **The Chief Executive reported that there had been issues concerning community dental data being included within the IQPR. He advised that given that this detail did not feature in this report or elsewhere on the Board agenda that a report setting out the information, risks and any actions being taken would be circulated to the Board.** It would also be ensured that this information would also be included within the next IQPR around dental services.

The Deputy Chief Operating Officer reported that a full suite of dental services information with Key Performance Indicators (KPIs) would be available within future IQPR reports. He presented an overview of the operations indicators and advised that there were continuing challenges in terms of the Warrington cancer 31 day waits from diagnosis to treatment which had changed from a green rating to a red rating in month, however there had been improvements in the Warrington 62 day dermatology referral to treatment indicator. He also noted challenges on a new indicator around 28 day cancer faster diagnosis. The Deputy Chief Operating Officer informed the Board that significant staffing challenges were continuing. The Trust was engaging via the procurement framework with a national insourcing framework to secure new capacity. This work would include a specific consultation on surgery which would aim to address the above targets and supporting clearing of any backlogs, alongside delivering services as usual. The Deputy Chief Operating Officer advised that the Trust was delivering against the dermatology two week waits consistently, however there remained issues around GP referrals, with a number of those patients being downgraded once seen by services. He explained that the Trust was working with primary care colleagues and redesigning the front interface to provide advice to GPs from consultant dermatologists that would support the appropriate management of patients. The Trust would then be enabled to manage capacity more systematically. The Deputy Chief Operating Officer reported that challenges continued within the community paediatrics service but the total waiting lists were beginning to level off with additional consultants now in post to enable the management of the waiting lists. Conversations were ongoing to retain those consultants at the end of April to continue to make reductions in the waiting lists.

Non-Executive Director, Tina Wilkins referred to the insourcing work and capacity and asked if this had been costed and whether there would be a financial impact. The Deputy Chief Operating Officer advised that the Assistant Director of Finance had been involved in the working group for this and the Trust had not incurred any spend on locums therefore there was a benefit, and in addition the current outsourcing arrangement hadn't provided any support providing a further financial benefit. The Director of Finance added that as part of the planning process for 2022/23, there would be cost pressures included in the baseline assessment. Any additional pressures would therefore be included within the plan and discussions would take place centrally on funding.

Non-Executive Director, Gail Briers highlighted that the Quality and Safety Committee would be undertaking a deep dive review concerning dermatology at its next meeting on the 17 February, focussed on the qualitative impact and challenges faced by the service. The Deputy Chief Operating Officer noted that there was a dermatology service improvement plan in place with a task and finish group meeting fortnightly which included qualitative elements along with a new clinical harm review process that was in place reviewing long waits and any impacts in terms of harm.

The Deputy Chief Nurse reported on quality indicators: She noted that seven indicators were red rated. In terms of indicators related to patient safety, she advised that a number of areas were positively reporting in month: management of incidents, falls, pressure ulcers and patient experience. One area related to patient safety reporting as red: percentage of risks identified as high at 47.8%. The Deputy Chief Nurse noted that this was a positive however, as there were less risks reporting as high. She considered that this was reflective of the maturity of the systems and processes in place to understand and quantify risks and the discussions and constructive challenge taking place at the Risk Management Council. This was also supported by fortnightly QIA panels.

The Deputy Chief Nurse reported that there were six red rated indicators in relation to mandatory training compliance: information governance, safeguarding training and PDR compliance. She noted that there had been challenges across the previous two years with mandatory training compliance alongside clinical priorities and maintaining service delivery, and that discussions had been taking place at a number of forums including the People Committee concerning this matter. Actions were continuing to drive progress forward at executive level, and there had been a slight increase observed in safeguarding adults level three training, however the other areas had deteriorated. The Deputy Chief Nurse highlighted that there had been previous issues experienced concerning the correct reporting of training once it had been completed by staff, and also staff being allocated the correct level of safeguarding training for their role following the release of national guidance. As a result there had been a decrease in compliance. She confirmed that work was continuing to understand priorities of operational services, working with teams to ensure they were getting up to date with mandatory training ensuring staff and patient safety.

The Director of People added that there had been considerable efforts made to increase compliance. She explained that a small team would be reviewing progress across each service area, working with staff with lower uptake levels to support them to undertake their training. She advised that both herself and the Chief Nurse were committed to reviewing the trajectories on mandatory training. As well as discussions at the People Committee, this matter was also being discussed at the performance council. The Board recognised that there was a balance required in terms of the emphasis on the need for staff to be fully compliant with their mandatory training to ensure staff and patient safety and recognising that it was important also not to overwhelm staff.

Non-Executive Director, Linda Chivers noted that mandatory training was still shown within the Board Assurance Framework as a tolerated risk. She challenged that the Board must consider if this remained appropriate, highlighting that the Trust had been through a number of challenges during the pandemic and would continue to do so as it recovered and dealt with any new variants that may emerge alongside the impact on staff resilience and wellbeing. She suggested that it would be important to consider the messages being shared with staff, avoiding placing further pressures on teams and including staff in the solution concerning mandatory training compliance and ensuring that they were safe to practice.

Non-Executive Director, Gail Briers advised the Board that the Quality and Safety Committee would receive an update to its February meeting concerning the development of quality indicators. She noted that the Committee had also discussed information governance training compliance as this matter had been escalated to Finance and Performance Committee and this had also been discussed at the Audit Committee.

Non-Executive Director, Linda Chivers observed a deteriorating position in medication errors. Whilst she acknowledged the current pressures for staff, she highlighted that there must be assurance that the organisation was addressing this noting that it would be a short step from medication errors to patient harms. The Deputy Chief Nurse acknowledged this and advised that the messages around this to staff were vital, ensuring the right culture was in place with the right local leadership which had been worked on. She explained that medication errors were routinely monitored at the quality council and that medicines management colleagues had undertaken significant work to raise awareness. She added that there had been work around insulin management as a quality indicator with a focussed quality report being produced as there had been some identified issues within this sphere. This would be taken through to the quality council. The reporting would include incidents internally and externally where the Trust had been impacted. Non-Executive Director, Tina Wilkins commented that alongside any work on this, it would be important to have a good communications strategy.

Non-Executive Director, Tina Wilkins highlighted target dates within the report for mandatory training which had been impacted by the pandemic. She asked whether new target dates had been considered for those areas and whether there would be a trajectory to enable performance management going forwards? The Director of People confirmed that this was being actioned as a priority between herself and the Chief Nurse, with trajectories to be agreed with monitoring to be undertaken of the mandatory training compliance reports and identification of any areas that were ahead and behind plan. Any challenged areas would be highlighted and there would be a risk assessment process with priority areas being reviewed and risk assessed.

The Director of People presented an overview of the People indicators. She highlighted the dashboard on page 15, with the five people indicators reporting as red for the month of November. She noted that since the report, there had been improvements in three of the indicators: turnover, actual sickness absence rates and PDRs. Attendance at induction remained at 99%. The Director of People referred to a recommendation to the Board from the People Committee, outlined in the Committee Chair's report later in the agenda, which recommended a change in the indicator for attendance at induction moving from 100% to 95%. If approved, this indicator would immediately be green rated. Turnover remained at around 14% against the target of 8%, however compared to the same time last year, this was 19.3% and therefore this was reducing. The main reasons behind this were better reward packages with staff moving around for other incentives and retirement. This had been reviewed at People Committee. Rolling sickness absence had slightly increased from 5.92% to 5.98% in addition, actual absence had decreased from 6.48% to 6.22% against a target of 4.8%. Absence had peaked at 14% which was unprecedented to the Trust. This was being monitored daily and the trends experienced by the Trust were being mirrored nationally, regionally and locally. The detail of absence trends were discussed at the People Committee. PDR take up had increased from 47.54% to 57.45%. against a target of 85%.

The Board noted the finance elements of the report, acknowledging that the finance report for month nine would be presented later in the agenda.

(ii) Trust Response to Omicron

The Deputy Chief Nurse presented the report, focussed on the actions taken in response to the current phase of the pandemic. She reported that on 13 December 2021, the Trust had received guidance via a letter 'Preparing the NHS for the potential impact of the Omicron variant and other winter pressures' on how to manage its services. This had been carefully considered by the executive management team and actions had been identified along with key priorities across December, January and February which were set out within the report.

The Deputy Chief Operating Officer reported that redeployment had taken place into priority one services, with learning applied from the previous waves of the pandemic. He advised that the Trust had appointed to posts in services which supported redeployment. The Trust

planned to continue with electives and priority one services whilst contributing to system flow. He acknowledged that the system continued to experience high levels of pressure and commented that it would be important to be cognisant of the extreme pressures that the Trust was contributing support to and managing and that resources had been put into place in anticipation of those pressures.

Non-Executive Director, Tina Wilkins asked if there would be an opportunity to receive feedback from staff and patients from the current phase of redeployment. The Deputy Chief Operating Officer advised that a full evaluation was undertaken during the first and second phase of the pandemic, and from this staff had advised that they wanted a more flexible approach. He explained that the Trust had ceased a number of elective services in previous waves but hadn't done so during the current wave as this was also a learning point from previous evaluations as well as directives from national guidance. There had been a more tactical approach deployed for the current wave with less staff being redeployed as there had been recruitment undertaken.

The Director of People provided a verbal update regarding Vaccination as a Condition of Deployment (VCOD). The mandate had currently been paused and the Trust had been advised not to issue notices of dismissal to any unvaccinated staff. A communication had been issued to staff to inform them of this and letters had been issued to affected staff directly. The Director of People advised that currently there had been no further information provided concerning the launch of the two-week consultation to confirm the reversal the mandate and when this would take place. However, the centre had advised that there would be a continued focus on professional responsibility and accountability concerning vaccination going forwards. The NHS had also been asked to review its policies on the hiring of new staff, and the deployment of existing staff, taking vaccination status into account. The Code of Practice, applicable to all CQC regulated services, was also to be updated in line with the latest guidance and Infection, Prevention and Control measures. The Director of People advised that there were still some questions to be resolved, such as whether staff continue to pursue exemptions via 119, and questions in relation to the guidance that the NHS was previously tasked with implementing. She explained that one key area of concern for HR Directors was currently recruitment pipelines, offers of employment that were already in the system, recruitment checks that were underway linked to occupational health that would check the vaccine status of individuals. A clear position was also required in terms of future advertising of roles. The Director of People confirmed that the Trust was continuing to take all necessary steps to support its staff and keep all updated. It was anticipated that further information may be available by the end of 4 February 2022.

Non-Executive Director, Martyn Taylor referred to hospital acquired covid-19, where patients were thought to have contracted covid in hospital, he asked whether the Trust tracked data to show where any patients could have contracted covid within any of its estates. He also asked whether the Trust would be involved in an imminent national review of hospital onset covid-19. The Deputy Chief Nurse advised that the Trust held one bed based intermediate care unit, Padgate House. If it appeared that a patient had contracted covid-19 whilst at Padgate House she advised that an investigation and root cause analysis would be undertaken. In terms of the imminent review, the Deputy Chief Nurse advised that information was awaited to clarify if the review would include acute settings only or if this would be widened to other areas such as care homes and intermediate care.

The Board received the report and acknowledged the key priorities and actions taken. The Board took the opportunity to thank all staff for their considerable work over a significantly challenging period.

(iii) Learning From Deaths Report

Medical Director, Aruna Hodgson presented the six-monthly report which provided an overview on the deaths of patients who were receiving services from the Trust at the time of their death. The Trust would utilise this information to develop further learning.
She explained that one key theme was that the total overall number of deaths for 2021 was broadly similar to that from previous reports, with a reduction of deaths in quarter one and

two compared to the same period in 2020 and this reflected the number of deaths at that time due to the pandemic. Each individual death that was subject to the learning from deaths process underwent an individual review. She advised that one area of identified learning was communication that could be improved between teams when a death had occurred. However there had been an improvement in this area compared to the last report but that some further work was still required.

Non-Executive Director, Linda Chivers referred to previous internal audit reviews that had been conducted into quality spot checks which had highlighted the consistency and embeddedness of NEWS2. She commented that the under-utilisation of NEWS2 being highlighted as a theme in the report was disappointing as the Trust was not then making full use of the tools at its disposal. Medical Director, Aruna Hodgson questioned whether the timings of the learning from deaths review may be out of alignment as there had been work undertaken to embed NEWS2 which could have improved since the last quarter information was produced, outdated by the quality spot check audit. The Deputy Chief Nurse advised that a report would be taken to the February Quality and Safety Committee meeting concerning the quality spot check which would outline work that had been undertaken. She confirmed that the Trust would be re-audited concerning this and that the dates for this had been agreed with MIAA. She added that considerable work had been undertaken to embed the necessary processes around documentation. She suggested that there was a factor to be investigated between this and the information around NEWS2 within the learning from deaths report.

The Board received the report for note.

08/22 SUSTAINABILITY -– to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability

(i) Finance Report

The Director of Finance presented the report to the Board setting out the financial position for month nine. The Trust was reporting a £320k surplus against plan. The Director of Finance explained that some elements to the recovery plan due to the pandemic had been delayed particularly around Dental General Anaesthesia (GA) sessions which had primarily driven the current underspend. The Trust had been asked by the centre to forecast a breakeven position for the end of the year which the Director of Finance reported would be achieved, He highlighted some key elements from within the circulated report, including that capital spend was below plan and was being monitored regularly with a capital group monitoring individual schemes on a monthly basis, reporting into the Finance and Performance Committee. Any slippage around the schemes would be re-prioritised.

The Director of Finance reported that run rates were stable. CIP of 2.5% was being achieved primarily via non-recurrent schemes which would be addressed moving into the new financial year and some work had been undertaken concerning this in advance. He explained that transformational work with partners would be a key element of this going forwards.

The Director of Finance highlighted the Trust's performance against the Better Payment Practice Code (BPPC) with a significant achievement against the target with 96% of invoices paid. This meant that the Trust was also just below the 95% national target. The Director of Finance advised that this achievement was due to budget holders across the organisation and the finance team working well on this as a whole. The Board welcomed this achievement and the work on this undertaken across the Trust.

(ii) Report from the Finance and Performance Committee held on 20 January 2022

The Board received a report from the latest Finance and Performance Committee from the Committee Chair, Tina Wilkins.

(iii) Report from the Audit Committee held on 13 January 2022

The Board received a report from the latest Audit Committee meeting from the Committee Chair, Linda Chivers.

09/22 PEOPLE – to be a highly effective organisation with empowered, highly skilled and competent staff and;
EQUALITY, DIVERSITY AND INCLUSION – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.

(i) Report from the People and Organisational Development Committee held on 19 January 2022

The Board received a report from the latest People and Organisational Development Committee from the Committee Chair, Abdul Siddique.

The Board approved the recommendation of the People Committee to amend the target for attendance at the Trust corporate induction from 100% to 95%. This was considered to be a more realistic target. The Board also approved the Gender Pay Gap Report which had been recommended to the Board for approval by the People Committee.

Non-Executive Director, Linda Chivers as the Audit Committee Chair, reminded the Board of the importance of undertaking Trust mandatory and statutory training and emphasised the need for the Board to lead by example and to ensure that Board members were fully compliant. The Chair acknowledged the importance of this point, commenting that the Trust was asking staff to prioritise this training and the Board had a responsibility to lead by example in this area.

(ii) Armed Forces Bill – Equality Update

The Director of People presented the report to the Board concerning new UK legislation in relation to the Armed Forces Bill 2021, for public sector organisations delivering services to the armed forces community. This covered provision of services and employment opportunities. She explained that an action plan had been put into place in response to this that would be progressed via the People PODs and People Hub, with progress reports to be taken through the People Committee with any exceptions being reported to the Board.

The Director of People advised that in addition to the information set out within the circulated report concerning ongoing work in relation to veterans, the Chair of the Veteran Aware programme, funded by NHS Improvement/England would be contacting NHS Chief Executives during February 2022 outlining a covenant and some pledges that organisations would be invited to sign up to. In addition to this, the Trust would also nominate an armed forces champion. The Board received the report for note and would be kept informed via the People Committee.

10/22 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) **Policies for Ratification**

The Trust Secretary presented the report and reminded the Board that in September 2021 the Board approved the Policy and Procedures process which outlined the controlled environment in which policies, guidelines, procedures and clinical pathways are approved to be used within the Trust. There were nine policies, listed within the circulated report that had been approved by the Corporate and Clinical Policy Group (CCPG) and signed-off by their recommending committees. Those policies now required Board ratification before being finalised and disseminated throughout the Trust.

The Trust Secretary explained that those policies were not appended to the report due to the fact they remained in draft form and due to the volume of papers this would create. She had advised Board members prior to the meeting that copies of the policies were available via the

policy officer. The Board was also asked to agree the future ratification of policies via e-governance recognising that the Board met six times per year and there may be policies for approval between those meetings taking place. This would prevent any delays in approvals.

Following discussion, **the Board agreed that a further paper would be circulated via e-governance to provide further assurance: to confirm the membership of the Corporate and Clinical Policy Group and where and when each policy for ratification had been considered previously. This paper must also clarify the role of the Board in terms of the approval of policies.** The Board agreed that future policies could be ratified via e-governance with a similar tracker to be provided to set out the timelines and forums where policies had been considered.

11/22 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

The Board agreed that there had been a good range of discussions and a good quality of presentations and reports.

It was agreed that statutory and mandatory training, particularly the Information Governance training, would be added to the narrative of the Board Assurance Framework. Non-Executive Director, Linda Chivers highlighted the potential impact of this on any future well-led review and the need for the Trust to understand wider ramifications. A robust communications plan around this would be key.

12/21 OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

No questions were raised.

13/21 DATE AND TIME OF NEXT MEETING

Thursday 7 April 2022, 10am, via Microsoft Teams.

MOTION TO EXCLUDE

(Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960)

The Trust Board reserves the right to exclude, by its resolution, the press and public wherever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons, stated in the resolution.

ACTION LOG

Key

Red	**Significantly Delayed and / or of High Risk**
Amber	**Slightly Delayed and / or of Low Risk**
Green	**Progressing to timescale**
Blue	**Completed**

Meeting: Bridgewater Community Healthcare NHS Foundation Trust Board – Public Meeting

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
30.09.21	64/21i	Finance Report	**The Board recognised that the Trust currently held a healthy cash balance and a decision was to be taken by the Board as to where this would best sit – either internally or to support the system. A Board discussion would take place, with background to the achievement of the cash balance, in December 2021.**	Nick Gallagher	**GREEN**	02.12.21 It was agreed that a further discussion would take place on this matter once more information was available from the centre.
02.12.21	77/21	BAF	**Board Committees to review the BAF and decide any actions to be removed that are outdated.** **BAF 8 – current risk score to be updated from 8 to 12 as agreed by the Finance and Performance Committee.** **BAF3 – Sarah Quinn to link in with Jan McCartney to provide amendments/updates.**	Jan McCartney	**BLUE**	April 2022: item completed – updated Board Assurance Framework included on the agenda.
03.02.22	07/22	IQPR	**There had been issues concerning community dental data being included within the IQPR. A report setting out the information, risks and any actions being taken would be circulated to the Board.**	Sarah Quinn/Eugene Lavan	**BLUE**	Information has been circulated to Board members.

ACTION LOG

Key

Red	**Significantly Delayed and / or of High Risk**
Amber	**Slightly Delayed and / or of Low Risk**
Green	**Progressing to timescale**
Blue	**Completed**

Meeting: Bridgewater Community Healthcare NHS Foundation Trust Board – Public Meeting

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
03.02.22	10/22	Policies for Ratification	**It was agreed that a further paper would be circulated via e-governance to the Board for assurance: to confirm the membership of the Corporate and Clinical Policy Group and where and when each policy for ratification had been discussed previously. This would also clarify the role of the Board in this process.**	Jan McCartney	**BLUE**	Item is now closed – policies have been ratified and process has been agreed for future ratification.
03.02.22	11/22	Board Assurance Framework	**It was agreed that the current position regarding statutory and mandatory training would be added to the narrative of the Board Assurance Framework, particularly in relation to information governance training.**	Jan McCartney	**BLUE**	BAF5 refers to statutory and mandatory training.

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date	7 April 2022
Board Part	Public
Agenda item	19/22

Title	Board Assurance Framework
Sponsoring Director	Colin Scales – Chief Executive Officer
Authors	Jan McCartney – Trust Secretary
Presented by	Committee Chairs and Lead Executive Directors
Exec Summary/Purpose	To approve the recommendations from the Committees of the Board
Previously considered at	N/A
Related Trust Objective/ Intentions	**Quality** - To deliver high quality, safe and effective care which meets both individual and community needs **People** – to be a highly effective organisation with empowered, highly skilled competent staff
Which BAF risks are addressed in this report?	**BAF 1 – Corporate Governance**
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	
Equality Impact assessment	
Next steps	
Recommendations	To approve the recommendations from the Committees of the Board

Bridgewater Community Healthcare NHS Foundation Trust

Title	Board Assurance Framework
Author	Jan McCartney – Trust Secretary
Date	7 April 2022
Purpose	To approve the recommendations from the Committees of the Board
Audience	Trust Board

1.0 EXECUTIVE SUMMARY

1.1 The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.

1.2 The BAF is the key mechanism which the Board uses to hold itself to account. It provides a structure to focus on risks that might compromise the Trust in achieving its strategic objectives and confirms to the Board of Directors that there is sufficient assurance on the effectiveness of controls.

1.3 The Board Assurance Framework is received at the Board, all the Committees of the Board and other key decision-making / operational meetings. It is a working document that is used in Committees and meetings to ensure the meeting agendas remain focused and proactive on strategic objectives.

1.4 The Board last met on 3 February 2022 at which the Board requested that each Committee conduct a thorough review of each BAF, removing legacy information and ensuring it was up to date. Except for the Audit Committee, which is due to meet on 27 April 2022, the Committees have reviewed their sections and make the recommendations in section 2.

2.0 CHANGES TO THE BAF

2.1 **BAF1 – Failure to implement and maintain sound systems of Corporate Governance**

This Audit Committee has not met since the last Board meeting; therefore, no changes are recommended. The Audit Committee will next meet on 27 April 2022.

2.2 **BAF2 – Failure to deliver safe and effective patient care**

The Quality & Safety Committee met on 17 February 2022 and the following changes are recommended.

Prevent Controls – updates were made to reflect the current structures in plan

Audits – the audits from 2018/19 were removed as the committee felt they no longer provided assurance

Gaps in Control – this was updated to reflect the risks more accurately on paediatric exodontia and 'staff compliance with mandatory and service specific training' was added.

The risk rating was reviewed, and the committee agreed that the current risk rating of 15 was appropriate.

2.3 **BAF3 – Managing demand and capacity**

The Quality & Safety Committee met on 17 February 2022 and the following changes are recommended.

Prevent Controls – Health roster implementation was added

Audits – the audits from 2019/20 were removed as the committee felt they no longer provided assurance.

Gaps in Control – this was updated to reflect the controlled re-deployment arrangements.

The risk rating was reviewed, and the committee agreed that the current risk rating of 16 was appropriate.

2.4 **BAF4 – Financial sustainability**

The Finance & Performance Committee met 24 March 2022 and the following changes were made

Principle Risk – This was updated to reflect the revision in funding regime.

Prevent Controls / Detect Controls / Assurances – Updated to remove out of date controls and MIAA audits over 3 years old.

Gaps in Control – This section will be updated one the final plan has been approved and submitted.

The risk rating was reviewed, and the committee agreed that the current risk rating remains appropriate.

2.5 **BAF5 – Staff engagement and morale**

The People & OD Committee met on 16 March 2022 and the following changes were agreed:

Principle Risks – reference to 'mandatory vaccination' was removed.

Prevent Controls – added the following: People Hub and PODs, Culture & Leadership, Recruitment & Retention, Health & Wellbeing, and Education and Professional Development.

Gaps in Control – The committee is no longer tolerating the risk relating to mandatory training, section updated.

The risk rating was reviewed, and the committee agreed that the current risk rating remains appropriate.

2.6 **BAF6 – Staffing levels**

The Quality & Safety Committee met on 17 February 2022 and the following changes are recommended.

Rationale for current score – this was updated to reflect the proposed wording received from the People and Organisational Development Committee.

Assurances – Healthcare support workers, this assurance was updated to the current position.

Audits – all audits prior to 2019/20 were removed as the committee felt they no longer provided assurance

The risk rating was reviewed, and the committee agreed that the current risk rating of 15 was appropriate.

The People & OD Committee met on 16 March 2022 and the following changes were proposed:

Rationale for Current Score – reference to mandatory Covid vaccination removed.

Prevent Controls – added the following: People Hub and PODs, Culture & Leadership, Recruitment & Retention, Health & Wellbeing, and Education and Professional Development.

2.7 **BAF7 – Strategy and organisational sustainability**

The Finance & Performance Committee met on 24 March 2022 and the following changes were made:

Prevent Controls / Assurances – these sections were updated to reflect the current governance and meeting arrangements with partners within the system.

The risk rating was reviewed with no change recommended.

2.8 **BAF8 – Digital Services which do not meet demands of the organisation**

The Finance & Performance Committee met on 24 March 2022 and the following changes were made:

Principal Risk – A minor update to the wording was made to reflect the style of the other strategic risks on the assurance framework.

Prevent Controls / Detect Controls / Assurances – Updated to remove out of date controls and MIAA audits over 3 years old.

Gaps in Controls – This section was updated to reflect current gaps.

The risk rating was reviewed with no change recommended.

The committee asked the Assistant Director of IT and the Director of Finance to meet before the next committee meeting to conduct a full review of this BAF.

3.0 RECOMMENDATION

3.1 The Board is asked to approve the changes recommended by the committees.

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 29 March 2022

STRATEGIC OBJECTIVES

- **Equality, diversity and inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
- **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living
- **People** – to be a highly effective organisation with empowered, highly skilled and competent staff
- **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs
- **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability.

BAF 1	BAF 2	BAF 3	BAF 4	BAF 5	BAF 6	BAF 7	BAF 8
Failure to implement and maintain sound systems of Corporate Governance	**Failure to deliver safe & effective patient care**	**Managing demand & capacity**	**Financial sustainability**	**Staff engagement & morale**	**Staffing levels**	**Strategy & organisational sustainability**	**Digital services which do not meet demands of the organisation**
BAF 1	**BAF 2**	**BAF 3**	**BAF 4**	**BAF 5**	**BAF 6**	**BAF 7**	**BAF 8**
Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4(C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2(L) = 8, **medium**	Inherent risk rating 5(C) x 5 (L) = 25, significant Current risk rating 5 (C) x 3 (L) = 15, significant Target risk rating 5(C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 4 (L) = 16, significant Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 1 (L) = 4, **low**	Inherent risk rating 5(C) x 4 (L) = 20, significant Current risk rating 5 (C) x 3 (L) = 15, significant Target risk rating 5 (C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 3 (L) = 12, **high** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4 (C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 2 (L) = 8, **medium**

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 1:	TRUST OBJECTIVES:	RISK RATING:	RISK APPETITE:
Failure to implement and maintain sound systems of Corporate Governance	• People • Sustainability	Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4(C) x 2 (L) = 8, **medium** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**CAUTIOUS**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Executive Officer Deputy CEO / Chief Nurse Last reviewed: Oct 2021 Audit Committee Last reviewed: Oct 2021 Risk Ratings reviewed: Oct 2021	**Failure to implement and maintain sound systems of Corporate Governance.** If the Trust is unable to put in place and maintain effective corporate governance structures and processes; Caused by insufficient or inadequate resources and / or fundamental structural or process issues caused by the pandemic; CQC, Requires Improvement for 'Well Led' **Risks on register 15 plus** No risks at this level	Governance structure approved by Board and audited by internal auditors. Substantial Assurance - Heads of Audit opinion 2020/21	**Prevent Controls** • Trust Board • Governance structure approved by the Board, SFIs and Scheme of Reservation and Delegation • Operational management structure (currently under review) and policies and procedures are in place • Board Assurance Framework **Detect Controls** • The committees receive by exception reports from operational leads these are reported to the Board • Staff engagement • Performance Council established • Senior Leadership Team meeting monthly • Risk Management Council • Executive Review **Assurances** • Clean Unmodified Audit Opinion & clean VFM opinion 2020/21 • Board, committees (Quality & Safety, Finance & Performance, and People) • Trust continuous improvement plan in place • Internal Audit Plan agreed for 21/22 • Participating in Moving to Good programme / Leader in Me • CQC Well Led programme • External independent Well Led review • Daily automated data reporting • Governance Structure • Declarations of Interests Register • Audit Committee Effectiveness Review (2020/21) • Effectiveness Review of External Audit and Anti-Fraud (2020/21) • Board Assurance Framework Review – (2020/21) • Risk Management Audit – substantial assurance (2021/21) • DSPT Audit – substantial / moderate assurance (2021/21)

Gaps in controls and assurance: (and mitigating actions)
CQC rating 'requires improvement' within Well Led Domain – External well led review complete.
Audit Committee monitoring recommendations

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 2:	TRUST OBJECTIVES:	RISK RATING:	RISK APPETITE:
Failure to deliver safe and effective patient care	• Quality	Inherent risk rating: 5 (C) x 5(L) = 25, **significant** Current risk rating: 5 (C) x 3(L) = 15, **significant** Target risk rating: 5(C) x 2 (L) = 10, **high**	**MINIMAL**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Nurse / Deputy CEO / Last reviewed: Feb 2022 Quality & Safety Committee Last reviewed: Feb 2022 Risk Ratings reviewed: Feb 2022	**Failure to deliver safe & effective patient care.** There is a risk that the Trust may be unable to achieve and maintain the required levels of safe and effective patient care. This could be caused by the effects of the pandemic and its recovery, inadequate clinical practice and/or ineffective governance. If this were to happen it may result in widespread instances of avoidable patient harm, this in turn could lead to regulatory intervention and adverse publicity that damages the Trust's reputation and could affect CQC registration. **Risks on register 15 plus** 2930 – Derm – cancer waiting times 2928 – Safeguarding IHA Pathway	Quality & safety governance structure in place. Robust QIA process for all services Number of ongoing high risks	**Prevent Controls** • Current Command and Control Structure in place • Clinical policies, procedures & pathways • Risk Management Council & Quality Council in place • Quality Impact Assessment Process • Trust Strategy – Quality and Place • Freedom to speak up guardian in place • **Detect Controls** • Quality & Safety Committee bimonthly meetings • Clinical & Internal Audit Programme • IQPR & quality dashboards • Quality Council • Learning from deaths report • Clinical Quality and Performance Groups (CQPGs) in place with all NHS commissioners. • Increased reporting of incidents, including medication incidents • Equality Impact Assessments • Quality Impact Assessments • End of Life group • Health and Safety group • Silver and Gold command and control **Audits** • Risk Management Substantial Assurance (2020/21) • Trust Improvement Plan – Significant Assurance (2019/20) • Quality Spot Check – Moderate Assurance (2020/21) • Quality Spot Check – Limited Assurance (2021/22)

Gaps in controls and assurance: (and mitigating actions)
Q&S Committee noted the number of high risks and accepted that recovery is likely to be a lengthy process, thus accepting overall the risk of 5 x 3 =15 significant
Capacity / demand risks - to be addressed as part of the People plan
Dental Services – paediatric exodontia - currently developing clinical harm review process
Staff compliance with mandatory and service specific training

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 3: Managing demand and capacity	TRUST OBJECTIVES: • People • Quality	RISK RATING: Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 4(L) = 16, **significant** Target risk rating: 4(C) x 2 (L) = 8, **medium**	RISK APPETITE: CAUTIOUS

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Operating Officer Last reviewed: Feb 2022 Quality & Safety Committee last reviewed: Feb 2022 Risk Ratings reviewed: Feb 2022	**Managing demand & capacity** If the Trust is unable to manage the level of demand; Caused by insufficient resources and / or fundamental process issues; or due to the recovery process following the pandemic It may result in sustained failure to achieve constitutional standards in relation to access; substantial delays to the treatment of multiple patients; increased costs; financial penalties; unmanageable staff workloads. **Risks on register 15 plus** 2930 – Derm - cancer waiting times	Quality & Safety Committee (temporarily stood down). Risk Management Council meets monthly. Daily joint operations and nursing meetings. Waiting lists increase due to Covid & pausing services. Managed risk with approval from the Board. Quality and safety under constant review to ensure no patient harm.	**Prevent Controls** • Quality & Safety Committee • Indicative activity baseline analysis • Patient pathway management arrangements • System One PAS – Patient Administration System • RTT lists to track 6 week and 18 week access standards • Risk management council • Monthly workforce information reports • Winter plans • IQPR • Daily Operations and Nursing meetings • EPPR • Health roster implementation • **Detect Controls** • Borough Quality & FWP meetings to gain overview of risks in relation to capacity at local level • Weekly Operational Management Team meetings • Temporary Command and Control meetings (Bronze/ Silver & Gold) • Contract meetings with commissioners & 1:1 meetings with commissioners • Daily system pressure calls • Workforce Strategy in place / Workforce POD • Audits monitored at each relevant Board Committee, exception reports to Audit Committee • Performance Council
Gaps in controls and assurance: (and mitigating actions) Controlled re-deployment to support priority 1 services			

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 4: **Financial sustainability**	**TRUST OBJECTIVES:** • Sustainability	**RISK RATING:** Inherent risk rating: 4 (C) x 4(L) = 12, **high** Current risk rating: 4 (C) x 3(L) = 12, **high** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **OPEN**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Director of Finance Last reviewed: March 2022 Finance & Performance Committee last reviewed: March 2022 Risk Ratings reviewed: March 2022	**Financial sustainability** If the Trust is unable to achieve and maintain financial sustainability; Caused by the scale of any recurrent deficit and the effectiveness of plans to reduce it; it may result in loss of public and stakeholder confidence with the potential for regulatory action. **Risks on register 15 plus** No risks at this level	Financial governance arrangements in place Bi-monthly F&P Committee National COVID-19 arrangements in place	**Prevent Controls** • Accountability Framework and Standing Financial Instructions with limits approved by the Board. • Financial plan and budgets signed off by the Board and submitted to NHSI • Process around Capital and Revenue Business Cases • Robust temporary staffing expenditure control and monitoring – MIAA follow up in progress **Detect Controls** • F&P Committee review bi- monthly financial performance • Audit committee receives reports from internal audit and external audit • Exec team and Committees receive Audit Recommendations tracker • HCP/ICS control and reporting • NHSE/I monthly returns **Assurances** Monthly Finance Report including • Financial position / Forecast Position • Cash & Capital • Working Capital • CIP **Internal audit** reports including • CIP – moderate assurance (2019/20) • Key Financial Systems (2020/21) and high and substantial assurance (2021/22) • Board review of internal audit plan **External audit** • Audit review findings – Clean Unmodified Audit (2020/21) • Board review of external audit plan and annual accounts

Gaps in controls and assurance: (and mitigating actions)
For H1 the Trust delivered a break-even position. H2 plans have been submitted to both HCP and NHSE/I. H2 plan is for breakeven position leading to overall breakeven position for 21/22
The Trust is setting budgets in line with recurrent expenditure to ensure budget monitoring control and reporting is in place. All Grip and control measures remain in place.
UTC contract not yet finalised

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 5: Staff engagement and morale	TRUST OBJECTIVES: • People • Quality	RISK RATING: Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 3(L) = 12, **high** Target risk rating: 4(C) x 1 (L) = 4, **very low**	RISK APPETITE: **OPEN**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Director of People and OD Last reviewed: Nov 2021 People Committee Last reviewed: Nov 2021 Risk Ratings reviewed: Nov 2021	**Staff engagement & morale** If the Trust loses the engagement of a substantial sector or sectors of its workforce. Caused by uncertainty of internal and/or external factors, influences and conditions i.e., pandemic. Impact on leadership and management practices, winter pressures and system incentives. It may result in low staff morale, leading to poor outcomes and experience for large numbers of patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover rates. **Risks on register 15 plus** No risks at this level	People Committee ensure governance and holds to account. Current risk rating reflects the Board acknowledges that, despite the controls and assurances in place, staff are currently fatigued; Restoration and recovery programmes / post covid effects Patient experience adversely affected (links to Q&S Committee) Uncertainty / Impact of national change programmes – Health & Care Bill: integration and collaboration Organisational structures and service redesigns and reorganisations	**Prevent Controls** • People Committee Organisational and local Staff engagement plan • Managers' Key brief/ communication, Time to Talk and CEO Q&A sessions • Local Negotiating Committee, Joint Negotiation & Consultative Committee • Occupational Health Service & Staff Health & Wellbeing Officer/Board Health & Wellbeing Guardian • Talent Management process and Succession Planning Tool • Staff Engagement Steering Group and SE & Wellbeing Champions • Revised Exit interview questionnaire / In house Resilience Training Programme • People Hub and POD Groups • Recruitment & Retention • Health & Wellbeing • Education & Professional development • Northwest Person-Centred approach to absence management • Fortnightly meetings with Staff Side **Detect Controls** • National Staff Survey. • Feedback from Quality and Safety Committee on workforce issues • Staff Friends and Family Test (SFFT) and Staff Engagement Surveys • E-rostering project plan and implementation PDR reporting • Staff Stress Audit Survey **Assurances** • Staff Survey and 'temperature check' surveys • DAWN – Disability and wellbeing Network • LGBT+ and Race Inclusion Networks • Stress Audit Survey Results and Action Plan • The Employee Relations Activity Report **Internal Audit MIAA Substantial Assurance** • Freedom to Speak Up (2020/21) • Attendance management Staff Engagement (2019/20) • Induction (2020/21) •

Gaps in controls and assurance: (and mitigating actions)
Engagement with staff groups including BAME and LGBT+ staff (remain until all established Networks are considered to be embedded)
PDR Compliance (to remain until processes embedded)
Mandatory Training – to be monitored at People Committee,
Staff morale and resilience – ongoing monitoring, communication, engagement and health and wellbeing services and programmes

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 6:	TRUST OBJECTIVES:	RISK RATING:	RISK APPETITE:
Staffing levels	• Equality, diversity and inclusion • People • Quality	Inherent risk rating: 5 (C) x 4(L) = 20, **significant** Current risk rating: 5 (C) x 3(L) = 15, **significant** Target risk rating: 5(C) x 2 (L) = 10, **high**	**CAUTIOUS - OPEN**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Operating Officer Last review: Feb 2022 Quality & Safety Committee Last review: Feb 2022 People Committee: March 2022 Risk Ratings reviewed: Feb 2022	**Staffing levels** If the Trust fails to have an appropriately resourced, focused, resilient workforce in place that meets service requirements; Caused by an inability to recruit, retain and/or appropriately deploy a workforce with the necessary skills and experience; or caused by organisational change; It may result in extended unplanned service closure and disruption to services, leading to poor clinical outcomes & experience for large numbers of patients; unmanageable staff workloads; and increased costs **Risks on register 15 plus** No risks at this level	Robust operational management structures in place. Adverse impacts to consider include: winter pressures, system wide incentives causing instability in recruitment and retention, potential for industrial action.	**Prevent Controls** • Business continuity plans in place • Organisational Development Strategy • Agreed medical and nursing revalidation protocols, preparation and remedial processes • Agreed recruitment and selection policies and processes • Workforce Strategy & Workforce Delivery Plan • HR Policies and working groups • Winter plans and staff redeployment plans in place • Fortnightly meetings with staff side • People Hub & PODs / Culture & Leadership / Recruitment & Retention / Health & Wellbeing / Education & Professional Development **Detect Controls** • Agency staff reporting / Staff sickness reporting • Turnover rate reporting • Premium Pay and Spend reporting • Bronze, Silver and Gold command and control / Ops and nursing meetings • Staff survey / pulse survey results **Assurances** • Quality & Safety Committee • Integrated Performance Report includes workforce metrics including training levels • Vacancy approval process reviews use of agency staff – regular review of staffing levels • Performance report indicating number of lapsed registrations each month • E-rostering / Safer Staffing Report • Key workforce metrics 'heat map' now received at Board via the IQPR • Phase one Healthcare support workers now in post. Phase two funding now secured **Audits – Substantial Assurance** Induction audit (2020/21) Attendance Management (2019/20)

Gaps in controls and assurance: (and mitigating actions)
Sickness Absence
Exit interviews – in relation to staff retention
BAME increasing representation across senior posts
Impact of Covid – capacity and demand

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 7: **Strategy and organisational sustainability**	**TRUST OBJECTIVES:** • Innovation and collaboration • Sustainability	**RISK RATING:** Inherent risk rating: 4 (C) x 3(L) = 12, **high** Current risk rating: 4 (C) x 3(L) = 8, **medium** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **CAUTIOUS - OPEN**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Director of Finance & Medical Director Last reviewed: March 2022 F&P Committee Last reviewed: March 2022 Risk Ratings reviewed: March 2022	**Strategy & Organisational Sustainability** If the Trust does not develop and deliver a strategy which demonstrates innovation and collaboration with partners and which is in line with current NHS Guidance and Health & Care Bill then the organisation may fail to deliver the best outcomes for patients and their families. The Trust may also lose its identity as a key system partner or lose influence within the ICS or provider collaborative which could result in services being assigned to other providers and the Trust would become financially unsustainable. **Risks on register 15 plus** No risks at this level	Trust involved in system-wide STP, Out of Hospital Cell development and MH Provider Collaborative. Trust Strategy is refreshed and re-launched.	**Prevent Controls** • Trust Board Oversight – engagement and delivery of Health & Care Bill • Regular Exec meetings with commissioners and other key stakeholders • Exec involvement with borough based integrated care partnerships visions; 'Warrington Together' and 'One Halton' • Execs carrying out SRO roles for system projects such as integrated community teams • Joints working on a number of projects with commissioners and local authority i.e. rapid community response and intermediate care • Plans in place to lead work across the system in relation to what good children's services look like and how we achieve this with our partners • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • CEO involvement with the Out of Hospital Cell • Chair working within wider system • COO 1:1s with commissioners • Exec attendance at Collaborative Commissioning Forum (CCF) • Developing our community dental services offer with a strategic plan of what we want the dental network to look like **Assurances** • Provider Collaborative member – BW Host Trust • Programme Director – Collaboration and Integration • Host provider collaborative – including employing staff • Emerging integrated governance structures with partners • MOU in place where services are delivered in conjunction with other partners • Chief Executive's monthly reports providing an overview of engagement activity • COO has regular meetings with all key partners and stakeholders • Regular business development reports
Gaps in controls and assurance: (and mitigating actions) None			

Board Assurance Framework (BAF) March 2022 – V5.1

BAF 8:	TRUST OBJECTIVES:	RISK RATING:	RISK APPETITE:
Digital services which do not meet demands of the organisation	• Innovation and collaboration • People • Quality • Sustainability	Inherent risk rating: 4 (C) x 4(L) = 16, **significant** Current risk rating: 4 (C) x 3(L) = 12, **high** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**SEEK**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Director of Finance & Medical Director Last reviewed: March 2022 F&P Committee Last reviewed: March 2022 Risk Ratings reviewed: March 2022	**If the Trust does not continue to maintain and develop digitally enabled services within a governance framework to meet the current and future needs of the Trust.** This includes IT, Systems, Security, Informatics and Performance Management. This could impact in our ability to; deliver key related Trust objectives, meet regulatory, contractual & reporting requirements and to enable the development of new and exemplar service models. Maintain our position as an innovator and influencer in enhancing Out of Hospital services, collaborate in system wide developments and recruit and retain highly skilled and motivated staff. **Risks on register 15 plus** 2428 – IT Cyber Threats	F&P Committee, DIGIT and Risk Council are all satisfied with the controls and assurances in place. COVID-19 has increased demand and required business continuity plans to be activated	**Prevent controls** Digital Strategy 2018–2021 approved by Board Local services business continuity and resilience plans in place and owned by service managers Cyber Solutions Annual IM&T capital and revenue budgets agreed by F&P Committee Participation and membership of ICS and Place based digital development groups DIGIT and Digital Programmes Groups Microsoft Core Datacentre and W10 licensing Cloud based migration capability training and developing solutions **Assurances** The Board receives reports from the F&P Committee which receives regular IT reports Relevant MIAA audit reports. SIRO & Caldicott Guardian Data, Security & Protection (DSP) Toolkit Cyber Essentials – on site assessment Business Continuity Management (BCM) and Cyber Incident Response Plan (CIRP) plans Qlik sense operational with bespoke Covid-19 infrastructure Data Quality Project Business Continuity Plans activated and in place **Audits – Substantial Assurance**: IT Threats & Vulnerability (2020/21) DSP Toolkit (2019/20 & 2020/21) Information Commissioners Officer Audit (2019/20)

Gaps in controls and assurance: (and mitigating actions)
Digital Strategy (undergoing a full refresh)
Population Heath Data not being fully utilised (work in line with ICS Cypher) and internal work on Qlik
IT Team Digital Services capacity and demand

Board Assurance Framework (BAF) March 2022 – V5.1

Appendix I: Risk grading criteria

Risk type	Consequence score & descriptor with examples				
	Very low 1	**Low 2**	**Moderate 3**	**High 4**	**Very high 5**
a. Patient harm or **b. Staff harm** or **c. Public harm**	Minimal physical or psychological harm, not requiring any clinical intervention. e.g.: Discomfort.	Minor, short term injury or illness, requiring non-urgent clinical intervention (e.g., extra observations, minor treatment or first aid). e.g.: Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. Intolerance to medication.	Significant but not permanent injury or illness, requiring urgent or on-going clinical intervention. e.g.: Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. Grade 2 or3 pressure ulcer. Healthcare associated infection (HCAI). Noticeable adverse reaction to medication. RIDDOR reportable incident.	Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual. e.g.: Loss of a limb Permanent disability. Severe, long-term mental illness. Grade 4 pressure ulcer. Long-term HCAI. Retained instruments after surgery. Severe allergic reaction to medication.	Multiple fatal injuries or terminal illnesses.
d. Services	Minimal disruption to peripheral aspects of service.	Noticeable disruption to essential aspects of service.	Temporary service closure or disruption across one or more divisions.	Extended service closure or prolonged disruption across a division.	Hospital or site closure.
e. Reputation	Minimal reduction in public, commissioner and regulator confidence. e.g.: Concerns expressed.	Minor, short term reduction in public, commissioner and regulator confidence. e.g.: Recommendations for improvement.	Significant, medium term reduction in public, commissioner and regulator confidence. e.g.: Improvement / warning notice. Independent review.	Widespread reduction in public, commissioner and regulator confidence. e.g.: Prohibition notice.	Widespread loss of public, commissioner and regulator confidence. e.g.: Special Administration. Suspension of CQC Registration. Parliamentary intervention.
f. Finances	Financial impact on achievement of annual control total of up to £50k	Financial impact on achievement of annual control total of between £50 - 100k	Financial impact on achievement of annual control total of between £100k - £1m	Financial impact on achievement of annual control total of between £1 - 5m	Financial impact on achievement of annual control total of more than £5m

Every risk recorded within the Trust's risk registers is assigned a rating, which is derived from an assessment of its **Consequence** (the scale of impact on objectives if the risk event occurs) and its **Likelihood** (the probability that the risk event will occur).

The risk grading criteria summarised below provide the basis for all risk assessments recorded within the Trust's risk registers, at strategic, operational and project level. +

Board Assurance Framework (BAF) March 2022 – V5.1

Likelihood score & descriptor with examples				
Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Less than 1 chance in 1,000 Statistical probability below 0.1% Very good control	Between 1 chance in 1,000 and 1 in 100 Statistical probability between 0.1% - 1% Good control	Between 1 chance in 100 and 1 in 10 Statistical probability between 1% and 10% Limited effective control	Between 1 chance in 10 and 1 in 2 Statistical probability between 10% and 50% Weak control	Greater than 1 chance in 2 Statistical probability above 50% Ineffective control

Risk scoring matrix						
Consequence	5	5	10	15	20	25
	4	4	8	12	16	20
	3	3	6	9	12	15
	2	2	4	6	8	10
	1	1	2	3	4	5
		1	2	3	4	5
		Likelihood				

Rating	Very low (1-3)	Low (4-6)	Medium (8-9)	High (10-12)	Significant (15-25)
Oversight	Specialty / Service level annual review		Borough quarterly review		Board monthly review
Reporting	None			Relevant Board Committee	

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date 7 April 2022

Board Part Public

Agenda item 20/22

Title	Key Corporate Messages
Sponsoring Director	Colin Scales, Chief Executive
Authors	Jan McCartney, Trust Secretary
Presented by	Colin Scales, Chief Executive
Exec Summary/Purpose	**To update the Board concerning key matters within the Trust and the NHS as a whole**
Previously considered at	N/A
Related Trust Objective/ Intentions ***Delete as applicable***	**Quality** – to deliver high quality, safe and effective care which meets both individual and community needs **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability. **People** – to be a highly effective organisation with empowered, highly skilled and competent staff **Equality, Diversity and Inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
Which CQC domains are supported by this report?	***Responsive*** ***Well-led***

Which BAF risks are addressed in this report?	**BAF 1** - Failure to implement and maintain sound systems of Corporate Governance
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	N/A
Equality Impact assessment	N/A
Explanation of any acronyms in the report	N/A
Next steps	N/A
Recommendations	**The Board is asked to note the report.**

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board

Title	Key Corporate Messages
Author	Colin Scales, Chief Executive
Date	7 April 2022
Purpose	To update the Board about key matters within the Trust and NHS as a whole.
Audience	Board

1.0 NON EXECUTIVE DIRECTOR UPDATES

1.1 The Trust Chair, Karen Bliss, has attended Cheshire & Merseyside System Oversight Board – Feb 10th and March 10th Cheshire & Merseyside Chairs meeting - Feb 15th and March 15th. 1:1 with Isla Wilson, the recently appointed Chair at Cheshire Wirral Partnership - 14th Feb. Time to Shine - March 4th. Time to talk with Widnes District Nursing Team – 16 March GGI ICS Breakfast seminar on Population Health - 23 March. Plus, the board time out/ development sessions 24th Feb & 9th March.

1.2 Non-Executive Director, Abdul Siddique, is working with Ruth Beresford to provide our frontline staff in Oldham, guidance on the month of Ramadhan (month of fasting for Muslims) that will begin on 2nd/3rd April. The idea is to give our staff providing services there some understanding of the cultural/religious implications on patients who come in for appointments. Ruth is also attempting to run a 'Big fast' day where staff can fast and give their dinner money to a charity of their choice.

1.3 Non-Executive Director, Gail Briers, is continuing one to ones with COO and attending Warrington and Halton Governors meeting.

1.4 Non-Executive Director, Linda Chivers, stated that beyond her normal duties with Board and Trust Committee meetings she had also undertaken the following, participating in : Good Governance Institute NEDs Development session – The pathway to End of Life Care. Good Governance Institute – The new NHS – Surrey Heartlands and good Governance Institute NEDs Development Programme – Delivering a Sustainable NHS. Prior to the next Board I am also intending to attend an Oldham services celebration event prior to them transferring out of the Trust and the MIAA Annual Outlook for the Public Sector event.

1.5 Non-Executive Director, Sally Yeoman, attended the Halton & Warrington Governor meeting.

2.0 EXECUTIVE UPDATE

2.1 An Executive Management Team Away Day took place on 1 March. This was a follow-up meeting to the Away Day which took place on 3 December 2021. The focus of the session was as follows:

1. Reflections from 3 December session
2. Update on Provider Collaborative
3. Operational Plan
4. Exec Team Review Implementation

2.2 The Chief Executive was part of the interview panel for the ICS Place Director for Halton, which took place on 28 February.

2.3 The Chief Executive also interviewed for the ICB chief people officer.

2.4 Executive and Senior Team Engagement

2.4.1 A monthly programme of 'Time to Talk' sessions has been set up to allow the Executive Team to update staff on Trust news, ask questions about the teams and service and to take an interest in staff health and wellbeing. It also provides an opportunity for staff to share good news stories and to ask any questions of the executive team.

Since the last Board meeting held on 3 February, the following Time to Talk sessions have taken place in February and March:

2.4.2 The Chief Executive met with the Halton Community Nursing Team on 16 March. The Chair joined the Chief Executive on this visit. In addition, the Chief Executive also undertook a number of service visits in March – the Immunisation Team in Warrington, Halton Wellbeing Nursing Team at The Bridges Learning Centre; Outreach session of the Driving Assessment Services in Preston; and all the dental service sites in Bury, Oldham and Rochdale.

2.4.3 Medical Director, Aruna Hodgson attended the Podiatry team in February.

2.4.4 Where possible, and as per the agreed Buddying Arrangements for Board Members, Non-Executive Directors join the Directors on their Time to Talk session with services as follows:

Director	Non-Executive Director
Colin Scales	Karen Bliss
Lynne Carter	Tina Wilkins
Sarah Quinn	Gail Briers
Paula Woods	Linda Chivers
Nick Gallagher	Abdul Siddique
Ted Adams	Sally Yeoman
Aruna Hodgson	Martyn Taylor

2.5 Events/Seminars

2.5.1 Board Time-Out sessions
Two Board Time-Out session took place during the months of February and March:

2.5.2 On 24 February the Board received training from MIAA on Anti-Bribery and Ros Connolly, Clinical Project Manager attended to provide a presentation on Our Just & Learning Culture 'Improving Patient Care by Caring for our Staff'. A number of clinical staff joined the Board in the afternoon to talk about their experiences during the pandemic.

2.5.3 On 9 March, the session focused on the operational, workforce and finance plans for 2022/23 and the staff survey, which is due for publication at the end of March 2022.

2.5.4 NHS Providers Board Development Workshop
On 14 March, session 3 of 5 workshop took place. This session was delivered by Mike Gill and Adrian Nash and featured Psychology of Persuasion and Building Rapport; System Working; Building Effective Relationships - Emotional Intelligence, and next steps.

2.5.5 Cheshire & Merseyside Dental session
On 10 March, the executive team and dental leaders met with our dental commissioners in Cheshire & Merseyside. The purpose of the meeting was to provide an update on where the service is on recovery as well as our progressive plans for this vital service.

2.5.6 Goodbye/Thank You Events
As our Oldham Right Start and School Nursing staff transfer to the new provider on 1 April, a number of goodbye/thank you events took place. A member of the executive team attended the events to thank the staff for all their hard work and commitment to the service during their time with Bridgewater and to wish each of them every success for the future.

3.0 DIRECTORS FEEDBACK FROM TIME TO TALK SESSIONS

3.1 During February and March 2022, four time to talk sessions took place, the reduction in time to talk session were due to Covid pressures on the Teams.

3.2 Monthly feedback from the Executive Team is collated and shared with Borough / Service Managers, example of feedback from February session below:

"The team have dealt admirably with the many challenges of the pandemic & have implemented learning from redeployment to enhance the service they offer."

4.0 EXTERNAL PUBLICATIONS AND REPORTS

4.1 Health and social care integration: joining up care for people, places and populations.
This white paper sets out measures to make integrated health and social care a universal reality for everyone across England regardless of their condition and of where they live.
Health and social care integration: joining up care for people, places and populations - GOV.UK (www.gov.uk)

4.2 NHS Providers' briefing - health and social care integration white paper
The government published the health and social care integration white paper, Joining up care for people, places and populations, on 9 February 2022. This briefing summarises its proposals for a single accountable person, shared outcomes, and increasingly pooled NHS and social care budgets at place level. It also sets out an initial analysis of the implications for trusts.
NHS Providers next day briefing - health and social care integration white paper - NHS Providers

4.3 The state of Integrated Care Systems 2021/22 (NHS Confederation report
This report seeks to assess this progress in ICS development. It presents the views of system leaders in autumn 2021, both on where they feel they have progressed well and where improvements are needed. It also assesses the prospect of further progression over the coming years, outlining where system leaders believe there are opportunities and identifying key barriers to the success of systems in future.
The state of integrated care systems 2021/22 | NHS Confederation

5.0 RECOMMENDATIONS

5.1 The Board is asked to note the report.

Bridgewater Board Date 7 April 2022

Board Part Public

Agenda item 21/22i

Title	Integrated Quality Performance Report – Month 10
Sponsoring Director	Colin Scales, Chief Executive Officer
Authors	Various Authors Information Team
Presented by	Executive Directors
Purpose	This report summarises the key issues relating to Bridgewater Performance for Month 10 January 2022
Previously considered at	Finance and Performance Committee – March 2022
Related Trust Objective/ Intentions	Quality – to deliver high quality, safe and effective care which meets both individual and community needs Innovation & Collaboration – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing, and independent living. Sustainability – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability. People – to be a highly effective organisation with empowered, highly skilled competent staff Equality, Diversity and Inclusion – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.

Patient Safety and Quality	The IQPR has several indicators which are related to patient safety and quality and a commentary in relation to performance against these indicators is included in the report.
Care Quality Commission Outcomes support by this paper	Safe, Caring, Responsive, Effective and Well Led
How does the paper address strategic risks identified in the BAF? *(please delete as applicable and describe how the paper connects to the risk – by strengthening the control or addressing a gap, or by offering assurance for example)*	BAF 1 - Failure to implement and maintain sound systems of Corporate Governance. BAF 2 – Failure to deliver safe & effective patient care BAF 3 – Managing demand & capacity BAF 4 – Financial sustainability BAF 5 – Staff engagement & morale BAF 6 – Staffing levels BAF 7 – Organisational sustainability
Legal implications/ regulatory requirements	N/A
Finance and resources Impact assessment	N/A
Equality Impact assessment	N/A
Next steps	To continue to monitor indicators in line with the recovery and restoration of services. To ensure that targeted actions are progressed to enable as many of the indicator as possible to be green.
Recommendations	The Board is asked to: • Accept this paper as assurance that indicators of performance in relation to operations, quality, people and finance are being reviewed and appropriate actions taken to rectify any indicators which are reported as red.

Bridgewater Community Healthcare NHS Foundation Trust

Integrated Quality and Performance Report

Information Team
Bridgewater Community Healthcare NHS Foundation Trust
Reporting Period: January 2022 (Month 10)

Within this report

Bridgewater Community Healthcare NHS Foundation Trust

Contents

Section 1: Trust Overview

- Section 2: Operations - Responsive
- Section 3: Safe, High-Quality Care
- Section 4: People
- Section 5: Finance - Making Good Use of Resources

Introduction

The monthly Integrated Quality and Performance Report (IQPR) provides an overview of the Trust's performance against the balanced scorecard Key Performance Indicators (KPIs)

KPIs are grouped by Domain and Executive leads are tasked with ensuring the KPIs are relevant, achievable, measurable, monitored, and managed.

This month's report describes activity in January 2022.

Within this report

1. KPI Amendments:

KPI	Change	Rationale

2. Recommendations:

The Board are asked to:

- Accept this paper as assurance that indicators of performance in relation to operations, quality, people, and finance are being reviewed and appropriate actions taken to rectify any indicators which are reported as red.

1 Trust Overview

Bridgewater Community Healthcare NHS Foundation Trust

Executive Summary

Due to validation and review timescales for Cancer, the RAG rating on the dashboard for these indicators is based on December's validated position.

Responsive (Operations)

Operational indicators have again not changed significantly in month and all red indicators are being monitored by the operational teams and plans are in place where these are within the control of the Trust to improve the performance of these indicators. The dermatology service is currently under the most challenge in terms of delivery of activity but there is a significant service improvement plan being worked upon to address areas of concern and to look at how the service can be delivered moving forward to manage the referrals more effectively into the service and there has been some improvement in the dermatology indicators in month. Dental indicators have been included in this month's IQPR to demonstrate the number of waiters and the waiting times; these will be included monthly.

Safe, High-Quality Care (Quality)

There is an improvement in month to the quality section of the IQPR with one indicator moving from red to green. There are no new red indicators in month.

People

All the people indicators are red in month. There is some positive improvement in the staff sickness (actual).

Making Good Use of Resources (Finance)

There is a positive position reported in relation to finance with most indicators reporting as green.

2 Operations

Executive Summary

Of the 19 Operations indicators which are reported; 8 are red and 11 are green.

The indicator that has changed from amber to red in month is:

- Halton Activity Variance

The indicator that has moved from red to green in month is:

- Cancellations by Patient

The remaining six indicators which were also red in December are as follows:

- Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment – improvement in month
- 28-day Cancer Faster Diagnosis – improvement in month
- Referrals to Plan – slight decrease in month
- Cancellations by service – these have decreased in month
- Percentage of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway) – deterioration in month
- Warrington Audiology - Number of 6 weeks diagnostic breaches – deterioration in month
- Warrington Activity Variance – slight improvement in month

Overall, there is not a significant change in the position in relation to the operational indicators collected.

There are three dental indicators included in this month's IQPR. Overall, the number of dental waiters has increased particularly in relation to minor oral surgery in Cheshire and Merseyside and inhalation sedation. There has been a reduction in the total number of long waiters for the 104 weeks +, 52-103 weeks and 26-52 week waiting bands.

2 Operations

Bridgewater Community Healthcare NHS Foundation Trust

Actions:

Indicator	Action	Target date	Responsible Committee
% of patients waiting under 18 weeks	Only 2 services now showing breaches of the 18-week RTT – dermatology and community paediatrics, both in Warrington. Additional resources are already supporting the delivery of these services, but they will be monitored closely to ensure that the RTT is achieved as soon as possible.	October 2022 – Revised date for achievement of waiting times. This is dependent on receiving the additional funding as per the Operational Plan	Chief Operating Officer

Operations

Trust Scorecard

Operations																
Code	KPI Name	Target	Trend Line	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93.00%		98.18% (▲)	95.06% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)	98.85% (▼)	97.07% (▼)	95.22% (▼)	98.08% (▲)	94.01% (▼)	96.58% (▲)	97.97% (▲)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94.00%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96.00%		75% (▲)	91.67% (▲)	100% (▲)	88.24% (▼)	100% (▲)	92.86% (▼)	87.5% (▼)	100% (▲)	83.33% (▼)	100% (▲)	92.86% (▼)	76.92% (▼)	93.33% (▲)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85.00%		100% (▲)	86.96% (▼)	100% (▲)	85.71% (▼)	83.33% (▼)	86.96% (▲)	100% (▲)	100% (►)	91.3% (▼)	80% (▼)	91.67% (▲)	86.96% (▼)	100% (▲)
OP22	28 day faster diagnosis	75.00%		64.63% (▲)	52.38% (▼)	28.77% (▼)	34.29% (▲)	41.76% (▲)	22.82% (▼)	31.58% (▲)	39.86% (▲)	28.57% (▼)	41.74% (▲)	40.78% (▼)	37.98% (▼)	47.67% (▲)
OP06	Referrals to plan	95.00%		73.33% (▲)	73.32% (▼)	74.03% (▲)	77.12% (▲)	80.84% (▲)	80.31% (▼)	78.83% (▼)	77.97% (▼)	77.7% (▼)	78% (▲)	77.89% (▼)	78.73% (▲)	77.74% (▼)
OP07	Cancellations by service	5.00%		10.49% (▼)	8.69% (▲)	9.02% (▼)	7.69% (▲)	9.07% (▼)	8.36% (▲)	9.23% (▼)	8.82% (▲)	7.77% (▲)	11.92% (▼)	12.99% (▼)	14.06% (▼)	9.27% (▲)
OP08	Cancellations by Patient	5.00%		3.23% (▼)	2.68% (▲)	2.84% (▼)	5.81% (▼)	6.12% (▼)	6.64% (▼)	6.93% (▼)	4.91% (▲)	5.01% (▼)	4.83% (▲)	5.06% (▼)	5.06% (▼)	4.65% (▲)
OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92.00%		59.22% (▼)	58.32% (▼)	57.5% (▼)	59.13% (▲)	72.87% (▲)	86.17% (▲)	88.46% (▲)	81.65% (▼)	76.32% (▼)	67.19% (▼)	60.74% (▼)	56.49% (▼)	53.79% (▼)
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		100% (►)	99.92% (▼)	100% (▲)	99.95% (▼)	99.92% (▼)	100% (▲)	99.96% (▼)	99.96% (►)	99.29% (▼)	97.93% (▼)	98.85% (▲)	99.05% (▲)	99.23% (▲)
OP12	Total time in A&E - 95th Percentile	4 Hrs		01:12 (▲)	01:31 (▼)	01:27 (▲)	01:27 (▼)	01:48 (▼)	01:41 (▲)	01:47 (▼)	01:53 (▼)	02:07 (▼)	03:12 (▼)	02:59 (▲)	02:56 (▲)	02:47 (▲)
OP13	A&E Time to treatment decision (median) <=60 mins	60 Mins		00:10 (▼)	00:03 (▲)	00:03 (▲)	00:03 (▼)	00:04 (▼)	00:04 (▲)	00:05 (▼)	00:05 (▲)	00:05 (▼)	00:07 (▼)	00:06 (▲)	00:05 (▲)	00:05 (▼)
OP14	A&E Unplanned re-attendance rate <=5%	5%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
OP15	A&E left without being seen <=5%	5%		0.04% (►)	0.04% (▲)	0% (▲)	0.02% (▼)	0% (▲)	0.1% (▼)	0.02% (▲)	0% (▲)	0% (►)	0.11% (▼)	0.1% (▲)	0.14% (▼)	0.07% (▲)
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches	0		89 (▼)	103 (▼)	73 (▲)	49 (▲)	47 (▲)	27 (▲)	49 (▼)	6 (▲)	8 (▼)	0 (▲)	0 (►)	2 (▼)	14 (▼)
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score	95%		95.7% (▼)	95.75% (▲)	95.2% (▼)	95.41% (▲)	94.97% (▼)	94.9% (▼)	94.81% (▼)	94.81% (▲)	94.78% (▼)	99.53% (▲)	99.52% (▼)	99.53% (▲)	99.53% (▲)
OP18	Halton Maternity Dashboard - Number of red rated areas	0		3 (▲)	1 (▲)	0 (▲)	0 (►)	1 (▼)	0 (▲)	1 (▼)	2 (▼)	2 (►)	2 (►)	0 (▲)	0 (►)	0 (►)
OP19	Warrington Activity Variance	3%		-27.73% (▲)	-28.12% (▼)	-28.24% (▼)	-26.41% (▲)	-23.21% (▲)	-24.02% (▼)	-24.84% (▼)	-24.33% (▲)	-24.28% (▲)	-24.87% (▼)	-23.58% (▲)	-23.72% (▼)	-23.17% (▲)
OP20	Halton Activity Variance	3%		-25.07% (▼)	-24.41% (▲)	-21.74% (▲)	-10.9% (▲)	-6.24% (▲)	-4.17% (▲)	-5.18% (▼)	-5.9% (▼)	-5.43% (▲)	-5.27% (▲)	-5.81% (▼)	-3.46% (▲)	-7.87% (▼)

2

Operations: Exception Reporting

Bridgewater Community Healthcare NHS Foundation Trust

Flagged Indicators

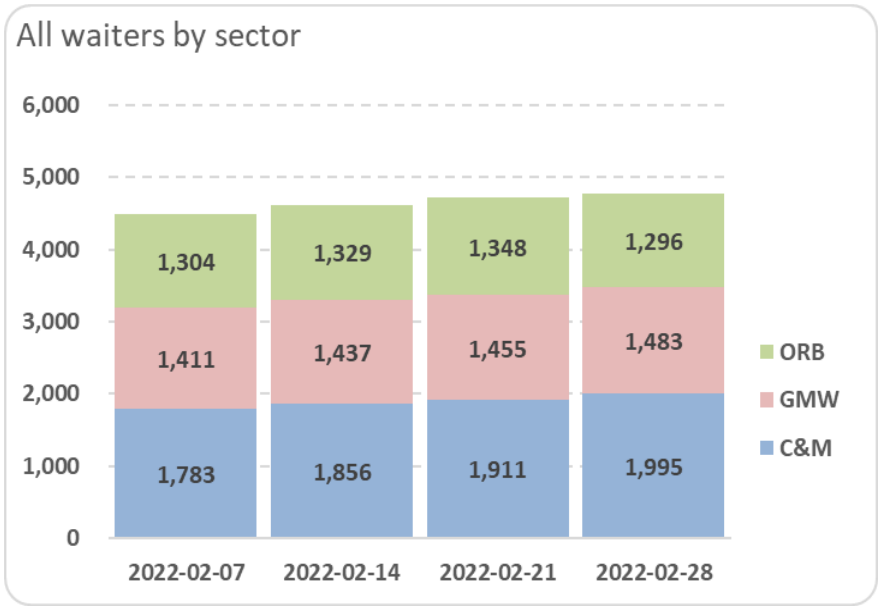
Operations			
OP07	Cancellations by service		Points above upper control limit
OP08	Cancellations by Patient		Points above upper control limit
OP12	Total time in A&E - 95th Percentile		Points below lower control limit
OP13	A&E Time to treatment decision (median) <=60 mins		Point below lower control limit
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches		Point above upper control limit
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score		Point below lower control limit

Operations: Exception Reporting

OP19	Warrington Activity Variance		Points below lower control limit
OP20	Halton Activity Variance		Points below lower control limit

Operations: Exception Reporting

SPC Charts



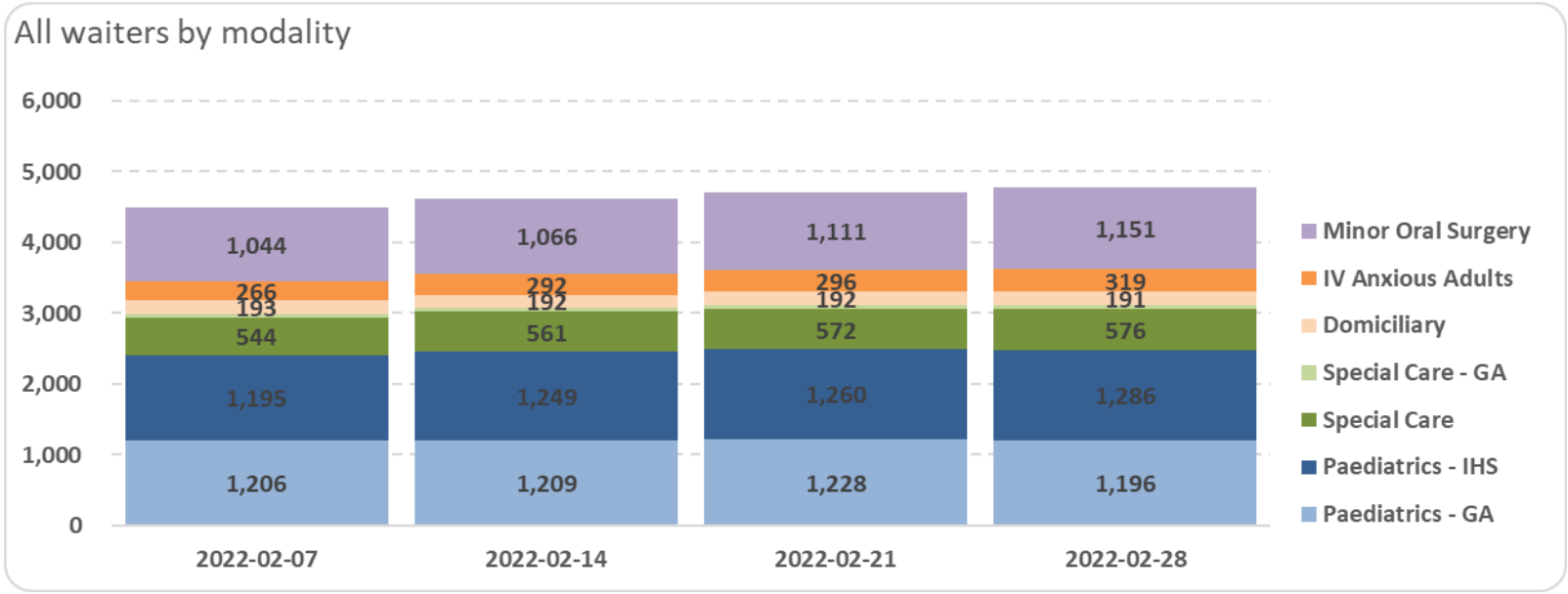
Issue

Dental - Patients waiting by Sector

The number of patients waiting for dental treatment has increased overall largely due to a rise in the number of patients waiting in Cheshire and Merseyside. This due to an increased number of referrals for minor oral surgery. The number of waiters has increased slightly in the Greater Manchester West sector and reduced slightly in Oldham, Rochdale and Bury. The number of waiters is monitored on a weekly basis.

Operations: Exception Reporting

SPC Charts



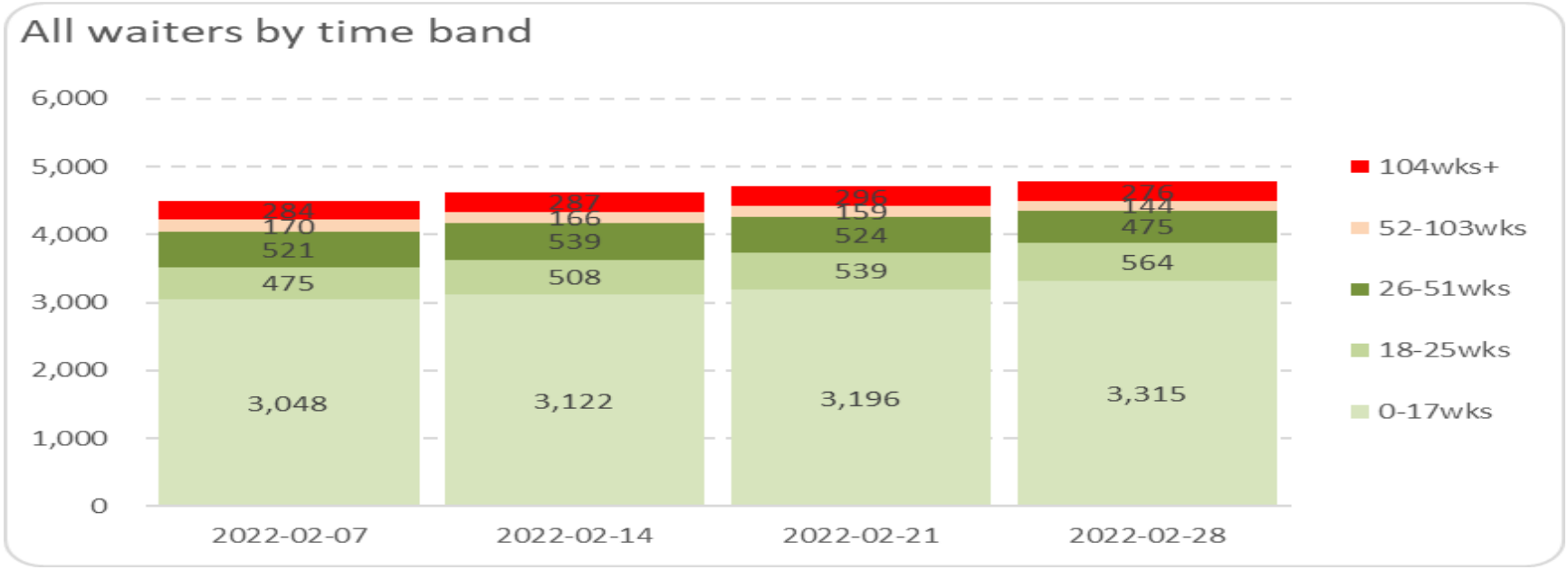
Issue

Dental - Patients waiting by treatment

The number of patients waiting on several of the pathways has increased in month. This is due to an increased number of referrals being received. This is monitored on a weekly basis.

Operations: Exception Reporting

SPC Charts



Issue

Dental - Patients waiting by time band

The number of patients waiting 104 weeks plus, 52-103 weeks and 26-51 weeks has decreased. Patients with the highest clinical need and longest waiting time are being prioritised for treatments. Waiting times are reviewed on a weekly basis.

Quality

Executive Summary

There are five Quality indicators reporting as red in January 2022. This is a decrease of one red indicator from the previous month.

The indicators which are no longer red in month are:

- Percentage of overall falls that are bed based

There are no new red indicators in month.

The remaining five indicators which were red in January are as follows:

- Information Governance Training – deterioration in month
- Safeguarding Children Level 2 Training – deterioration in month
- Safeguarding Adults Level 2 Training – deterioration in month
- Safeguarding Adults Level 3 Training – improvement in month
- Percentage of risks identified as high – deterioration in month

Actions:

Indicator	Action	Target date	Responsible Committee
Safeguarding Level 3 – Children's and Adults	Staff to be supported to participate in training.	June 2022– ***this date has been revised due to the impact of the Omicron outbreak of COVID***	Borough/Directorate Director and Clinical Managers

Quality

Bridgewater Community Healthcare NHS Foundation Trust

Trust Scorecard

Quality																	
Code	KPI Name	Target		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Incidents																	
QU01	Number of Never Events	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU02	Number of patient safety incidents reported	97.217		137 (▲)	136 (▲)	171 (▼)	149 (▲)	157 (▼)	165 (▼)	165 (►)	148 (▲)	134 (▲)	167 (▼)	141 (▲)	121 (▲)	170 (▼)
QU03	% of incidents High impact Level 3-5	7.88%		1.46% (▲)	0.74% (▲)	2.34% (▼)	1.34% (▲)	0.64% (▲)	1.21% (▼)	1.82% (▼)	2.03% (▼)	3.73% (▼)	0.6% (▲)	0.71% (▼)	2.48% (▼)	1.76% (▲)
QU04	% Of Incidents Low impact Level 1-2	68.97%		78.1% (▼)	78.68% (▼)	84.21% (▼)	85.23% (▼)	79.62% (▲)	78.79% (▲)	80% (▼)	72.97% (▲)	82.09% (▼)	76.65% (▲)	78.01% (▼)	80.99% (▼)	77.65% (▲)
QU05	Number of Serious Incidents Reported	9		3 (▲)	2 (▲)	4 (▼)	1 (▲)	1 (►)	2 (▼)	3 (▼)	3 (►)	3 (►)	5 (▼)	0 (▲)	4 (▼)	2 (▲)
QU06	Percentage of Serious Incidents Reported - Compliance with reporting time frames for StEIS within 48 hours	100.00%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU07	RCA investigations compliance submitted within 60 day time frame	100.00%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU08	DOC (Duty of Candour) - 10 day compliance	100.00%		83.33% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	75% (▼)	100% (▲)	100% (►)	100% (►)
QU09	CAS Alert Compliance	100.00%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU10	Total Number of Medication Errors	33		19 (►)	14 (▲)	12 (▲)	14 (▼)	8 (▲)	13 (▼)	11 (▲)	9 (▲)	21 (▼)	20 (▲)	25 (▼)	10 (▲)	21 (▼)
QU11	Medication Errors That Caused Harm	6		2 (▼)	0 (▲)	0 (►)	1 (▼)	0 (▲)	0 (►)	2 (▼)	0 (▲)	0 (►)	3 (▼)	0 (▲)	1 (▼)	2 (▼)
QU12	Medical Device Incidents	14		7 (▲)	5 (▲)	20 (▼)	10 (▲)	13 (▼)	17 (▼)	9 (▲)	1 (▲)	4 (▼)	15 (▼)	7 (▲)	10 (▼)	10 (►)
Training Compliance																	
QU13	Information Governance	95.00%		79.45% (▲)	80.04% (▲)	79.6% (▼)	82.72% (▲)	78.66% (▼)	83.15% (▲)	81.56% (▼)	83.59% (▲)	82.74% (▼)	81.22% (▼)	80.1% (▼)	79.84% (▼)	79.51% (▼)
QU14	Safeguarding Childrens Level 1	85.00%		88.88% (▲)	89.06% (▲)	90.05% (▲)	90.41% (▲)	88.24% (▼)	82.54% (▼)	85.6% (▲)	84.3% (▼)	85.42% (▲)	83.62% (▼)	80.11% (▼)	85.91% (▲)	86.11% (▲)
QU15	Safeguarding Childrens Level 2	85.00%		84.47% (▲)	85.29% (▲)	86.78% (▲)	87.69% (▲)	86.46% (▼)	86.89% (▲)	84.51% (▼)	84.2% (▼)	83.93% (▼)	81.6% (▼)	73.37% (▼)	74.21% (▲)	73.67% (▼)
QU16	Safeguarding Childrens Level 3	85.00%		60.26% (▲)	60.15% (▼)	80.69% (▲)	81.01% (▲)	80.29% (▼)	81.12% (▲)	65.38% (▼)	65.63% (▲)	76.42% (▲)	74.11% (▼)	84.3% (▲)	85.3% (▲)	85.33% (▲)
QU17	Safeguarding Adults Level 1	85.00%		89.43% (▲)	89.64% (▲)	93.35% (▲)	93.69% (▲)	91.58% (▼)	90.96% (▼)	89.58% (▼)	88.98% (▼)	88.04% (▼)	87.35% (▼)	86.24% (▼)	86.13% (▼)	86.98% (▲)
QU18	Safeguarding Adults Level 2	85.00%		87.04% (▼)	87.36% (▲)	88.46% (▲)	88.77% (▲)	86.97% (▼)	87.74% (▲)	85.38% (▼)	85.09% (▼)	82.76% (▼)	80.14% (▼)	80.2% (▲)	79.09% (▼)	77.84% (▼)
QU19	Safeguarding Adults Level 3	85.00%		57.32% (▲)	51.57% (▼)	40.73% (▼)	42.4% (▲)	44.59% (▲)	45.06% (▲)	33.58% (▼)	33.98% (▲)	35.19% (▲)	33.02% (▼)	44.93% (▲)	44.98% (▲)	46.97% (▲)
Risks																	
QU20	Total Number of risks	258		252 (▼)	250 (▲)	227 (▲)	236 (▼)	234 (▲)	237 (▼)	230 (▲)	227 (▲)	222 (▲)	209 (▲)	211 (▼)	213 (▼)	204 (▲)
QU21	Total Number of risks identified as High	111		100 (▼)	102 (▼)	100 (▲)	104 (▼)	103 (▲)	102 (▲)	98 (▲)	98 (►)	103 (▼)	100 (▲)	101 (▼)	99 (▲)	104 (▼)
QU22	Percentage of risks identified as High	44.02%		39.68% (▼)	40.8% (▼)	44.05% (▼)	44.07% (▼)	44.02% (▲)	43.04% (▲)	42.61% (▲)	43.17% (▼)	46.4% (▼)	47.85% (▼)	47.87% (▼)	46.48% (▲)	50.98% (▼)
QU23	Total Number of risks identified as High 12	57		35 (▲)	33 (▲)	32 (▲)	32 (►)	31 (▲)	33 (▼)	31 (▲)	32 (▼)	29 (▲)	26 (▲)	25 (▲)	27 (▼)	22 (▲)
QU24	Percentage of risks identified as High 12	15.17%		13.89% (▲)	13.2% (▲)	14.1% (▼)	13.56% (▲)	13.25% (▲)	13.92% (▼)	13.48% (▲)	14.1% (▼)	13.06% (▲)	12.44% (▲)	11.85% (▲)	12.68% (▼)	10.78% (▲)
QU25	Total Number of risks identified as Extreme	21		9 (▼)	8 (▲)	5 (▲)	9 (▼)	5 (▲)	3 (▲)	2 (▲)	4 (▼)	3 (▲)	5 (▼)	4 (▲)	4 (►)	4 (►)
QU52	Percentage of risks identified as Extreme	4.69%		3.57% (▼)	3.2% (▲)	2.2% (▲)	3.81% (▼)	2.14% (▲)	1.27% (▲)	0.87% (▲)	1.76% (▼)	1.35% (▲)	2.39% (▼)	1.9% (▲)	1.88% (▲)	1.96% (▼)

3

Quality

Bridgewater Community Healthcare NHS Foundation Trust

Quality																
Code	KPI Name	Target		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Falls (Bridgewater)																
QU26	Total Number of falls	23		4 (▲)	11 (▼)	7 (▲)	8 (▼)	17 (▼)	14 (▲)	10 (▲)	12 (▼)	10 (▲)	17 (▼)	11 (▲)	9 (▲)	17 (▼)
QU27	Total Number of falls identified as Catastrophic	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU28	Falls per 1,000 bed days - bed based	14		2.5 (▲)	5.49 (▼)	3.86 (▲)	4.76 (▼)	10.93 (▼)	11.43 (▼)	5.72 (▲)	11.28 (▼)	8.92 (▲)	10.89 (▼)	6.93 (▲)	7.93 (▼)	13.26 (▼)
QU29	Percentage of overall falls that are bed based	88.28%		50% (▲)	45.45% (▲)	57.14% (▼)	62.5% (▼)	70.59% (▼)	85.71% (▼)	60% (▲)	100% (▼)	70% (▲)	64.71% (▲)	72.73% (▼)	88.89% (▼)	82.35% (▲)
QU30	Total Number of Community Falls	11		2 (▲)	6 (▼)	3 (▲)	3 (►)	5 (▼)	2 (▲)	4 (▼)	0 (▲)	3 (▼)	6 (▼)	3 (▲)	1 (▲)	3 (▼)
QU31	Percentage of overall falls that are community falls	55.01%		50% (▼)	54.55% (▼)	42.86% (▲)	37.5% (▲)	29.41% (▲)	14.29% (▲)	40% (▼)	0% (▲)	30% (▼)	35.29% (▼)	27.27% (▲)	11.11% (▲)	17.65% (▼)
Pressure Ulcers																
QU32	Total Number of Category 2 Pressure Ulcers acquired in Bridgewater	44		29 (▲)	28 (▲)	37 (▼)	30 (▲)	29 (▲)	27 (▲)	38 (▼)	20 (▲)	20 (►)	32 (▼)	24 (▲)	32 (▼)	25 (▲)
QU33	Total Number of Category 3 Pressure Ulcers acquired in Bridgewater	5		0 (▲)	1 (▼)	0 (▲)	2 (▼)	1 (▲)	0 (▲)	1 (▼)	1 (►)	0 (▲)	3 (▼)	0 (▲)	1 (▼)	0 (▲)
QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater	2		2 (▼)	0 (▲)	0 (►)	1 (▼)	0 (▲)	1 (▼)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	2 (▼)	2 (►)
QU35	Total Number of Unstageable Pressure Ulcers acquired in Bridgewater	3		1 (▲)	0 (▲)	2 (▼)	1 (▲)	0 (▲)	1 (▼)	2 (▼)	1 (▲)	2 (▼)	1 (▲)	0 (▲)	0 (►)	0 (►)

Quality																
Code	KPI Name	Target	Trend Line	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
Health Care Acquired Infections																
QU36	MRSA - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU37	C.Diff - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU38	Bacteraemia - Total Number of outbreaks	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Harm Free Care																
QU40	VTE - Bed Based - % of patients risk assessed	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
Patient Experience																
QU41	Friends and Family Test	95.00%		97.59% (▼)	100% (▲)	99.32% (▼)	98.85% (▼)	99.09% (▲)	97.8% (▼)	97.9% (▲)	97.15% (▼)	98.01% (▲)	98.45% (▲)	98.48% (▲)	98.61% (▲)	98.72% (▲)
QU42	Number of Complaints	9		2 (▲)	1 (▲)	6 (▼)	5 (▲)	5 (►)	5 (►)	3 (▲)	2 (▲)	1 (▲)	4 (▼)	3 (▲)	1 (▲)	6 (▼)
QU44	Patient Experience - Dignity and Respect	95.00%		100% (▲)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	99.29% (▼)	100% (▲)	99.31% (▼)	99.71% (▲)	99.8% (▲)	99.49% (▼)	100% (▲)
QU45	Patient Experience - Information / Communication	95.00%		100% (▲)	100% (►)	100% (►)	99.35% (▼)	100% (▲)	100% (►)	98.7% (▼)	98.92% (▲)	98.8% (▼)	99.71% (▲)	99.49% (▼)	99.33% (▼)	99.03% (▼)
QU46	Patient Experience - Access/Waiting Time	95.00%		95.24% (▲)	100% (▲)	99.32% (▼)	98.04% (▼)	97.36% (▼)	97.76% (▲)	97.05% (▼)	97.23% (▲)	96.74% (▼)	97.37% (▲)	97.34% (▼)	97.98% (▲)	99.03% (▲)
Patient Experience																
QU51	CQUIN - Data Quality Maturity Index (DQMI) MHSDS quarterly score	95.00%		95.7% (▼)	95.75% (▲)	95.2% (▼)	95.41% (▲)	94.97% (▼)	94.9% (▼)	94.81% (▼)	94.81% (▲)	94.78% (▼)	99.53% (▲)	99.52% (▼)	99.53% (▲)	99.53% (▲)

3

Quality: Exception Reporting

Bridgewater Community Healthcare NHS Foundation Trust

Flagged Indicators

Quality			
QU15	Safeguarding Children's Level 2		Two out of three in the out sigma
QU17	Safeguarding Adults Level 1		Points above upper control limit
QU20	Total Number of risks		Two out of three in the out sigma
QU22	Percentage of risks identified as High		Points above upper control limit

Quality: Exception Reporting

QU23	Total Number of risks identified as High 12		12 points in a row below the mean
QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater		Point above upper control limit

4 People

Bridgewater Community Healthcare NHS Foundation Trust

Executive Summary

All five People indicators are shown as red in January 2021.

The five indicators which were red in January are as follows:

- Percentage Headcount of new starters attending induction programme – deterioration in month
- Staff turnover (rolling) – deterioration in month
- Percentage Overall organisation sickness rate (rolling) – deterioration in month
- Sickness absence rate (actual) – improvement in month
- Percentage of staff with current PDR – deterioration in month

Actions:

Indicator	Action	Target date	Responsible Committee
% Headcount of new starters attending induction programme	Ensure staff do not start in post prior to completing the induction sessions.	Compliance Target changed to 95% from 1st February 2022	Will be amended for the Month 11 IQPR

4

People

Bridgewater Community Healthcare NHS Foundation Trust

Trust Scorecard

People																		
Code	KPI Name	Target		Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22
PO01	% Headcount of new starters attending induction programme	100.00%		91.02% (▲)	90.98% (▼)	91.43% (▲)	91.35% (▼)	91.97% (▲)	93.16% (▲)	99.65% (▲)	99.59% (▼)	99.53% (▼)	99.41% (▼)	99.29% (▼)	99.71% (▲)	99.47% (▼)
PO02	Staff turnover (rolling)	8.00%		17.48% (▲)	17.16% (▲)	9.67% (▲)	9.76% (▼)	10.08% (▼)	10.65% (▼)	10.57% (▲)	11.95% (▼)	12.4% (▼)	14.71% (▼)	14.56% (▲)	14.68% (▼)	15.56% (▼)
PO03	% Overall Organisation Sickness rate (rolling)	4.80%		5.45% (▲)	5.33% (▲)	5.27% (▲)	5.27% (▲)	5.32% (▼)	5.44% (▼)	5.56% (▼)	5.68% (▼)	5.84% (▼)	5.92% (▼)	5.98% (▼)	6.25% (▼)	6.45% (▼)
PO04	Sickness absence rate (Actual)	4.80%		5.36% (▼)	4.5% (▲)	5.18% (▼)	5.55% (▼)	6.21% (▼)	6.14% (▲)	6.52% (▼)	6.13% (▲)	6.59% (▼)	6.84% (▼)	6.22% (▲)	7.69% (▼)	7.2% (▲)
PO05	% of staff with a current PDR	85.00%		25.11% (▲)	23.51% (▼)	26.63% (▲)	25.57% (▼)	25.4% (▼)	26.77% (▲)	31.59% (▲)	38.3% (▲)	43.38% (▲)	47.54% (▲)	52.45% (▲)	54.16% (▲)	53.89% (▼)

4 People

Bridgewater Community Healthcare NHS Foundation Trust

Flagged Indicators

People			
PO01	% Headcount of new starters attending induction programme		Point above upper control limit
PO02	Staff turnover (rolling)		Points below lower control limit
PO04	Sickness absence rate (Actual)		Point above upper control limit

5 Finance

Bridgewater Community Healthcare NHS Foundation Trust

Month 10 Finance Report

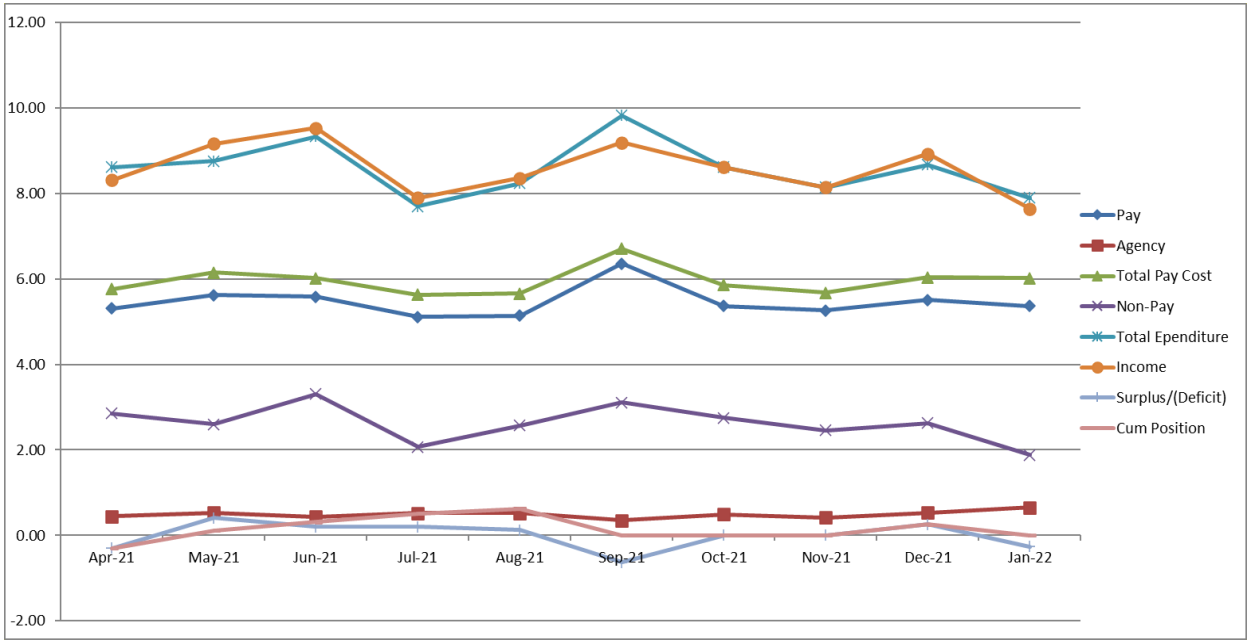
The purpose of this paper is to update the Committee on the financial position of the Trust at the end of January 2022 (Month 10). The plan referred to is the final version of the H2 plan submitted to NHSE/I and reflects the transfer out of Maternity Services on 1st November 2021.

Summary Performance Month 10 2021-22	Month 10 Plan (£M)	Month 10 Actual (£M)	Month 10 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M9 (£M)
Income	(8.22)	(7.64)	△ (0.58)	(84.57)	(85.77)	● 1.19	(101.01)	(102.83)
Expenditure - Pay	5.44	5.37	● 0.07	55.43	54.63	● 0.80	66.13	65.33
Expenditure - Agency	0.64	0.65	△ (0.02)	5.12	4.90	● 0.22	6.38	5.89
Expenditure - Non Pay	2.15	1.88	● 0.27	24.17	26.17	△ (2.00)	28.65	31.66
EBITDA	0.00	0.27	△ (0.26)	0.15	(0.07)	● 0.21	0.15	0.05
Financing	0.00	(0.01)	● 0.01	0.17	0.07	● 0.10	0.17	0.08
Normalised (Surplus)/Deficit	0.00	0.26	△ (0.26)	0.32	(0.00)	● 0.32	0.32	0.13
Exceptional Costs	0.00	0.00	● 0.00	0.00	0.00	● 0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.00	0.26	△ (0.26)	0.32	(0.00)	● 0.32	0.32	0.13
Other Adjustments	0.00	0.00	● 0.00	(0.32)	0.11	△ (0.43)	(0.32)	0.21
Adjusted Net (Surplus)/Deficit	0.00	0.26	△ (0.26)	(0.00)	0.11	△ (0.11)	0.00	0.34
CIP	0.20	0.21	● 0.01	1.74	1.77	● 0.03	2.16	2.16
Capital	0.20	0.38	△ (0.18)	1.73	1.04	● 0.69	1.78	1.78
Cash	4.52	23.02	● 18.50	4.52	23.02	● 18.50	19.80	19.80
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

● Favourable Variance △ Adverse Variance

Finance

Run Rates to Month 10 2021/22



5 Finance

Bridgewater Community Healthcare NHS Foundation Trust

Cumulative Performance against NHSE/I Plan – Breakeven to Month 10

- The Trust is reporting a surplus of £0.01m at month 10, slightly better than plan.
- H2 CIP requirement is currently 2.50%. The Trust is currently planning for 2.76% (Est £1.40m). This equates to a year-to-date target of £1.74m which is reported as achieved.
- FRF suspended until further notice.
- Income is £85.77m year to date - £1.19m above the plan.
- Expenditure is £85.76m year to date – £1.08m above plan.
- Pay underspent by £0.80m year to date against a plan of £55.43m.
- Agency spend of £4.90m year to date against a plan of £5.12m.
- Non pay expenditure is £26.17m year to date, overspent by £2.0m against a plan of £24.17m.
- Capital charges are £0.1m below plan.

6 Appendix

Bridgewater Community Healthcare NHS Foundation Trust

Indicator	Detail
Operations	
Diagnostic waiting times – 6 weeks	All diagnostic tests need to be carried out within 6 weeks of the request for the test being made. The national target is 99% or over within 6 weeks.
Four-hour A&E Target	All patients who attend a Walk in Centre or Urgent Care Centre (A&E Type 4) should wait no more 4 hours from arrival to treatment/transfer/discharge. The national target is 95%.
Cancellation by Service	The Trust aspires to ensure that no patient will have their appointment cancelled. In exceptional circumstances, however the service may need to cancel patient appointments. In these instances, patients/carers will be contacted and offered an alternative appointment at their convenience acknowledging the maximum access times target.
Cancellation by patient	A patient cancellation or rescheduling request occurs when the patient contacts the service to cancel their appointment. Short notice cancellations i.e.: within 3 hours of appointment time should also be recorded as cancellation.

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date	7 April 2022
Board Part	Public
Agenda item	21/22ii

Title	COVID-19 Update Report
Sponsoring Director	Lynne Carter, Chief Nurse / Deputy Chief Executive Officer Sarah Quinn, Chief Operating Officer
Authors	Sarah Quinn, Chief Operating Officer Paula Halsall, Lead Infection Prevention Control Nurse / Deputy DIPC
Presented by	Sarah Quinn, Chief Operating Officer
Exec Summary/Purpose	To provide the Trust Board with an update in relation to the current actions taken to manage the impact of the COVID -19 pandemic.
Previously considered at	N/A
Related Trust Objective/ Intentions	**Quality** – to deliver high quality, safe and effective care which meets both individual and community needs **People** – to be a highly effective organisation with empowered, highly skilled, and competent staff
Which CQC domains are supported by this report?	***Safe*** ***Effective*** ***Caring*** ***Responsive*** ***Well-led***
Which BAF risks are addressed in this report?	**BAF 2 - Failure to deliver safe and effective patient care** **BAF 3 – Managing demand and capacity** **BAF 6 - Staffing levels**
Other risks highlighted/addressed in this paper? (e.g., financial, quality, regulatory, other)	N/A

Equality Impact assessment	N/A
Explanation of any acronyms in the report	Included in the report.
Next steps	Actions will continue to be monitored daily by the operations and nursing team call and via the command-and-control structure.
Recommendations	The Board is asked to note the content of the report and the work that is currently being undertaken to respond to the COVID -19 pandemic.

Board

Title	COVID-19 Update Report
Author	Sarah Quinn, Chief Operating Officer Paula Halsall, Lead Infection Prevention Control Nurse / Deputy DIPC
Date	28th March 2022
Purpose	To provide the Trust Board with an update in relation to the current actions taken to manage the impact of the COVID -19 pandemic.
Audience	Board

1.0 EXECUTIVE SUMMARY

1.1 During the last few weeks, staff absence levels have decreased from the levels of absence recorded in January but are on an increasing trend with a notable rise in absence related to COVID.

1.2 Several services remain escalated at amber, but this is monitored at the Daily Operations Huddle and via the Command-and-Control Structure and the QIA Panels review the quality impact on service delivery.

1.3 There have been changes to the isolation and COVID testing guidance and policies and procedures have been updated to reflect this.

1.4 Vaccination as a condition of deployment was revoked on 15th March 2022.

1.5 The Board is asked to recognise the pressures of the management of the increasing numbers of positive COVID-19 cases and to note the actions that have been taken to support staff to deliver safe and effective care.

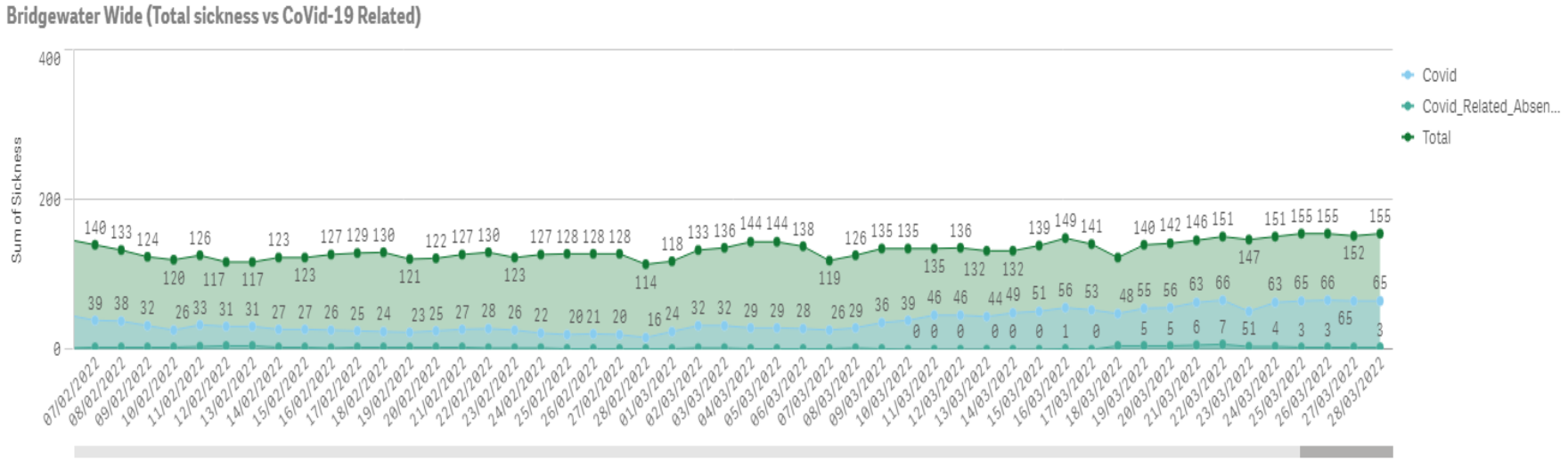
2.0 COMMAND AND CONTROL STRUCTURE

2.1 The command-and-control structure have been deescalated to twice weekly on Wednesdays and Fridays.

2.2 The daily operations and nursing calls have been stepped down to Mondays, Tuesdays and Thursdays and renamed the ‘Daily Operational Huddle. Silver meetings taking place in the 9am slots on Wednesdays and Fridays so there is always an opportunity to escalate any issues or concerns.

3.0 STAFF ABSENCES

3.1 The following chart is an extract from the Trust's Qlik system (performance reporting software):



3.2 Week commencing 28th March 2022, absence was recorded as 155 which is less than the peak at the beginning of January where 240 staff were absent from work. COVID absence has however steadily increased since the beginning of March. Fluctuations in the number of staff absent on a day-to-day basis, which is managed within Boroughs/Directorates and via the daily Operational Huddle meetings and the Command-and-Control Structure.

3.3 Significant absences have continued to be experienced in the priority 1 services and there have been challenges due to the impact of use of annual leave and increased sickness particularly in the district nursing services in Halton and Warrington. These pressures have been managed via business continuity plans and there has been no requirement to redeploy staff from other services.

4.0 STATUS OF CLINICAL SERVICES

4.1 As of 25th March 2022, the Trust's clinical services reporting as Red, or Amber are as follows:

Halton Borough:

- Services at Red status:
  - None
- Services at Amber status:
  - Treatment Rooms
  - Palliative Care service
  - Podiatry service
  - Runcorn West District Nursing
  - Widnes North and South District Nursing
  - Community Paediatric Service
  - Paediatric OT and Physio
  - 0-19 Health Visiting team
  - IV Therapy Service

Warrington Borough:

- Services at Red:
  - Paediatric Continence Service
  - Palliative Care Service
- Services at Amber status:
  - District Nursing
  - IV Therapy Service
  - Dermatology
  - Additional Needs Nursing Service
  - Paediatric Speech and Language Therapy
  - Health Visiting Service

Oldham Borough:

- Services at Red status:
  - None

- Services at Amber Status
  - Safeguarding Children Team
  - School Nursing service

Dental Network:

- Services at Red status:
  - None

- Services at Amber Status
  - Oral Surgery – Cheshire and Merseyside

Corporate

- Services at Red status:
  - None

- Services at Amber status:
  - Performance and Information

4.2 Business continuity plans have been and continue to be implemented and flexed according to service pressures.

4.3 The Trust continues to maintain the Quality Impact Assessment (QIA) panels on a fortnightly basis chaired by the Chief Nurse / Deputy Chief Executive for services that have been escalated through the command-and-control structure as implementing business continuity or services changes.

5.0 STAFF ISOLATION

5.1 Guidance in relation to Polymerase Chain Reaction (PCR) and Lateral Flow Device (LFD) testing as part of the exit plan of the pandemic continues to challenge the operational requirements of the organisation.

5.2 UKHSA distributed a letter to the organisation on the 23rd February on Living with Covid-19 White Paper delivering an initial message to expect updates in the changes in guidance.

5.3 This letter delivers the expectation of Health and Social care staff to continue PCR and LFD testing complete with ensuring organisations have robust reporting mechanisms with oversight of Trust board until the guidance is reviewed in April 2022.

5.4 On the 24th February 2022 the government removed domestic legal restrictions to isolate following a positive LFD test or on presentation of symptoms with the intention to treat Covid19 the same as other infectious diseases such as flu.

5.5 As of the 24th of February, UKHSA superseded advice on the 14th January by removing the requirement for non-fully vaccinated staff to isolate for the full 10 days following a positive Covid9 test or as an identified contact of Covid19.

5.6 All NHS staff, contractors and agency staff are required to routinely lateral flow test twice weekly, reporting all results via the government portal. Trust staff are expected to submit these results to the Performance team via the generic email address provided

5.7 NHS staff and contractors, agency staff who are positive cases of Covid-19 or contacts of Covid-19 can return to the workplace on day 6 if they had a negative lateral flow test on day 5 and day 6.

5.8 Covid19 positive cases are to LFD test daily from day 5 up to and including day 10.

5.9 Staff who test positive by LFD and do not display symptoms of Covid-19 as per definition are not required to obtain a PCR test, they isolate immediately and follow the return-to-work guidance as point 7.6.

5.10 NHS staff and contractors, agency staff who are contacts of Covid19 are asked to arrange a PCR test via the IPC team and LFD test daily for 10 days reporting their results to the national portal and the Trust generic LFD inbox.

5.11 Staff identified as contacts of Covid19 reporting positive LFD tests during the 10 days are to remain absent from the workplace for 5 days and follow instructions for LFD testing on day 5 and 6 as point 7.6.

5.12 Covid19 positive cases who remain positive by LFD test past days 5 and 6 are to continue daily LFD testing until they have had 2 consecutive negative tests until day 10.

5.13 Staff testing positive by LFD after day 10 are advised to discuss with their line manager and IPC team.

5.14 Risk assessments are advised for staff who are not fully vaccinated and are supported with appropriate measures to reduce the risk of transmission in the workplace

5.15 Social distancing measures are reduced to a minimum of 1 metre however always advise where possible to comply with 2 metres

5.16 Contacts of Covid-19 working during this 10-day period and staff returning on day 6 should comply with all relevant infection control precautions and PPE and have completed the appropriate training required. Any breaches should be reported immediately to their line manager and a Ulysses.

5.17 Those staff who test positive and return to work on day 6 should avoid working with clinically extremely vulnerable patients or residents and discuss with their line manager their programme of work.

5.18 A Standing Operating Procedure is in place and updated to reflect national guidance and is updated accordingly.

5.19 Staff can order a delivery of 7 LFD kits via the government portal to their home address or place of work every 3 days.

5.20 The Department of Health have communicated issues with stock and delivery of LFD kits since the removal of domestic guidance.

5.21 Local authority Public Health teams have provided the Trust with support with stock of LFD kits.

5.22 The IPC team continue to support the Trust with PCR testing.

6.0 IPC GUIDANCE

6.1 It remains an expectation for all Trust staff to wear face masks provided by the organisation at all times. Services are asked to be vigilant during break out times as this period impacts the workforce and service delivery where exposures to positive cases causes contacts to isolate.

6.2 Compliance with social distancing in the Trust remains following national guidance from in July 2021.

6.3 The Covid-19 Board Assurance Framework continues to be reviewed monthly in line with the Health and Social Care Act Code of Practice reporting and monitored via the Infection Prevention and Control Group and Quality and Safety Committee.

6.4 The Covid-19 Secure risk assessments and individual staff risk assessments further support the control measures as part of the requirements.

6.5 Outbreak management policies and guidance will also expect staff to wear the defined PPE during these circumstances.

6.6 Updated guidance is expected in April in relation to testing requirements and review of IPC guidance.

6.7 IPC have purchased artificial intelligence to support the delivery of robust performance reporting in relation to Donning and Doffing mandatory training.

6.8 This will supersede the requirement for staff to watch the Department of Health videos to comply with this mandatory training specifically.

6.9 Face fit testing is now mandatory and is performance reported via the educational and Professional Department.

6.10 The IPC team is trained to deliver qualitative and quantitative method of face fit testing.

6.11 This is a mandatory requirement as directed by NHSE and HSE.

6.12 The qualitative method uses key solutions to detect inaccuracies in the fitting of the masks and is known to be subjective. Performance reports identify a high failure rate of approximately 45% of tests.

6.13 The quantitative method for face fit testing has reduced the failure rate significantly on average between 15% and 20% per month.

7.0 FLU AND COVID BOOSTER VACCINATIONS

7.1 The Trust staff Covid-19 vaccination programme was completed in November 2021.

7.2 The building lease for the Vaccination Centre at Spencer House expired 9th January 2022.

7.3 The Trust has submitted an offer to support the autumn vaccination programme to NHSE.

7.4 The target for the Flu Immunisation programme for 2021/22 is: Frontline health care workers 100% offer with an 85% ambition.

7.5 The Flu programme for 2021 2022 completed on the.

7.6 Overall, Trust compliance is 69% for all Trust staff.

7.7 Overall compliance for patient facing staff is 68%.

7.8 The final figures have been submitted to Immform 3rd February 2022.

7.9 Work has commenced regarding the CQUIN for the delivery of the Flu programme 2022 2023

7.10 National guidance has been received to start planning the Flu vaccination programme for 2022 / 23.

7.11 The Trust has purchased the Flu vaccinations ready for the 2022 / 23 programme.

7.12 The Trust Immunisation Group (TIG) will continue to meet to support the operational planning of the vaccination programme for 2022 2023

8.0 VACCINATION AS A CONDITION OF DEPLOYMENT (VCOD)

8.1 Following a Department of Health and Social Care consultation from 9th to 16th February 2022, the VCOD regulations were revoked on 15th March 2022.

9.0 SYSTEM PRESSURES

9.1 The Trust has continued to support discharge and flow and to manage any discharge pressures from both acute trusts.

9.2 The urgent treatment centre in Widnes continues to see high numbers of patients attending the facility and activity is monitored daily via the performance dashboard.

9.3 Our intermediate care tier services in both Boroughs are at full capacity based on the current staff numbers. There is recruitment underway in both areas.

9.4 The numbers of patients in hospital with COVID has steadily increased and on 28th March Warrington and Halton Hospitals declared OPEL 4. St Helens and Knowsley Hospital have also experienced significant pressures.

10.0 RECOMMENDATIONS

10.1 The Board is asked to note the content of the report and the work that is currently being undertaken to respond to the COVID -19 pandemic and that all the guidance is being followed and that the required actions have been implemented.

Bridgewater Community Healthcare NHS Foundation Trust

Committee Chairs Report

Name of Committee/Group:	Quality and Safety Committee	**Report to:**	Board of Directors
Date of Meeting:	17 February 2022	Date of next meeting:	21 April 2022
Chair:	Gail Briers	Parent Committee:	Board of Directors
Members present/attendees:	**Present** Gail Briers, Non-Executive Director and Committee Chair Abdul Siddique, Non-Executive Director (from 11am) Sally Yeoman, Non-Executive Director Lynne Carter, Chief Nurse **In attendance** Sarah Quinn, Chief Operating Officer Jeanette Hogan, Deputy Chief Nurse Kristine Brayford-West, Director of Safeguarding Maxine Dickinson, Quality Matron, Halton (for her item only) Paula Hassall (for DD item only) Jan McCartney, Trust Secretary Sue Mackie, Director of Quality Governance Lynda Richardson, Board and Committee Administrator Samantha Scholes, Head of Corporate Governance **Observers** Rita Chapman, Lead Governor (to item 11/22), Diane McCormick, Public Governor, Halton (to item 19/22)	Quorate (Yes/No):	Yes
		Key Members not present:	Martyn Taylor, Non-Executive Director Ted Adams, Medical Director Aruna Hodgson, Medical Director Susan Burton, Director of Nursing, Warrington

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Impact of the COVID-19 Pandemic on Quality Within the Trust	2,3,6		The Committee received the report which detailed both the national and local requirements during the pandemic and the Trust's response during the key stages. The paper also discussed the impact on quality and the governance arrangements put in place to monitor this.	A further paper to be presented providing assurance that the impact of the pandemic on quality is being managed appropriately.
Risk Register Update Report	2,3,6		As the Risk Management Council had been stood down in December 2021 and January 2022 there was no output to report. The Deputy Chief Nurse and the Head of Risk Management had reviewed the Risk Register and in December 2021 there was concern 20.3% of risks had passed their review date. Each risk owner was contacted and in January 2022 an improved position of 13% of risk which had passed their review date was reported. The Risk Management Council would recommence in February 2022 and the April Quality & Safety Committee would receive a full report.	
IQPR	2,3,6		**i) IQPR** Based on data from December 2021, 6 indicators were reporting as red quality indicators which was an improvement from 11 previously reported. There had been a positive increase for safeguarding training levels 1 and 3.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			A new red indicator was in place for the number of bed-based falls. It was noted that the acuity of patients had changed at Padgate House during the pandemic and this was being actively monitored and reviewed. Trajectories were in place for the delivery and achievement of compliance for Information Governance and Safeguarding training with staff being rostered to undertake this. The 95% compliance target for Information Governance was required to be met once within a 12-month period and the deadline was June 2022.	The Chief Nurse would clarify and confirm the target date for achievement of staff compliance with training trajectories. The update could also be provided to the Audit and Finance and Performance Committees.
	2,3,6		**ii) Indicators with the Quality Domain of IQPR Dashboard** It was recognised that the organisation had changed over time with the divestment and onboarding of different services whilst the indicators being measured had not been amended. In addition, there were a number of indicators that the Trust was expected to measure that were purely acute trust focussed. The Chief Nurse advised that the targets had been adjusted in line with statistical process chart methodology to reflect changes in the Trust's size and services. Some of the metrics would be removed as it was considered that they did not add any value and demonstrate quality of services. Those that did add value and those that the Trust was required to report against would be retained. Further work would be undertaken to consider indicators that reflected services the Trust delivered, such as	The Committee noted that the level of detail within the report was appropriate and questions were able to be answered providing assurance that the Quality Council was managing areas of concern across the organisation.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			dental and additional indicators to enhance the approach in the monitoring of quality. Regional and national work was being undertaken concerning indicators which the Trust was linked into. Assurance was given that merging some indicators around pressure ulcers would ensure reports to Board or Committees were clearer and more meaningful by differentiating between similar indicators.	
Dermatology Improvement Plan: Progress Report	2,3,6		The report was presented to provide the committee with assurance that the improvement plan was being delivered. The issues and challenges were described well including the availability both locally and nationally of key dermatology staff. Innovative solutions are being pursued. The Committee noted that some areas of challenge remained within the service and the report provided assurance around the steps that were being taken to progress those areas, including internal processes and the broader discussions taking place to improve the service and its resilience and workforce.	The Committee Chair asked that this report be shared with the Finance and Performance Committee, recognising that the dermatology service had been raised as an issue by that forum.
Report from the Quality Council	2,3,6		Following increasing pressures on the Trust and the system due to the Omicron wave of the pandemic, the Quality Council meeting planned for January 2022 had been cancelled. Monitoring of patient safety and escalation of any patient safety/quality issues had been maintained within the Trust with service and borough	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			quality and operational meetings taking place in addition to the command-and-control structure. The report explained the actions at section three that had been taken during this time to ensure consideration of quality matters: • Quality Impact Assessment (QIA) panels continued • The monthly risk council meetings were cancelled however oversight of risks had been maintained by the Risk Manager and Deputy Chief Nurse and risk register information provided to risk owners and service leaders. • Quality Improvement Plan monitoring and assurance oversight had been maintained. • Patient Safety and Serious Incident Review Panels had continued. • Patient Experience Group deferred until March 2022. • Quarterly Quality Reports as identified on the Quality Council Business cycle (appended to the report at appendix a) would be deferred until March 2022 • Risk Register summary, Quality Improvement, MIAA quality spot check and Infection Prevention and Control reports had been submitted directly to this Committee and had been included as part of today's agenda. The Deputy Chief Nurse advised she had contacted all members of the Quality Council to ask if there were any issues that required escalation to the Committee. Two issues required escalation and were discussed in detail by the Committee.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Item Escalated From The Audit Committee – To Consider The Professional Clinical Structure Supporting The New Operational Management Structure	2,3,6		The Chief Nurse confirmed that a chart detailing the clinical structure was being updated by the Executive Management Team and therefore was not available to be presented today. She reported that workforce planning was being reviewed for every service within the Trust and this would be completed by the end of March 2022. A proposal for professional leadership would be completed within the same timescale.	The Committee Chair proposed that feedback to the Audit Committee would set out that the operational restructure had led to consideration around the clinical and quality agenda and this restructure would be taken through the Board as part of workforce and operational planning for 2022/23.
Quality Impact Assessment of Clinical Services Business Continuity During the Covid-19 Pandemic (Quarter Three October 2021 to December 2021)	2,3,6		**i) Quality Impact Assessment IQPR ongoing quality and safety issues from pre-pandemic** The Deputy Chief Nurse introduced a report that provided an overview of the QIAs undertaken during quarter three. The panel considered there were two QIAs which must be reviewed again at a further point in time: • Dermatology • Warrington community paediatric services. Whilst the panel accepted the work that the Warrington community paediatric service had undertaken, it was felt that further oversight was required from a quality perspective regarding new ways of working and the impact for staff and patients. This must be properly assessed before any further discussions took place concerning scoring.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			The Chief Nurse advised that QIA panels were now taking place for all service redesigns, irrespective of whether they were small or larger scale. This was supporting resilience within the organisation and helping to mitigate against risks. **ii) Trust Improvement Plan Updates** The Deputy Chief Nurse presented an update report concerning the improvement plans that were currently being monitored via the Life QI system. She explained that there were currently 11 plans and each one was being reviewed with the owner of the plan on a monthly basis. The owners would be required to provide evidence and assurance to the QI group where this information was reviewed in detail. There were currently no plans that required escalation to this Committee.	The Committee Chair suggested that there may be a need for improvement plan areas to be considered to be brought back to this Committee for a deep dive, such as the carer's strategy, and would be added to the business cycle as required. It was agreed that the Trust Improvement Plan update report would be presented back to the Committee at every other meeting (June, October for the remainder of 2022)
Assurance of Infection Prevention And Control Management and Processes	2		The Lead Infection Prevention and Control Nurse presented a report to set out how the IPC team were continuing to manage and monitor the IPC service within the Trust. This included assurance that the Trust was compliant with the Health and Social Care Act; Code of Practice, A rolling action plan had been developed to support the ongoing monitoring of the Code of Practice which incorporated the Covid-19 BAF. She confirmed that the Quality Assurance Framework Covid-19 Vaccination Sites and the Covid-19 BAF were reviewed	The Committee Chair proposed that the Finance and Performance Committee were made aware of this as part of their considerations of digital updates and the digital strategy. The Committee had committed to supporting the IT solution and the Committee Chair commented that the Committee must be kept updated as to how this was progressing and what the timescales would be.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			and updated prior to being submitted to the IPC Group, where the evidence was reviewed and discussed on a monthly basis. The face fit testing programme was continuing during the quarter with a plan in place. The Committee Chair highlighted that from the deep dive undertaken at the October Committee, there were two areas of concern: the lack of ability to demonstrate compliance with the code of practice and an associated IT solution. She asked if there was any update on those aspects. The Lead Infection Prevention and Control Nurse advised that the IPC group had implemented an assurance table within Microsoft Teams which enabled staff to declare their compliance with the hand hygiene code, 'bare below the elbows' and environmental cleanliness. This was implemented on 10 February 2022. This would provide evidence of reporting through to the next IPC group. This could be provided back to the Committee if required. Concerning the IT solution, the Chief Nurse confirmed that this was still being progressed and was part of the overarching digital strategy and IT systems for other elements such as audit. Dates were not yet available as to when this would be implemented	
Review of MIAA audits – Quality spot check	2		The Quality Matron for Halton presented the report which provided an update against the quality spot check action plan. She reported that has been updated to reflect the progress including evidence against actions and there were seven actions which had now been fully completed. The paper included the action plan following	The Committee acknowledged the limited assurance opinion assigned by MIAA but recognised this had moved the Trust into a position with comprehensive actions which would translate into an improvement plan. The

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			the clinical audit of NEWS2 and sepsis in April 2021. This action plan would be monitored via the Clinical Audit team and Quality Matron (Sepsis/NEWS2 trust Lead). Assurances on progress of the action plan would be included in the Halton Quality Council Update Report. The Quality Matron advised that a follow-up audit would take place at the end of February 2022 led by MIAA to evaluate the effective embedding of change within clinical practice. This would include obtaining documentary evidence to demonstrate that actions agreed as part of this review had been implemented. The Quality Matron advised the MIAA had received evidence and had indicated that they were satisfied with the progress that had been made, however they would sense check the evidence and the embeddedness within services as part of their review. Work would continue to embed improvements for NEWS2 and sepsis. The Chief Nurse advised that implementation had been regularly checked, even during challenging periods such as redeployment during the pandemic, consistency had been in place around those regular checks and embedding of the process. Discussion took place concerning the confidence level around an improved audit opinion following MIAAs review. The Committee acknowledged the work that had been undertaken and would await the outcome of the review.	Committee was assured that sufficient plans were in place to address the issues and advised that the Committee would continue to monitor this position and ensure progress.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Review of Strategies			**i) Children's strategy** The Chief Nurse delivered a presentation setting out progress with the children's strategy. She explained that the initial aims of the strategy were to ensure system leadership and insight, to ensure integration into the system, working with partners and avoiding replication of work and a having a deep level of data driven insight into children's health service provision and exploring how this was best used. The Chief Nurse explained the four key themes of the strategy which were interconnected to provide opportunity for the Trust to take a lead in the development of 0-25, children's and young people's health services in Warrington, Halton and Oldham: - Opportunities to further connect the Trust's services to enable improved outcomes - Use of Bridgewater data to proactively drive improved outcomes. This was following the development of the data warehouse. - Ensuring that governance, controls and permissions were enablers and not barriers to delivering improved outcomes - Creating a broader system desire to work with the Trust and optimise the internal offer to support improved outcomes. The Chief Nurse described recent issues which had an impact on the original work plan. The Chief Nurse advised that work was now being undertaken to review the original work plan in the light of the above developments and the timescales were to be finalised for this. The initial timescales had now passed.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			ii) Safeguarding strategy The Director of Safeguarding presented a report concerning the safeguarding strategy for 2022 to 2025. The strategy had been approved by the STAG, and the concise strategy considered the necessary steps to prevent safeguarding issues from escalating and how the Trust protected children, young people and adults as the foundation of its duty of care. She advised that the strategy also featured the provision of leadership for safeguarding at every level across the Trust and that it aimed to deliver robust safeguarding arrangements and appropriate, timely, and effective use of procedures, policy, and guidelines to protect those who are most at risk. This would also form a strong link with the Quality and Place Strategy. The strategy reflected legislation, partnership working, a 'Just Culture', Bridgewater's Strategic Objectives and PEOPLE Values. The Committee Chair questioned how the Committee could be assured that the statements made within the strategy were being delivered. The Director of Safeguarding responded that work was continuous to retain a key focus on safeguarding such as training, safeguarding supervision, support for staff with case reviews and briefings in the Trust bulletin including updates on safeguarding legislation and a dedicated safeguarding page on the Trust Hub. There were also	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			safeguarding policies, guidelines, procedures and legislation available that staff could readily access. In terms of the key elements to be drawn to the Committee's attention, the Director of Safeguarding commented that the cases that staff had dealt with during the pandemic had been particularly harrowing, but that the safeguarding team had continued to deliver and the commissioners had been content with the service provided. There were strong links in boroughs with the safeguarding boards and it would be key to continue to ensure that staff were accessing and understanding their safeguarding training. The Trust Secretary highlighted that once the Committee reviewed the strategy to assess how effective this was, it would be possible for evidence to be provided against each of the 15 statements made within the document	
Review of Committee Terms of Reference			**i) Terms of Reference** The Trust Secretary introduced the Terms of Reference. She explained the changes that had been made from the previous version of the document: - Additional Non-Executive Director added (Martyn Taylor) who was now a member of the Committee. - Addition of the Chief Operating Officer as a member of the Committee. The Committee agreed the above amendments.	The Committee Chair proposed that the quorum should state the number of members to ensure quoracy opposed to a percentage to align with other Committee Terms of Reference. Following discussion, the quorum was three Non-Executive Directors (including the Committee Chair) and two Executive Directors. A further detailed review of the terms of reference would take place between the

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			The Trust Secretary advised that the quorum would remain the same at 50% of the membership.	Trust Secretary, Chief Nurse and the Committee Chair. The Committee Vice Chair would be discussed and agreed at the Non-Executive Director's meeting in March. Discussion took place concerning attendance of a workforce representative which was referred to in the terms of reference. The Committee agreed that due to a number of inter-related quality and workforce related matters, it would be important for a representative to attend future Committee meetings. The Trust Secretary would liaise on this with the Director of People. Following discussion, it was agreed that a review would be required of section eight duties and responsibilities as there were a number of elements reflected within the section that pre-dated the establishment of the Quality Council, Performance Council and Risk Management Council. It was agreed that the Committee Chair, Chief Nurse and Trust Secretary would meet separately to review and update this section of the Terms of Reference.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			ii) **Annual Committee Effectiveness Review** The Trust Secretary presented the results of the Committee's annual effectiveness review. She highlighted that there had been few responders to the self-effectiveness survey that had been circulated to members, attendees and observers. Only seven returns were received, with three of those returns from Committee members. The majority of responses to the questions were 'agreed' or 'strongly agreed' with the exception of question seven which asked if the responders thought the meeting papers were concise, relevant and received in a timely fashion. One responder disagreed with this statement. The Committee received the report for assurance and welcomed the positive response but recognised that there was a disappointing level of response and that members of the Committee had an obligation to complete the effectiveness review questionnaire.	
Quality and Safety Committee Business Cycle				The Committee agreed that the business cycle would be reviewed following finalisation of the Terms of Reference
BAF	1		The Trust Secretary reported that she had reviewed the Board Assurance Framework recently with the Deputy Chief Nurse.	The Committee approved the changes and updates.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			BAF2 The areas highlighted in yellow were proposed to be removed. The areas highlighted in green were new additions for the Committee to accept. **The Committee agreed that it was comfortable with the proposed removals and additions.** **The Committee broadly agreed that the risk ratings would remain unchanged** and there had been no discussions today that would change those. **However, the Committee Chair suggested that a review be undertaken of the assurances provided by item 13/22 in relation to QIAs**, although it was considered that a change to scorings was not expected. The areas of concern were not considered to have changed the risk scores and were picked up within the BAF. Additional areas that had been discussed such as children's services were not yet having an impact. **BAF3** The Trust Secretary referred to a section for discussion by the Committee as to whether it remained current: this related to fortnightly meetings with 0-19s commissioners (Warrington and Halton) and **CEO chairs OOH cell meetings and COO in attendance**. The Chief Nurse advised that the fortnightly meetings were not a detect control. However the CEO chairs OOH cell meetings were still taking place but were being progressed in a different way. It was agreed that this element should read **'CEO and COO attend system pressures**	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			meetings as required and support out of hospital working'. It was agreed that this item should remain on the BAF and the fortnightly meetings were still also taking place as additional meetings to provide updates and assurance. The Committee agreed that the scorings for BAF3 remained unchanged. **BAF6** The Committee reviewed and agreed the highlighted section detailing the rationale for the current BAF6 score from the People Committee. The Committee agreed the highlighted areas for removal/addition and agreed that the scoring for BAF6 remained unchanged.	

Risks Escalated.

Feedback would be provided on the Information Governance target elements to the Audit and Finance and Performance Committees.

The dermatology paper on the agenda would be shared with the Finance and Performance Committee.

Paper on the quality indicators would be shared with the Finance and Performance Committee.

The changes in the quality indicators would also be shared with the People Committee.

It was also proposed that the approval of the new quality indicators be highlighted in particular to the Board within the Committee Chair's report.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date 7 April 2022

Board Part Public

Agenda item 22/22i

Title	Finance Report – February 2022
Sponsoring Director	Nick Gallagher – Executive Director of Finance
Authors	Rachel Hurst – Deputy Director of Finance
Presented by	Nick Gallagher – Executive Director of Finance
Exec Summary/Purpose	To brief the Board on: • Financial position as at Month 11
Previously considered at	
Related Trust Objective/ Intentions	Sustainability – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability.
Which CQC domains are supported by this report?	Well-led
Which BAF risks are addressed in this report?	BAF 1 - Failure to implement and maintain sound systems of Corporate Governance. BAF 2 - Failure to deliver safe and effective patient care. BAF 4 – Financial sustainability BAF 7 - Strategy and Organisational sustainability
Other risks highlighted/addressed in this paper? (e.g., financial, quality, regulatory, other)	N/A
Equality Impact assessment	N/A
Explanation of any acronyms in the report	

Next steps	
Recommendations	The Board is asked to: • Note the contents of this report. • Recognise the risks identified in the report. • Be assured that the mitigations / controls identified are appropriate and effective.

Bridgewater Board

Title	Finance Report – February – Month 11
Author	Nick Gallagher – Executive Director of Finance
Date	7 April 2022
Purpose	To brief the Board on: • Financial position as at Month 11
Audience	Board

1.0 Executive Summary

1.1 The purpose of this report is to brief the Board on:

- Financial position as at Month 11
- CIP plans and delivery
- Capital and Cash.

2.0 Financial Position as at Month 11

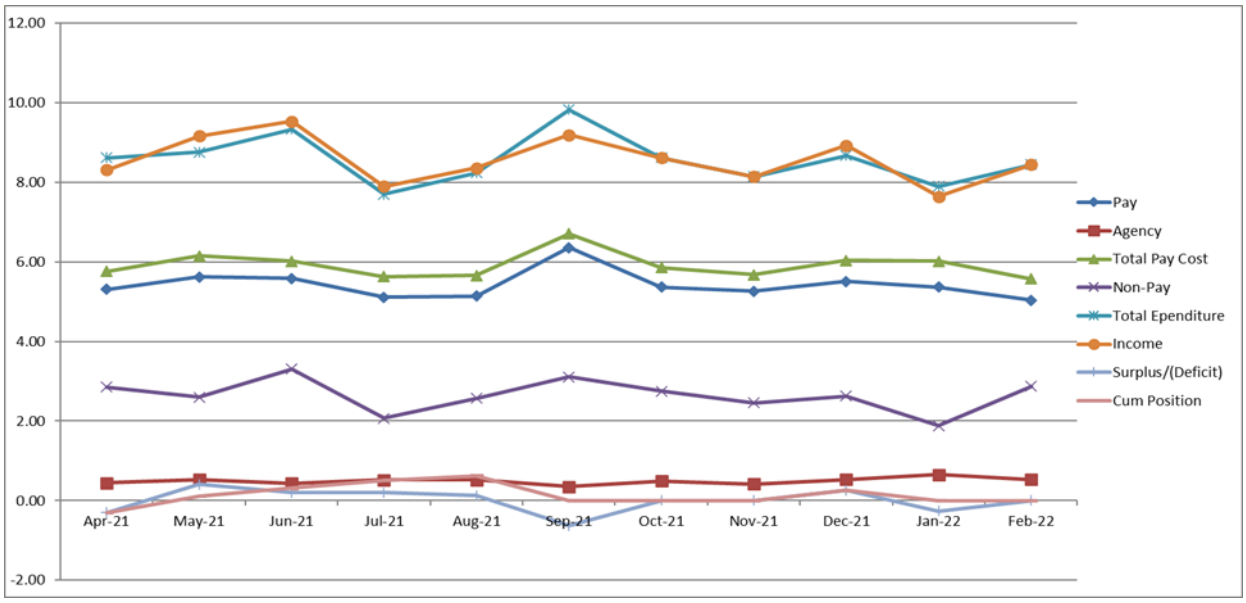
2.1 The key headlines for month eleven are shown in the table below:

Summary Performance Month 11 2021-22	Month 11 Plan (£M)	Month 11 Actual (£M)	Month 11 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.22)	(8.44)	0.22	(92.79)	(94.20)	1.41	(101.01)	(102.68)
Expenditure - Pay	5.40	5.04	0.35	60.83	59.67	1.16	66.13	65.19
Expenditure - Agency	0.64	0.53	0.11	5.75	5.43	0.33	6.38	5.89
Expenditure - Non Pay	2.18	2.88	(0.69)	26.35	29.05	(2.70)	28.65	31.66
EBITDA	(0.00)	0.01	(0.02)	0.15	(0.05)	0.20	0.15	0.05
Financing	0.00	(0.01)	0.01	0.17	0.06	0.11	0.17	0.06
Normalised (Surplus)/Deficit	(0.00)	0.00	(0.01)	0.32	0.00	0.31	0.32	0.11
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	(0.00)	0.00	(0.01)	0.32	0.00	0.31	0.32	0.11
Other Adjustments	0.00	0.00	0.00	(0.32)	(0.11)	(0.21)	(0.32)	(0.10)
Adjusted Net (Surplus)/Deficit	(0.00)	0.00	(0.01)	(0.00)	(0.11)	0.10	0.00	0.01
CIP	0.21	0.18	(0.03)	1.95	1.95	0.00	2.16	2.16
Capital	0.26	0.00	0.25	1.99	1.04	0.94	1.78	1.78
Cash	4.52	24.58	20.06	4.52	24.58	20.06	19.80	26.00
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Favourable Variance Adverse Variance

2.2 The plan referred to is the final version of the H2 plan submitted to NHSE/I and reflects the transfer out of Maternity Services on 1st November 2021.

2.1 All month 11 run rates are consistent with average year to date spend.



3.0 Cost Improvement Programme (CIP)

3.1 National guidance required the Trust to make CIP savings of 0.28% (£0.14m). Savings identified in 2020/21 H1 met this requirement. The Trust was required to deliver additional system savings of 1.25% (£0.61m) to support the system financial gap. The Trust was required to deliver £0.75m of overall savings in months 1 – 6 which were reported as being achieved.

3.2 For H2 the CIP requirement is currently 2.50%. The Trust is currently planning for 2.76% (estimated £1.40m). This equates to a year-to-date target of £1.95m which is reported as achieved, predominantly due to reduced travel, non-recurrent vacancies, a reduction in the IT support contract and the unavailability of additional Dental GA sessions included in the plan.

3.3 The table below provides further analysis of CIP achieved to date.

Area	H1 Actual £m	M11 Actual £m	H2 YTD £m	H2 Forecast £m	Recurrent	Non Recurrent
Dental GA Sessions	0.38	-	0.040	0.030		✓
ERF	0.08	-		-		✓
Travel	0.14	0.015	0.091	0.107	✓	✓
Workforce	0.16	0.075	0.660	0.735		✓
Procurement		0.004	0.039	0.105	✓	
Estates & Facilities		0.060	0.216	0.258	✓	✓
Other		0.026	0.152	0.177	✓	✓
Unidentified						
Total	**0.75**	**0.180**	**1.198**	**1.412**		

3.4 The Director of Finance meets with operational assistant directors and senior service managers on a monthly basis to discuss CIP development, monitoring and reporting. CIP savings already made continue to be identified, along with further saving opportunities.

4.0 Financial Out turn and Risk Range

4.1 The NHSE/I guidance expects systems to deliver a cumulative breakeven position at the end of the financial year.

4.2 Risks for Bridgewater have been included in the plan and the Trust is planning to manage these within the resource envelope; these include an element of pay award relating to local authorities which is unfunded and the risk associated with CIP above the system requirement.

5.0 Capital, Loans, Cash and Better Payment Practice Code

5.1 Total capital expenditure as at 28th February 2022 is £1.04m against the amended planned figure of £1.76m.

5.2 The underspend is primarily due to delays in delivering some of the schemes, a reduction in value of other scheme, and some schemes which are no longer required. Capital spend is reviewed on a monthly basis by the Capital Council and performance and variances reported to the Finance and Performance Committee.

5.3 The Trust remains confident the capital plan will be achieved.

5.4 In February there was a net cash inflow of £1.55m with a closing cash balance of £24.58m.

5.5 The Trust cash balance is primarily due to the recovery of long term aged over the past 18 months that had been included in working capital cash loans prior to 2020/21. As part of the Department of Health loan restructure, these loans were converted to Public Dividend Capital. The Trust has continued to chase all debts, and a significant proportion of these debts has now been settled.

5.6 The Trust is in discussions with the national cash management team regarding the future utilisation of this cash balance.

5.7 Total debt as at 28th February is £9.59m excluding bad debt and credit note provisions, of which £7.21m relates to invoiced debt. Overall debt continues to decrease and reduced by £3.8m from January. This follows substantial payments received from Oldham Borough Council and Warrington Borough Council.

5.8 The table shows the percentage (number and value) of invoices paid within BPPC terms. Additionally, a creditor review has commenced with the aim of improving performance further.

	Target to be paid %	No of Invoices %	Value of Invoices %
Apr-21	95	93.9	85.1
May-21	95	91.8	87.2
Jun-21	95	92.4	87.0
Jul-21	95	98.5	99.7
Aug-21	95	99.3	99.4
Sep-21	95	97.7	96.4
Oct-21	95	97.9	98.2
Nov-21	95	97.8	98.9
Dec-21	95	98.1	97.8
Jan-22	95	99.4	97.2
Feb-22	95	97.9	99.3
Year to date performance	95	96.8	95.2

5.9 NHSE/I continues to focus on BPPC performance relating to the value of non-NHS invoices paid within terms in the coming months. The Trust has improved approval and payment times. The national target is 95% and the Trust is now cumulatively exceeding this.

6.0 2021/22 Year end forecasts

6.1 The Trust is forecasting to break even for the year ending 31 March 2022.

6.2 By 31 March 2022, the Trust is forecasting to spend its full capital allocation.

6.3 The Trust is forecasting full achievement of the required savings by 31 March 2022.

7.0 Use of Resources Rating (UOR) Finance

6.1 Due to the Covid-19 pandemic, reporting against the use of resources rating remains temporarily suspended.

8.0 Recommendations

8.1 The Board is asked to:

- Note the contents of this report.

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	Finance and Performance Committee	**Report to:**	Board of Directors
Date of Meeting:	24 March 2022	Date of next meeting:	28 April 2022
Chair:	Tina Wilkins	Parent Committee:	Board of Directors
Members present/attendees:	**Present:** Tina Wilkins, Committee Chair Linda Chivers, Non-Executive Director Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Nick Gallagher, Director of Finance Sarah Quinn, Chief Operating Officer (to 10.30am) **In attendance:** Lynne Carter, Chief Nurse Rachel Hurst, Deputy Director of Finance Debbie Weir, Financial Controller Gareth Pugh, Assistant Director of Finance Dave Smith, Assistant Director of IT (from 11.30am) Jan McCartney, Trust Secretary Sam Scholes, Head of Corporate Governance Eugene Lavan, Deputy Chief Operating Officer Anita Buckley, Information Team **Observers:** Rita Chapman, Lead Governor	Quorate (Yes/No):	Yes
		Key Members not present:	Jan McCartney

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Finance	4		Month 11 finance report received and provided assurance. The Committee noted that: • forecast for H2 21/22 is breakeven • improvement in BPPC performance • healthy cash position • significant recovery of aged debt • Capital behind plan - forecast to achieve	The Committee noted that once the plan for CIP for 22/23 has been agreed there will be a separate paper outlining the plan and workstreams and the CIP section of the finance paper will be expanded to provide further detail and assurance. The Committee noted that underspends on staff and agency costs was not as a result of holding vacancies and that all efforts were made to secure staffing both on a temporary and substantive basis including the use of agency. The Committee noted the significant improvement in BPPC due to the efforts across both operational teams and finance. The Committee noted that work was focused on ensuring that aged debt was resolved/progressed before year end.
Finance	4		2022/23 draft 202/23 Financial Plan was received. The Committee received the 2022/23 draft planning presentation that was made to and was approved by Board. The Committee were updated on the process and work that was being undertaken to review the draft plan. The Committee were informed that a final plan will be presented to Board for approval in April.	The Committee noted the paper and they were assured by the progress being made in terms of review of the draft plan and the consequent financial impact.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			The current review includes the exploration of alternative funding sources, the utilisation of existing workforce and vacancies to deliver the operational ask. The Committee was also updated on discussions with Commissioners around prioritisations, service scope and growth in demand. Charitable funds report was received and noted. A verbal update was provided to the Committee on the interim audit.	The Committee noted that the accounts are due in on 26th April with the external audit due to commence on 3rd May 2022.
Performance	4,8		The Committee received the IQPR report followed by a presentation from the COO providing an update on the operational recovery plan. The Chair's report from Performance Council was presented. The New Business and Divestment report was received and noted.	The Committee noted that performance had remained stable. Partnership working is helping to deliver progress in certain areas, for example Dental GA access. The Committee noted the clinical harms review and the children's dental review. The Committee noted that Performance Council would review the rag rating for teams and services and how to represent that on the feedback from the Chair's report. The Committee noted its thanks to those staff transferring out of the Trust.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

			The Dermatology Improvement Plan was also shared for information from the Quality and Safety Committee.	The Committee noted the assurance provided by the plan.
Digital	8		Digital Strategy – a verbal update was provided.	The Committee noted that the Programme Director – Collaboration and Innovation is aiming to have a draft Digital Strategy complete to go to Board in May 2022.
Digital	8		Chair's report from DIGIT distributed via e governance.	The Committee noted the further national DSPT compliance requirements. Of the 13 review areas, these were then split into immediate (six) – of these five were green and one was amber. In the priorities (seven), four are green and three are amber. Any amber areas will be complete by the end of April. The Committee noted that a report will come back to the April meeting to provide assurance that these areas were on track to be completed.
Estates	4		Estates workplan was received and noted. Green plan update was received and noted.	
Audit	4		Audit recommendations report - received and noted.	
Risk	4		Operational risk report - received and noted.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

BAF	4,7,8		BAF 4 – risk remains the same BAF 7 – risk remains the same BAF 8 – risk remains the same	The Committee reviewed all the BAFS and proposed amendments and deletions to be presented to Board. BAF 8 will be further reviewed and come back to the May Committee. No change to current risk ratings was proposed. No risks of 15 or above for BAF 4,7,8	
Review of Committee Business Cycle	4,7,8		Review of Committee Business Cycle – reviewed and updates proposed in terms of timings for Internal Audit reports in order to provide assurance to Audit Committee.		
Meeting Review – The Committee noted that there was a high degree of review and challenge regarding the BAF. The Committee deferred the Terms of Reference to the next meeting pending further clarification of governance regarding sub groups. The Committee noted that actions arising should be dealt with on the related agenda item.					
Risks Escalated – None **Actions delegated to other Committees** – **None**					

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Bridgewater Community Healthcare
NHS Foundation Trust

Bridgewater Board Date	7 April 2022
Board Part	Public
Agenda item	23/22

Title	Integration & Collaboration
Sponsoring Director	Colin Scales – Chief Executive Officer
Authors	Rob Foster – Programme Director Collaboration and Integration Sarah Quinn – Chief Operating Officer
Presented by	Rob Foster – Programme Director Collaboration and Integration
Exec Summary/Purpose	To provide an update on progress to date
Previously considered at	N/A
Related Trust Objective/ Intentions	**Quality** – to deliver high quality, safe and effective care which meets both individual and community needs **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing, and independent living **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability. **People** – to be a highly effective organisation with empowered, highly skilled, and competent staff **Equality, Diversity, and Inclusion** – to actively promote equality, diversity, and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
Which CQC domains are supported by this report?	***Responsive*** ***Well-led***

Which BAF risks are addressed in this report?	**BAF 1 - Failure to implement and maintain sound systems of Corporate Governance** **BAF 2 - Failure to deliver safe and effective patient care** **BAF 3 – Managing demand and capacity** **BAF 4 – Financial sustainability** **BAF 5 – Staff engagement and morale** **BAF 6 - Staffing levels** **BAF 7 - Strategy and Organisational sustainability** **BAF 8 - IM&T systems which do not meet the requirements of the organisation**
Other risks highlighted/addressed in this paper? (e.g., financial, quality, regulatory, other)	N/A
Equality Impact assessment	N/A
Explanation of any acronyms in the report	C&M – Cheshire and Merseyside ICS – Integrated Care System ICP – Integrated Care Partnership ICB – Integrated Care Board LGA – Local Government Association MHLDC PC – Mental Health, Learning Difficulty and Community Provider Collaborative MOU – Memorandum of Understanding NHSEI – NHS England and Improvement PCN – Primary Care Network PC – Provider Collaborative UEC – Urgent & Emergency Care
Next steps	To continue to progress and review areas of collaboration and integration.
Recommendations	To note the contents of this paper and the identified actions

Bridgewater Community Healthcare NHS Foundation Trust

Board

Title	Integration & Collaboration
Author	Rob Foster, Programme Director – Integration and Collaboration Sarah Quinn, Chief Operating Officer
Date	7th April 2022
Purpose	To provide an update to the Board in relation to integration and collaboration.
Audience	Public Board

1.0 Executive Summary

1.1 The purpose of this report is to provide insight and oversight to the Board about the progress with integration and collaboration development and opportunities across the Trust.

2.0 ICS Update

National

2.1 The new Integrated Care System (ICS) agenda is due to become statutory on 1st July 2022, subject to the passing of the Health and Care Bill.

Cheshire & Merseyside

2.2 Appointments have been made to key leadership roles for NHS Cheshire and Merseyside Integrated Care Board (ICB). The table below lists key roles and appointments:

Role	Appointment
Designate Chief Executive	Graham Urwin
Designate Assistant Chief Executive	Clare Watson
Designate Director of Finance	Clare Watson
Designate Director of Planning & Performance	Anthony Middleton
Designate Medical Director	Prof. Rowan Pritchard-Jones
Designate Associate Medical Director	Dr. Fiona Lemmens
Designate Director of Nursing and Care	(Interim) Marie Boles & Prof. Maggie Boyd (as interim Clinical Quality Advisor)
Designate Chief People Officer	Christine Samosa
Designate Chief Digital Information Officer	Alex Chaplin

2.3 Following a recruitment process, the ICB has also appointed the nine Place Directors for Cheshire and Merseyside.

2.4 The successful candidates will take up their posts on 1 July 2022, but will become involved from early April so they can contribute to the further design of the integration agenda.

Place	Appointed Place Director
Warrington	Carl Marsh
Halton	Anthony Leo
Cheshire East	Mark Wilkinson
Cheshire West	Delyth Curtis
Knowsley	Alison Lee
Liverpool	Jan Ledward
Sefton	Deborah Butcher
St. Helens	Mark Palenthorpe
Wirral	Simon Banks

3.0 Provider Collaborative update

3.1 Work of the Mental Health, Learning Disability and Community Provider Collaborative (MHLDC PC) has continued to support the development of the workplan, governance and delivery focus.

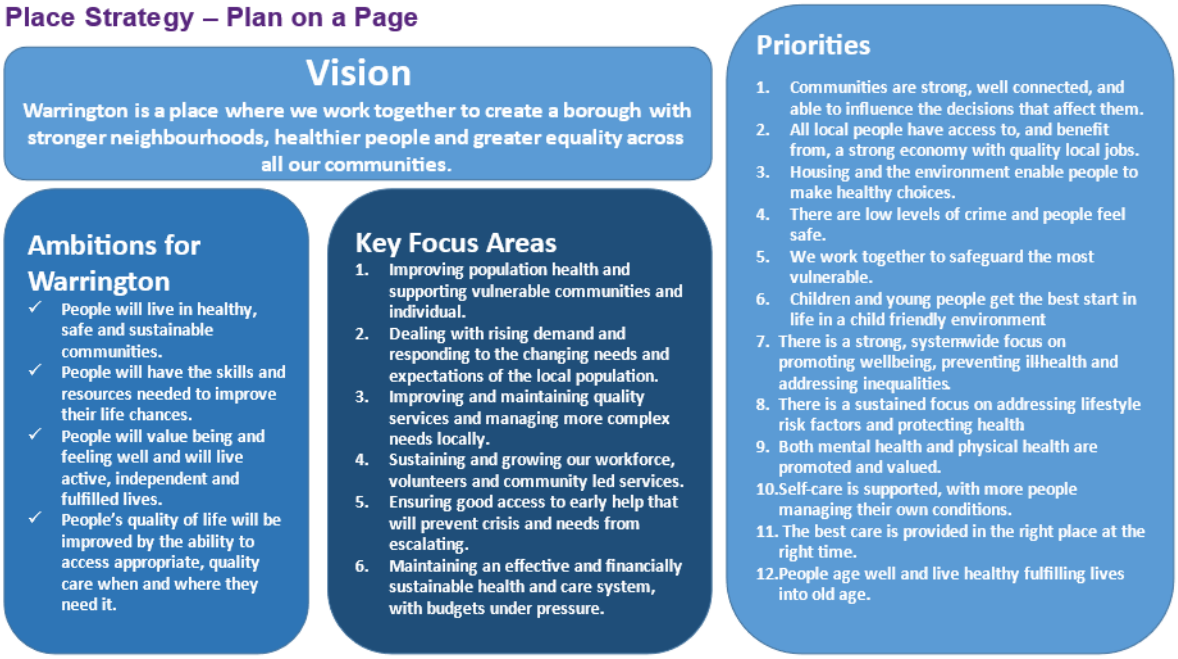
3.2 To support this, the MHLDC PC have commissioned the Good Governance Institute (GGI) to support the development of its strategy and governance arrangements

3.3 Critical to this is ensuring the right collaborative and partnership arrangements are developed with the ICB, our places, the Acute Provider Collaborative (CMAST) and other bodies and groups across the ICS footprint.

4.0 Warrington Update

4.1 The Warrington governance arrangements have continued to be developed. This work is being led by the new Transformation Lead Lauren Sadler in conjunction with the place partners.

4.2 The place strategy has been developed into a plan on a page format and this will be reviewed in preparation for the launch of a new Health and Wellbeing Strategy for Warrington for 2023-28.

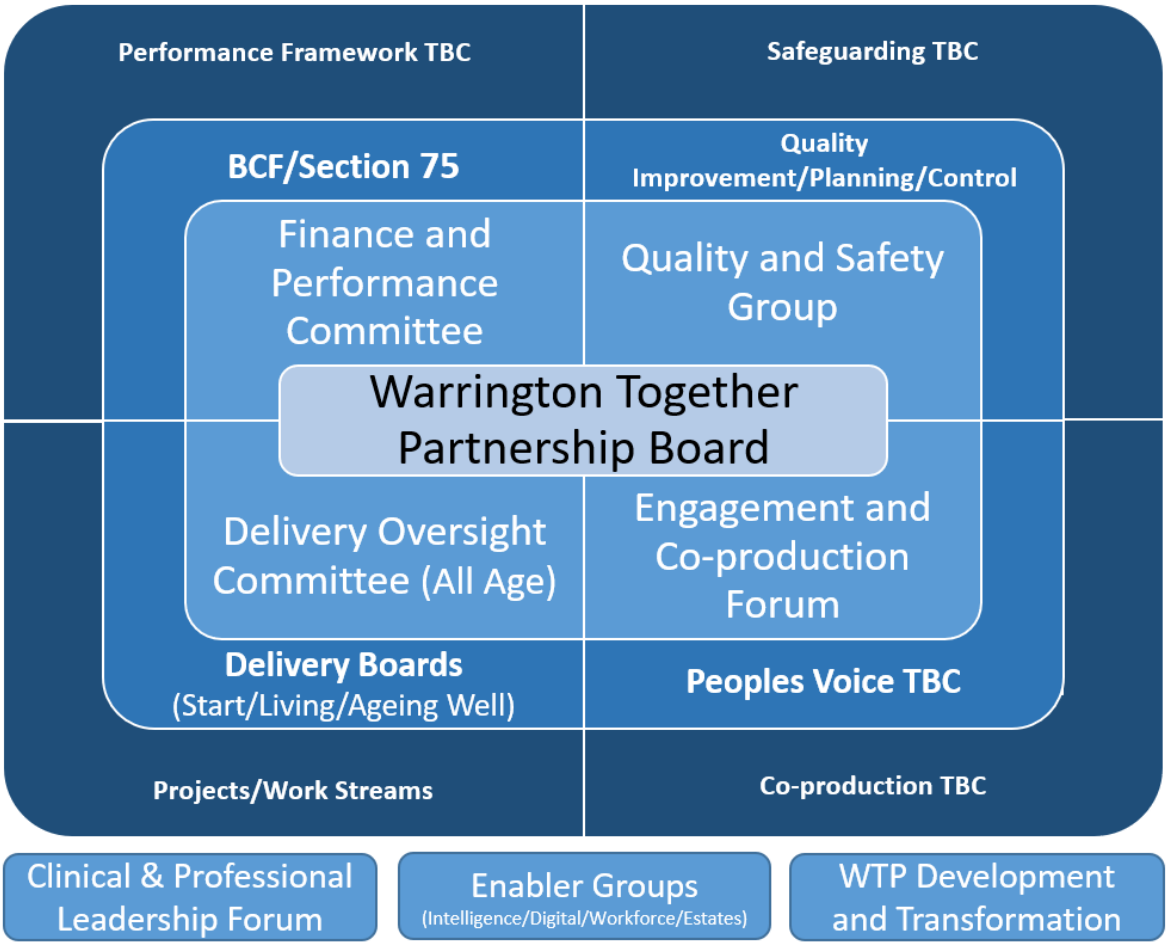


4.3 Through the governance arrangements it has been decided that the Warrington Together Partnership Board will report to the ICB and the Health and Wellbeing Board on a bi-monthly basis after each meeting of the WTPB and the members of the WTPB will report to each of their respective organisations.

4.4 The WTPB and the Health and Wellbeing Board will work closely together and will provide reports to each other. The reports the WTPB receives from the Health and Wellbeing Board will include the Board's recommendations to the WTPB on matters concerning the delivery of Place health and care priorities and objectives so as to ensure alignment with and the implementation of the health and care components of the Joint Health and Wellbeing Strategy. The Health and Wellbeing Board will

continue to have statutory responsibility for the Joint Health and Wellbeing Strategy and Joint Strategic Needs Assessment for the Warrington Place.

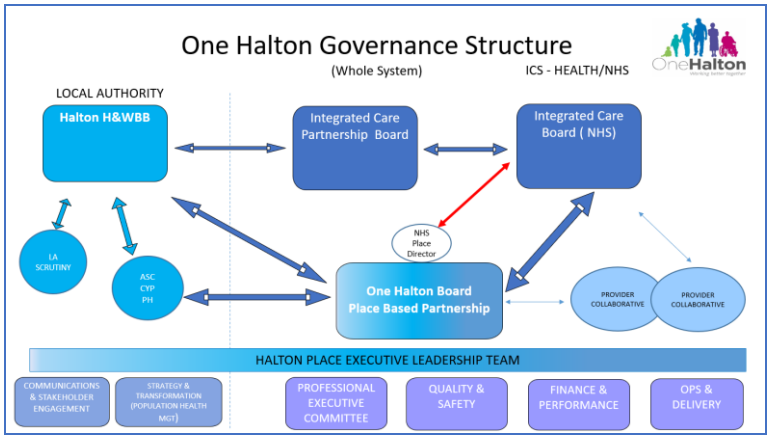
4.5 The diagram below shows the proposed governance arrangements of the partnership board.



5.0 Halton Update

5.1 The One Halton programme continues to develop, with the new governance arrangements being embedded.

5.2 The diagram below sets out the governance approach, with all sub committee's now meeting and reporting into the One Halton Partnership Board



5.3 The Operations & Delivery Group (Ops & Delivery) is the forum where multi-agency transformation projects are being overseen. At present, the projects being developed and implemented include (not exhaustive):

- Halton Intermediate Care & Frailty Service (HICaF)
- Community multi-disciplinary working
- The development of a Single Point of Access (SPA)

5.4 Work is continuing to finalise a revised One Halton Strategy. This will be themed against the Starting Well, Living Well and Ageing Well framework.

6.0 Dental

6.1 The newly developed draft Dental Network Strategy has been shared with a range of stakeholders as part of a consultation process.

6.2 Work is now underway to develop a robust project plan to drive the delivery of the strategy.

6.3 The Dental Team and members of the Bridgewater EMT have met with commissioners from both Cheshire & Merseyside and Greater Manchester to discuss the strategy and its ambitions. The feedback has been very positive and ongoing engagement with the commissioners will be a key element of the delivery of the strategy.

7.0 Recommendations

7.1 The Board are asked to note the contents of the report

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	16 March 2022	Date of next meeting:	11th May 2022
Chair:	Abdul Siddique, Non-Executive Director	Parent Committee:	Board of Directors
Members present/attendees:	Members Abdul Hafeez Siddique, Non-Executive Director (Chair) Linda Chivers, Non-Executive Director Sally Yeoman, Non-Executive Director Tina Wilkins, Non-Executive Director Paula Woods, Director of People & Organisational Development Lynne Carter, Deputy CEO/Chief Nurse (joined from item 33/22) In attendance Jo Waldron, Deputy Director of People Christine Whittaker, Associate Director of Organisational Development Mike Baker, Assistant Director of Communications Susan Mackie, Director of Quality Governance Paula Halsall, Lead Infection Prevention and Control Nurse/Deputy Director Infection Prevention and Control Ruth Besford, Equality and Inclusion Manager Denise Bradley, Unison Bridgewater Branch Secretary & Staff Side Chair (joined from item 27/22) Jan McCartney, Trust Secretary Sam Scholes, Head of Governance **Observers** Martyn Taylor, Non-Executive Director Rita Chapman, Lead Governor	Quorate (Yes/No):	Yes
		Key Members not present:	Rachel Game, Governor Observer

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
COMMITTEE EFFECTIVENESS REPORT	5 and 6		The Committee Effectiveness Report was presented to the Committee for information and assurance purposes. The following areas were highlighted to the Committee by Jan McCartney, Trust Secretary. Most responders either agreed or strongly agreed to the statements, demonstrating a high level of satisfaction with the effectiveness of the Committee. The comments received recognised that the agendas were complex and there was a need to maintain the Committee's strategic overview. Challenge and debate was robust and work to ensure papers were more concise, where possible was ongoing. It was appreciated that some papers do require all the detail to meet legal requirements. The minutes of the meetings were commended for their excellent quality and the Terms of Reference were clear and comprehensive. Overall, responders felt the Committee was focused on its business, well chaired, well attended by colleagues with appropriate mix of skill and experience.	To support authors with a consistent format and style, reporting templates will be revisited (Trust wide). Communication has already been sent to the SLT. Focus on support will be the following: • Use of Exec Summary to emphasise the key highlights • Use of appendices, enabling the reader to opt to read should they wish to do so • Use of links, rather than attaching full documents
COMMITTEE ANNUAL ACTIVITY REPORT	5 and 6		The Committee Annual Activity Report was presented to the Committee for information for throughput to the Audit Committee to provide assurance that appropriate governance and processes are in place. The Director of People & OD, Paula Woods presented key highlights and standing items on the People Committee agenda:	The People Committee noted the content of the report for assurance. Audit Committee will be asked to review the activity of the People Committee and be assured that appropriate governance and processes are in place for the Committee to satisfactorily discharge its role and responsibilities.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			• Board Assurance Framework and HR & OD Risk Registers • Integrated Quality & Performance Report • Director of People & Organisational Development Update Report – highlighting the significant focus throughout the year on the following: - Our Just & Learning Culture Journey – a significant culture change programme, incorporating the national Civility & Respect Framework - Our response to the pandemic – the establishment of 3 People Hubs for Redeployment, Extended Occupational Health Support and Health & Wellbeing Services, including the SWOT (Staff Wellbeing Outreach Team). The Committee received assurance by way of Covid-19 Action Plans - VCOD – Vaccination as a Condition of Deployment Regulations - E-roster – the national requirement to implement e-roster systems - Workforce planning – an overview of our Apprenticeship Scheme and Levy since its introduction, including the successful recruitment campaign for Health Care Assistants - Talent Management & Succession Planning Frameworks – implementation and roll out, including plans for 'Scope for Growth' career conversations	This is logged as an item for escalation to the Audit Committee via the Trust Secretary.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			- Staff Health & Wellbeing Programmes, including a pilot scheme for 'mental fitness' with Rugby League Cares - Safe staffing levels assurance reports with links to e-roster - Staff Survey results and Staff Survey Action Plans (including communication and engagement plans and frameworks) - The establishment and embedding of Staff Networks: Race, Disability, LGBT+ and Menopause • Employee Relations Report (illustrating positive trend in ER activity/caseloads) • HR Policies & Procedures • Sickness Absence Trends Report • MIAA – Audits • People Hub and People Operational Delivery Groups (PODs) focussing on the following workstreams within the People Plan: - Culture & Leadership POD - Education and Professional Development POD - Health and Wellbeing POD - Recruitment and Retention POD	
RISK REPORT UPDATES • **HR** • **OD/EPD**	5 and 6		The Risk Reports for HR, OD/EPD and Communications were tabled for information and assurance purposes. The detail and discussions relating to the risks as presented, are addressed in more detail at the Trust's Risk Management Council.	The Committee were assured on the progress and governance around the management of risks through Risk Council. Updates will be provided at future meetings As per changes to portfolios in line with the retirement of the Associate Director of Organisational Development, the next

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
				Committee report will be an integrated HR, OD and EPD Risk Report.
IQPR – PEOPLE INDICATORS	5, 6 and 9		The 5 IQPR people indicators were presented to the Committee. An 'as is' position was included to mitigate the delays in receiving timely information due to meeting cycles. All People indicators were reporting at red in the month 8 IQPR presented to the Finance & Performance Committee. That said, as per the approved changes to the Induction attendance target from 100% to 95% as of February 2022, Induction is reporting green as of month 11. 3 of the 5 indicators slightly improved between month 7 & 8, however as per the 'as is' position narrated for month 11, only Induction and PDR's have seen an improvement in month 11 as 99.30% and 57.32% respectively. Work continues in the HR and OD Team to support progress against the People Indicators. The standing up of the relevant committees/councils will support closer scrutiny at an operational level and the actions required to make improvements. A discussion took place in relation to growing concerns both internally, regionally and nationally in relation to turnover rates. It was reported that the Recruitment and Retention POD focuses on driving interventions to support this, with a key focus on gaining feedback from staff. The Committee requested that a deep dive be conducted into Turnover rates and reasons for leaving. Mandatory and Statutory Training continues to be a challenge. A paper was presented and discussions noted later in the agenda.	The Committee noted and were assured of the progress with the indicator. Further updates will be provided at future meetings. A Deep dive into Turnover rates and reasons will be presented at the next Committee meeting. See Mandatory & Statutory Training item below.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			Tina Wilkinson noted that as the use of Qliksense was a priority. The timeliness of data will continue to improve.	
DIRECTOR'S UPDATE REPORT	5 and 6		The Director's Update Report was presented to the Committee for information and assurance purposes. The following areas were highlighted to the Committee by Paula Woods, Director of People & OD, paying attention to any developments since the writing of the report. **Staff Survey** -The NHS Staff Survey results are usually published in February. As the Committee are aware, the 2021 Survey was changed to reflect the NHS People Plan and People Promises. The only 2 themes remaining are staff engagement and motivation. This means that there will be areas of the Survey where we cannot compare to last year. That said, we should be able to benchmark against other Trusts. The significant changes to last year's survey and the enhancements being made to the reporting outputs mean that there is additional quality assurance work that must be undertaken, compared to previous years. This is to ensure the quality and accuracy expected of the survey as an official statistic is maintained. An overview of the key changes to the 2021 survey was provided to the Committee as an appendix. Paula advised that these had been presented at a Board Development Session recently. The Staff Survey results and Action Plan will be shared at the next Committee Meeting in May.	The Committee noted the report and its contents. Further updates on the workstreams will be provided in future meetings as they progress. Staff Survey Results and Action Plans will be presented at the Committee Meeting in May 2022. **Rugby League Cares** - Work is ongoing in order to capture the types and location of the interventions that have taken place across the Trust. The Health and Wellbeing Team are working with Rugby League Cares and the other Trusts taking part in the pilot (Warrington and Halton Hospital and St Helens and Knowsley Trust) to agree an appropriate evaluation model. Update will be provided at the next Committee in May. **Oldham Transfer** – Evaluation of the secondment into the transferee for consideration as a potential future model for TUPE transfers - to be provided at the next Committee meeting in May.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			VCOD – The revoking of the regulations mandating Covid-19 Vaccinations as Condition of Employment - The Government conducted a public consultation from 9th February to 16th February 2022 on whether to revoke provisions which required Covid-19 vaccination as a condition of deployment in health and social care settings. A formal Government response to the consultation has concluded, confirming that the Government intends to proceed with bringing forward regulations to revoke vaccination as a condition of deployment. As we await guidance from NHS England on this matter, we are assuring those directly affected by this that we will communicate updates in our Bridgewater Bulletins as soon as we have the information available to share. You can read more about the consultation by accessing the link below: https://www.gov.uk/government/consultations/revoking-vaccination-as-a-condition-of-deployment-across-all-health-and-social-care?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=11c33988-5371-49f1-a3c1-95eff39784ae&utm_content=daily What we do know is that the Government has confirmed that the revocation of the Mandatory Vaccination Requirement for both care homes and the wider health and social care sector will take effect on 15 March 2022. It is understood that the revoking of regulations will be passed using the 'Negative' procedure under which the regulations become law on the day they are laid before Parliament.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			When the Secretary of State initially announced the intention to revoke the Mandatory Vaccination Requirement, on 31 January 2022, he indicated that, in its place, he would be taking three steps: (1) writing to professional regulators asking them to review their guidance to registrants on vaccinations, and to emphasise their professional responsibilities in this area; (2) asking the NHS to review its policies on the hiring of new staff and the deployment of existing staff, taking into account their vaccination status; and (3) asking the Department of Health & Social Care (DHSC) to consult on updating the Code of Practice (presumably the 'Health and Social Care Act 2008: code of practice on the prevention and control of infections' which applies to all CQC regulated providers). The GMC, NMC, and HCPC have all issued statements reinforcing the importance of Covid vaccination and encouraging registrants to be vaccinated. However, although these statements reinforce that registrants do have professional obligations to look after their own health, it appears that a failure to be vaccinated will not in itself, result in Fitness to Practice proceedings being taken against individual clinicians. Further updates will be provided as information starts to formally filter through. ***Update since the writing of the report was presented by Paula Woods: FAQ's have now been received from NHSE/I. We are in the process of working through the FAQ's, communication to staff has already been disseminated***	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			through the Bulletin and those unvaccinated will be offered up the opportunity for 121's. Risk assessments are already in place and will be reviewed in line with the revoking of the regulations. **Reciprocal Mentoring for Inclusion Programme (RMfIP) –** Our Project Lead, Ros Connolly met with the Leadership Academy on the 2nd February. They advised of the following: - The RMfI Programme had been 'switched off' at the beginning of the pandemic. - Meeting attendees had expressed concern that this had not been adequately communicated. The Academy apologised for poor communication. - Further delays were explained by the Academy in the context of recruitment issues and the suppliers not being sufficiently diverse in their selection processes. - The Academy have developed materials and resources (Stepping Up and Train the Trainer Programmes) which will be free to access. - There may be some additional support from the Academy in utilising the resources locally, with the potential for sharing facilitation across the region. Our Project Lead, Ros Connolly is seeking more information on the above. We have been advised that there may now be a cost implication for Trusts requiring external facilitation. The details on this are not yet clear. Additional costs may require	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			us to reconsider our options. Further updates will be provided. Our Programme has been put back to September. Pending that, we will ascertain what might be available to us in advance of that. **Disability Confident Pilot: Accreditation and Recruitment Programme - Acceptance of our Expression of Interest -** Further to my last update, we are able to confirm that we: - have had our Disability Confident Self-Assessment independently validated. - are taking all of the required core actions to be a Disability Confident Leader. - are offering at least one action to get the right people for our business and at least one action to keep and develop our people. - have provided evidence demonstrating what we are doing as a Disability Confident Leader. In continuing our Disability Confident journey, we are ensuring that disabled people have the opportunities to fulfil their potential and realise their aspirations. We are now successfully registered as a Disability Confident Leader and have received the following: • **Disability Confident Leader** certificate - Level 3 (was included as an appendix) • **Disability Confident Leader** badge, which is valid up to 27/02/2025 (for use on our company stationery, correspondence, and websites)	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			'Find a Job' is a free government service on which we can now advertise jobs and publicise that we are Disability Confident. Going forwards, we will share our stories and the good practice in our organisation with the Disability Confident Team at the Department for Work and Pensions. As a Disability Confident member, we get exclusive access to the scheme's LinkedIn group. Group members receive regular updates, early access to events, and have the chance to talk to other Disability Confident employers, to share best practice or ask questions. **North-West Apprenticeships Strategy Group: Newly established from February 2022.** Health Education England North West held its first strategic group meeting as planned and previously reported on. The time was spent reviewing membership, the Terms of Reference and its aims and objectives. It was noted that the membership was pitched at Director level and that there were various levels of management in attendance. More information is to follow on the group's composition as it endeavours to meet quarterly. A survey is to be conducted that aims to explore if, and how, apprenticeships are included in workforce planning cycles and processes across the North West. The data provided will be used to support future leadership and strategic planning around apprenticeships, via this Strategy Group. **Occupational Health Services – Stock take and strategy development -** The NW Regional People Team, under the leadership of Karen Gallagher, are looking to undertake a	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			survey/ stocktake of Occupational Health services across Cheshire and Merseyside. They are commissioning the CSU to undertake this work on their behalf, and they will be linking in with our Occupational Health Managers. The work will help us better understand what Occupational Health services are being offered and where we have challenges. From this, the region will look to develop a wider strategy which can help us prioritise and focus some of our health and wellbeing priorities. Our Occupational Health Managers will be asked to complete the stocktake work direct and will be asked to share the information with ourselves before submitting. This will ensure that we are aware of the content and any identified or perceived gaps. Further updates will be provided. **National endorsement of our bid for Regional Health & Wellbeing Funds: Award of £22,500 to support our Safeguarding and Children in Care Teams -** As per the Trust's 'Time to Talk' Sessions, myself and Non-Executive Director, Linda Chivers met with the Trust's Safeguarding and Children in Care Teams. They shared their experiences of having had extremely difficult times during the pandemic, coping with huge increases in referrals and increasing complexity. This has led to a huge toll on their emotional resilience and decreased their overall mental health and wellbeing. Whilst reporting to us that Safeguarding supervision was in place within the Trust, this was primarily focused on the management of the Safeguarding caseload rather than providing direct health and wellbeing support for the	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			members of staff. Fortuitously, we were advised by the region that there was scope to bid for health and wellbeing funds as individual Trusts. This was to be routed through the Health and Care Partnership and considered at national level. We bid accordingly for a programme of work costed at £22,500. The programme proposed and accepted was to establish face to face restorative supervision for a period of 12 months for these staff provided by clinical phycologists, similar to the Family Nurse Partnership Supervision Model. Whilst Professional Nurse Advocates are in place within the Trust, it was felt that these staff required a higher level of psychological support that a newly trained PNA could provide. Expected outcomes: - Improvement in staff survey scores related to health and wellbeing. - Reduction in sickness absence. - Improvement in recruitment and retention. - Improvement in overall morale and resilience of the teams involved. Measures of success for the programme: - NHS Staff Survey Results and Pulse Survey Results. - Departmental absence rates – rolling and actual. - Vacancy rates. - Turnover rates. - Activity/caseload. - Patient experience surveys, incidents, etc.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			Programme Evaluation Evaluation will be discussed with the provider. The expectation is that some form of assessment/survey will take place pre and post interventions to demonstrate impact and improvement. Team Stress Risk Assessments will also be used as well as the metrics described above. We are delighted that the national team have agreed that this programme can be funded and £22,500 will be awarded to our Trust very shortly to enable us to commission the programme. **Allied Health Professionals' Workforce Development (AHPs) – Workforce Quarterly Forums -** Throughout January and February our AHP Lead, Jilly Wallis commenced Allied Health Professional Workforce Forums. Further sessions have now been planned and will be taking place via Teams: - Physiotherapy: 20th April 2022 from 10am to 12pm. - Occupational Therapy: 19th April 2022 from 10am to 12pm. - Podiatry: 7th April 2022 from 9am to 10.30am. - Speech and Language: 21st April 2022 from 10am-12pm. - Audiology: 22nd April 2022 from 1pm-3pm. There will also be an AHP Support Workforce Session on the 18th May 2022. **Celebrating practice placement achievements in Bridgewater: A 'Thank you' to our Practice Educators across our Nursing and Allied Health Professions** - We have continued our dedication to supporting students across	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			services pandemic pressures. Those Students have been surveyed with regards to their placement experiences which have been 100% positive across the board. Since January 2021, Bridgewater has received a significantly higher rate of placement evaluations than the regional return rate with **97.85%** of the students who were evaluated providing us with positive feedback about their placements. Feedback shows that: • **100%** of our students would be happy for themselves or a loved one to be cared for in our teams. • **100%** of students felt that their placement experience did not need to be improved for future learners. • **100%** of students reported that their placement enabled them to learn from team working and care delivery consistent with core NHS values and behaviours. • **100%** of our students reported they were encouraged to promote dignity and respect for the diversity of culture and values of service users and carers. • **100%** felt able to raise concerns regarding standards of care if/where required. A 'Thank you' to all Practice Educators and our Teams and services that support all our students was circulated widely. **People Directorate Retirements -** Previously the Director of People & OD reported on changes to reporting lines within the People Directorate which are working well. She advised that we have two retirements taking place at the end of March and took the opportunity to recognise and thank those staff	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			members for their contributions over many years with the NHS and Bridgewater. Both members of staff have witnessed significant national, regional and local organisational changes over the duration of their careers, and both were wished a happy and healthy retirement: - Chris Whittaker – Associate Director of People & Organisational Development. - Sandra Cunliffe – HR Business Partner (supporting Warrington Adult Services). Recruitment for a replacement HRBP has been undertaken with further consideration of the People Directorate's structure in relation to Leadership and OD. The plan, at present, is for Jo Waldron to be the Deputy Director of People & OD. She is currently considering business continuity. In doing so, we do not envisage any organisational change that would require formal consultation. Staff have been kept updated and we have plans to meet with all those directly affected imminently. **Our Just and Learning Journey: update on progress -** A Board Development Session held on 24th February included a presentation on the progress made with our Just & Learning Culture Journey. The session was highly interactive with discussion held on standards of behaviour and conduct, along with our values. Amanda Oates, Director of People at Merseycare will brief our Board on their approach to the programme on the 25th April. Work is underway to further outline our project plans as we finalise our processes with our Staff-side colleagues.	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			Transfer of Services (TUPE): Oldham Children's Services and GP Enhanced Care Services – Warrington - Work continues to ensure the smooth transfer of our Oldham Children's Services, and our GP Enhanced Care Services in Warrington at midnight on the 31st March 2022. The transfer of both services to the respective receiving organisations has previously been reported on. The work that has been done by both services has been acknowledged by the Trust and will continue to be, up to the date of transfer. It was noted that a Bridgewater staff member had been seconded to the Local Authority to support a smooth transition of service and the Committee ask that this be evaluated in terms of this potentially being a future model for TUPE transfers.	
PEOPLE PLAN AND PROMISE: PEOPLE OPERATIONAL PLAN REPORT	5 and 6		The People Plan and Promise: People Operational Plan Report was presented to information and assurance. The paper focused on the progress of the four People Operational Delivery Groups (PODs) that have been established to deliver on the NHS People Plan and People Promises, along with other People agendas. The four PODs are: 1. Recruitment and Retention 2. Health and Wellbeing 3. Education and Professional Development and; 4. Culture and Leadership	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			The Committee appreciated the focus for this report on highlighting the updates since the last report presented in November 2021. It was discussed how the report with evolve over time, focussing on outcomes and impact.	
NATIONAL STAFF OPINION SURVEY – RESULTS REPORT AND ACTION PLAN			Deferred due to national publication and embargo being 30th March 2022. As stated earlier, key headlines were picked up in the Director Update Report.	It was noted that full detailed results and action plans will be presented at the next Committee Meeting in May.
EQUALITY, DIVERSITY AND INCLUSION	5 and 6		The reports were provided for information and assurance on our ED&I agenda with those requiring approval highlighted accordingly. The papers provided an update to this Committee on areas of equality, diversity, and inclusion as follows: **(i) Equality, Diversity & Inclusion Strategy: Refresh** **(ii) Equality, Diversity & Inclusion Objectives and Action Plans Updates** **(iii) Public Sector Equality Duty (PSED) for Workforce and Services Annual Report (for sign off)** **(iv) Equality Delivery System 2 (for sign off)** **The Equality Strategy and Action Plans** - Action plans are overseen by one or more of the four People Operational Delivery groups, and the 2022 – 2023 action plan seeks to clarify which group each action sits under as equality runs across all four in many areas.	The Committee approved both mandated documents for submission and overall approval/sign off, subject to small update to the annual report regarding Governors. Reports are attached (as logged in the items of escalation section below). A word version of EDS2 has also been provided as the toolkit does not fully expand on the data sets when saving as a document.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			EDS2 - mandated within the NHS Standard Contract, it requires us to look at 18 outcomes for patients and workforce and determine our level of achievement based on impact on the nine protected characteristic groups. The late date of publication of the Staff Survey results, negatively impacted on EDS2 as it is one of the main sources of data for Goal 3. As a result, we have had to revert to 2020 results for both the NHS Staff Survey and EDS2, as the EDS2 must be submitted to NHS England on or before 30th March, the day the Staff Survey results are published. Results will be internally reviewed in the Trust, once the latest data is available. EDS3 is anticipated and will be more detailed in nature with a focus at ICS level. **The Equality Annual Report** – this is a legal requirement of the Equality Duty. It requires us to publish at least annually, evidence of how we meet due regard to the three aims of the Duty. The Trust must publish our report by 30th March in any financial year. This year's report was appended to the report. In line with annual reporting requirements, the Committee were asked to approve onward referral of EDS2 and the Annual Report to Trust Board for overall sign off and approval.	
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET	5, 6 and 9		The report was provided for information and assurance purposes. Trust sickness absence for the period 01 March 2021 to 28 February 2022 was 6.67% compared to 01 March 2020 to 28 February 2021 (5.32%). The trust sickness absence target is 4.80.	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied. The next Committee report in May to show a 2 year picture of absence for both

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			Over the rolling 12-month period, rolling sickness absence rates have fluctuated between 5.27% and 6.67%. Rolling absence % rate has shown an increase from April 2021. Actual sickness absence % rate has fluctuated month on month. From September 2021 it has shown a month on month increase to Jan 2022 were sickness absence was at the highest rate. It has reduced in February 2022. The report highlighted the interventions in place to support improvements in sickness absence rates, including dedicated HR support and guidance to service areas and the Trusts Health & Wellbeing offer. There was a discussion around Stress/Anxiety and Depression being the highest reason for absence and whether this was isolated to during the pandemic. It was clarified that Stress/Anxiety and Depression has been our highest reason for absence both pre and post pandemic; however Infectious Diseases had seen an increase throughout the pandemic. It was requested that the next Committee report in May shows a 2 year picture of absence for both Stress/Anxiety and Depression and Infectious Diseases.	Stress/Anxiety and Depression and Infectious Diseases.
FLU CAMPAIGN AND COVID VACCINATION PROGRAMMES	5 and 6		This report was provided for assurance purposes on the operational delivery and current status of this season's annual flu and COVID-19 booster vaccination programme. The paper detailed the background to the vaccination programme, the challenges the Immunisation team had faced, updates on the percentage of staff who had received Covid-19 and flu vaccinations at 82% and 68% respectively along with data collection and analysis methodologies and communication and	The People Committee was asked to acknowledge this report for assurance on the delivery and achievements of the Trust vaccination programme.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			wellbeing plans. The Committee noted the positive progress made, despite the challenges faced and the fact that the Trusts position was favourable in comparison with neighbouring Trusts. It was noted by Lynne Carter, Chief Nurse that now that the mandatory COVID-19 vaccination had been revoked as a condition of employment, appropriate risk assessments would be in place.	
EMPLOYEE RELATIONS REPORT INCLUDING FREEDOM TO SPEAK UP REPORT	5		The report was provided as further assurance on the management of employee relations cases and the Committee were asked to note the progress with the management of various employee relations cases. The Trust's Just & Learning Culture journey will continue to support improvement and promotion of restorative interventions wherever appropriate.	The report was noted by the Committee as were the positive trends in employee relations activity.
SYSTEM STAFFING IMPLEMENTATION UPDATE	5 and 6		Significant progress has been made and all Warrington & Halton service rosters are not built into the system with plans to progress Dental throughout January and February. The introduction of SafeCare will support better caseload management based on complexity of care and skills required. It was noted by Lynne Carter, Deputy CEO/Chief Nurse that staff are spending excessive amounts of time on record keeping so there are processes in place to look to how we can support. Acuity and dependency of patients has grown although safer staffing has been looked at throughout. Workforce Planning will support in ensuring we have the right workforce to deliver the changes to the required patient care. The Committee asked if there were any agreed timescales in relation to the interface with EMIS. Lynne Carter advised that	The report was noted and the Committee were assured on the progress. Indicative dates for the EMIS/Allocate interface to be included in the next Committee report in May.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			Allocate are working closely with EMIS and she would get some indicative dates for the next Committee in May.	
HR POLICIES AND PROCEDURES	5		The progress with the review and approval of HR Policies and Procedures was provided for information and assurance purposes. It was noted that 4 policies had been reviewed with highlights of the key legislative and organisational changes provided to the Committee for ease of reference: • Capability and Performance Management Policy • Education and Professional Development and Study Support Framework Policy • Mandatory Training and Induction • Organisational Change Policy	The report was accepted.
MEDICAL APPRAISAL AND GMC REVALIDATION REPORT	5 and 6		The Committee noted the contents of the report. The Chair noted that there had been a suggestion by Ted Adams, Medical Director that this be tabled annually to ensure information was sufficiently detailed to provide a richer update. • The Chair noted he had discussed and agreed this with the Medical Director.	This report will be tabled annually.
ORGANISATIONAL DEVELOPMENT UPDATES:	5 and 6		Three reports were presented for information and assurance purposes – PPDR & Mandatory and Statutory Training Compliance, Talent Management and Succession Planning and Staff Engagement and Recognition Annual Report – March (with updates).	

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE	5 and 6		The Committee noted the contents of the report. MT compliance is 85% with the exception of Data Security Awareness, which remains at a nationally mandated target of 95%, and Corporate Induction compliance, which is internally mandated at 95% following agreement at Board in February 2022 to a reduction from 100%. The revised target of 95% took effect from 1st February. Based on the trends, this will be ragged green in month 11. Month 10 compliance with Mandatory Training showed 12 of the 22 requirements at green, (an improvement by 1, in month), 8 at amber and 2 remaining at red. There was an overall slight increase in compliance from the month 9 position in 14 modules. PPDR compliance decreased slightly and remains significantly adrift of the 85% target despite the instruction to submit details of Health & Well-being conversations in lieu of formal PPDR. Messages have been communicated in the Trust Bulletin and February's Team Brief. The Committee Chair welcomed the increased compliance in 14 modules and was keen to see further improvements. Director of People and OD, Paula Woods advised that the EMT had agreed four trajectories for compliance: Level 2 Children's Safeguarding, Level 3 Adult Safeguarding, IG and RESUS. Each Executive Director took accountability of one of these to work with the teams on compliance for an added push. There will be increased comms in relation to H&WB conversations and the recording of such via the Education and Professional Development Team along with a request for time to be allocated in the E-Roster system.	The Committee noted the reports. 'Week of Action' type approach to be considered to drive update of Data Security Awareness Training. Update will be provided at next Committee Meeting in May.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			Tina Wilkins asked if there was a likelihood of us meeting the 95% target for Data Security Awareness and it was noted by the Associate Director of Organisational Development that this is not likely given the current absence levels. Non-Executive Director, Linda Chivers advised that the target of 95% only had to be achieved by the Trust once during the year and proposed that the Trust carries out a week of action to focus all efforts at one time to achieve the target.	
TALENT MANAGEMENT AND SUCCESSION PLANNING	5 and 6		The Committee noted the contents of the report and the actions associated. It was noted by the Associate Director of Organisational Development that the Scope for Growth Programme had been stood down by the National team during the pandemic. There has been no recent communication in relation to when this will be launched; however the Organisational Development Team are prepared and we have Trainers lined up for when the programme commences.	
STAFF ENGAGEMENT & RECOGNITION ANNUAL REPORT -MARCH (WITH UPDATES)	5		The Committee noted the contents of the report. Staff Engagement work has continued across the Trust, despite the Covid-19 pandemic, to ensure that staff feel valued, have the opportunity to be innovative, proud of the quality patient care they contribute to and/or provide and would continue to recommend the Trust as a place to work. Mike Baker highlighted the following: - In April 2021 the Trust celebrated its 10th anniversary. Using technology the Trust hosted a	The Committee noted the report and were assured of the activities in place to communicate and engage with staff.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			successful virtual event, providing an opportunity to give thanks and to show appreciation to all staff. The event was a huge success and was recognised across multiple platforms, - Two successful Leader in Me online live events were held in the past 12-months, - The Trust continues to develop executive team and senior management visibility amongst staff encouraging a two-way communication approach, - Staff engagement has very strong links to the Trust's health and wellbeing agenda, equality, diversity and inclusion in various undertaken workstreams. The Committee members expressed words of thanks and appreciation to the Engagement and Communications team for all the hard work, commitment and achievements in a very challenging year. It was noted that some targeted work on visibility of the Non-Executive Directors would be valuable going forward.	
MIAA INTERNAL AUDIT UPDATE – WITHIN REMIT OF THE PEOPLE COMMITTEE	5 and 6		No audits to update on at this Committee. Paula Woods, Director of People advised the Committee that an audit schedule had been agreed for 22/23 and subsequent actions would be shared with the Committee.	
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	5 and 6		A full review of BAF5 was undertaken. The following was agreed:	The Committee were assured on the progress and governance around the monitoring of the BAF.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			- VCOD should be removed now that the regulations had been revoked and Paula Woods, Director of People assured that appropriate support was in place with a focus on risk assessment and communication. - Internal Audit MIAA Assurance section was highlighted, as some audit assurances were from over three years ago. It was agreed that any assurances older than three years should be removed and the newest one from the last three years should remain on the BAF. - Gaps in Controls and Assurances – it was agreed that mandatory training was no longer a tolerated risk. - It was agreed that the mandatory training risk should be moved to BAF 6. - The Committee Chair concurred that the risk rating should remain as is. - Addition of induction being resumed and the MT trajectories as agreed by EMT, with executive directors accountable for each. - Was agreed that assurances in the Directors Report and in the POD report would be added A full review of BAF6 was undertaken. The following was agreed: The Chief Nurse, Lynne Carter advised that robust workforce planning was in place now and the BAF would need to be rewritten to accurately reflect this. There were also assurances coming from e-rostering programme as well as being a part of national pilot for Safer Staffing.	The agreed changes to BAF5 will be reflected by Trust Secretary, Jan McCartney along with the re-writing of BAF6.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
			The Trust Secretary, Jan McCartney advised that the Quality & Safety Committee had reviewed BAF 6 and concluded that the risk rating should remain as is.	
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	5 and 6		Agreed items for escalation were as follows: - Annual Report from the People Committee to be escalated to the Audit Committee by the Trust Secretary - The Equality Annual Report 2022 - Equality Delivery System (EDS) 2 A word version of the EDS2 submission has also been provided as the toolkit does not fully expand on the data sets when saving as a document.	Items for escalation noted by Committee Chair and Trust Secretary: - Annual Report of the People Committee to be escalated to the Audit Committee via the Trust Secretary - The Equality Annual Report 2022 (attached) - Equality Delivery System (EDS) 2 (attached)
REVIEW OF MEETNG ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			The Governor Observer, Rita Chapman praised the quality of the reports presented to the Committee. On behalf of the Council of Governors, she wished all the best to the retirees – Chris Whittaker and Sandra Cunliffe. The Committee Chair expressed his best wishes of happy retirements to Chris Whittaker and Sandra Cunliffe. Well-Led – it was acknowledged that multiple links to the Well-led Action Plan had been included on the agenda and within the Director's Update Report. The Trust Secretary would pick these up and update the Well-led Action Plan.	Agenda items and items within the Directors report to be added to the Well-Led Action Plan by Trust Secretary, Jan McCartney.

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Risks Escalated **None**				
•				

	No assurance – could have a significant impact on quality, operational or financial performance;
	Moderate assurance – potential moderate impact on quality, operational or financial performance
	Assured – no or minor impact on quality, operational or financial performance

Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Bridgewater Community Healthcare NHS Foundation Trust

People Committee

Date: 16th March 2022
Agenda item: 31/22

Title	Equality, Diversity, and Inclusion (EDI) Update
Sponsoring Director	Paula Woods (Director of People and Organisational Development)
Authors	Ruth Besford (Equality & Inclusion Manager)
Presented by	Ruth Besford (Equality & Inclusion Manager)
Exec Summary/Purpose	To provide an update on: • EDI Strategy • EDI Objective and Action Plan 2022-23 • Public Sector Equality Duty 2022 • Equality Delivery System 2 (EDS2) 2022
Previously considered at	n/a
Related Trust Objective/ Intentions ***Delete as applicable***	• **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs • **People** – to be a highly effective organisation with empowered, highly skilled and competent staff • **Equality, Diversity, and Inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
Which CQC domains are supported by this report? ***Delete as applicable***	***Safe*** ***Effective*** ***Caring*** ***Responsive*** ***Well-led***
Which BAF risks are addressed in this report? ***Delete as applicable***	**BAF 2** – Failure to deliver safe & effective patient care **BAF 5** – Staff engagement & morale

Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	Failure to comply with legal and contractual mandates as per Equality Duty and NHS Standard Contract
Equality Impact assessment	There are no potential negative impacts in relation to protected characteristic groups, the Equality Duty, or the principles and articles of the Human Rights Act 1998 within this paper. The actions set out support equality, diversity and inclusion and the requirements of equality and human rights legislation.
Explanation of any acronyms in the report	EDI – Equality, Diversity, and Inclusion EDS2 – Equality Delivery System 2
Next steps	Submission of EDS2 to NHS England by 30th March 2022. Publication of EDS2 and Equality Annual Report on Trust internet by 30th March 2022. Board oversight of EDS2 and Equality Annual Report 2022.
Recommendations	That the Committee approve the updates and reports provided.

Why has the paper been presented to the Committee? (Please tick):

For **approval** by the Committee	x
To provide **assurance** to the Committee	
For the Committee's **information** / to note	

Bridgewater Community Healthcare NHS Foundation Trust

People Committee

Title	Equality, Diversity, and Inclusion (EDI) Update
Author	Ruth Besford (Equality and Inclusion Manager)
Date	7th March 2022
Purpose	To provide to this Committee an update on the EDI Strategy, Objective and related action plan. And to ask for approval of the mandated 2022 EDS2 assessment and grading, and Equality Annual Report.
Audience	People Committee

1.0 EXECUTIVE SUMMARY

1.1 This paper provides the following:

- An update on the EDI Strategy 2020 – 2023, the Strategic Equality Objective, and the action plans that underpin these
- The 2022 Equality Delivery System 2 (EDS2) assessment and grading document
- The Equality Annual Report 2022

1.2 The Strategy, and Strategic Objective set out Trust approach to equality, diversity, and inclusion, and the action plans give an overview of how we will achieve these.

1.3 EDS2 and the Equality Annual Report are mandated legal and contractual requirements that review and publish information about our equality performance over the previous 12 months.

1.4 This paper provides an update on Strategy, Objective, and action plan, and asks that this Committee, through delegated responsibility from Board, approve the EDS2 and Equality Annual report to allow for publication by 30th March.

2.0 EQUALITY STRATEGY, STRATEGIC OBJECTIVE, AND ACTION PLANS

2.1 The Equality Strategy was approved in 2020 and set out Trust approach to equality for the next three years through its principles, aims, and values. It supported the Trust's Strategic Equality Objective, as set out in the cover paper to this report. These remain unchanged. To note is that equality objectives are a legal mandate within the Equality Duty.

2.2 As this Committee will be aware we updated out equality action plans in June 2022 in line with an NHS England/Improvement mandate regarding race equality. We chose to create the Six High Impact Areas for Equality Action Plan to address the national mandate whilst also not neglecting other areas of equality. An update is provided on progress in Appendix 1 to this report.

2.3 A 2022-2023 action plan has been drafted to build on the work undertaken in 2021-2022, getting more into the real and detailed actions we need to now undertake. We need to retain the Six High Impact Areas for Equality Action Plan as it is mandated, but we have something more Trust based to work on in the background that will support these target areas.

2.4 Action plans are overseen by one or more of the four People Operational Delivery groups, and the 2022 – 2023 action plan seeks to clarify which group each action sits under as equality runs across all four in many areas.

2.5 We do of course also have an action plan for services and patients that sits outside of the remit of this Committee, but an update can be provided on request.

3.0 EDS2

3.1 EDS2 is mandated within the NHS Standard Contract, it requires us to look at 18 outcomes for patients and workforce and determine our level of achievement based on impact on the nine protected characteristic groups.

3.2 There are four levels of achievement based on how many groups fare as well or better than comparator groups, for example Black, Asian, and minority ethnic groups as compared to White groups. It has its limitations as it doesn't reflect intersectionality in individuals and can fail to pick up on smaller minority groups within larger ones, for example people with autism face an employment gap significantly greater than people with disability as a whole.

3.2.1 Undeveloped – less than 3 groups
3.2.2 Developing – 3 to 5 groups
3.2.3 Achieving – 6 to 8 groups
3.2.4 Excelling – all 9 groups

3.3 Evidence is generally provided via engagement and feedback, and from data. We have for a long time faced some gaps in this in relation to patient date, and you will be able to see in the following Equality Annual Report where we have blank fields in SystmOne and EMIS for fields such as disability and sexual orientation. Engagement of course has been very difficult for the last two years.

3.4 We are part of the Merseyside and Cheshire EDS2 Collaborative, working on projects to deliver evidence without this engagement and data, for example a reasonable adjustments for patients policy that is just awaiting the completion of work being undertaken internally on flagging reasonable adjustments in patient records.

3.5 In relation to workforce we have faced some difficulties this year due to the late release of the NHS Staff Survey results for 2021, usually one of the main sources of data for Goal 3 of EDS2. As a result we have had to revert to 2020 results for both the NHS Staff Survey and EDS2, as the EDS2 must be submitted to NHS England on or before 30th March, the day the Staff Survey results are published. Qualitative data from staff network members suggested they feel the Trust is positively improving in relation to staff equality and inclusion, the results should hopefully give us the data to support this assertion.

3.6 Finally we are starting discussions in the Trust and at a regional level about how we will manage EDS3. Consultation closed on this new iteration of EDS in January and we await the outcome. But it is likely we will be reporting on fewer outcomes but will need input from patients and communities in terms of assessment, and will need to work at ICS level.

3.7 EDS2 2022 can be seen as Appendix 2 for this report.

4.0 EQUALITY ANNUAL REPORT 2022

4.1 The Equality Annual Report is a legal requirement of the Equality Duty. It requires us to publish at least annually evidence of how we meet due regard to the three aims of the Duty, (eliminating discrimination, advancing equality of opportunity, fostering good relations).

4.2 We must publish our report by 30th March in any financial year, we have always remained with this year end date following the original publication in March 2011.

4.3 Appendix 3 is the draft Equality Annual Report 2022.

5.0 RECOMMENDATIONS

5.1 That this Committee note the update to the Six High Impact Areas for Equality Action Plan.

5.2 That this Committee approve EDS2 and the Equality Annual Report 2022 to allow for publication and submission to NHS England by 30th March 2022.

5.3 That through Chair's Report from this Committee that Board are given information in relation to the publication of these reports.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

EQUALITY
DIVERSITY &
INCLUSION

Equality Annual Report 2022

Quality first and foremost

Contents

Introduction

Welcome to our Equality, Diversity, and Inclusion Annual Report for 2022.

Within this annual report we hope to provide you with information on our equality, diversity, and inclusion activities over the last year, and also provide you with an update on our current and planned projects.

If you have any questions or queries regarding the information in this report, or if you require the information in another language or format, please don't hesitate to contact us using the contact details below.

Thank you

Paula Woods (Director of People and Organisational Development)

Ruth Besford (Equality & Inclusion Manager)

Contact Details:

Ruth Besford

ruth.besford@nhs.net

07919 898475 (mobile)

1st Floor Spencer House, 81 Dewhurst Road, Birchwood, Warrington. WA3 7PG

Executive Summary

The Equality Act came into force in England in 2010.

The Act brought together 116 separate pieces of equality legislation into one simplified and streamlined act that brought protection from discrimination for nine protected characteristic groups:

- Age
- Disability. This includes
    - Physical, mental, sensory, learning, and hidden disabilities
    - Neurodiverse differences such as for example autism, dyslexia, and dyspraxia
    - Some people with long term conditions, where these impact significantly on day to day living.
- Gender Reassignment (Transgender)
- Marriage & Civil Partnership (including same sex marriage)
- Pregnancy and Maternity
- Race (Ethnicity)
- Religion or Belief
- Sex (we chose to include all gender identities and not the few identified in the Act)
- Sexual Orientation (we chose to recognise and value all sexual identities, recognising that this is a wide and not static spectrum of personal identity)

As a provider of healthcare services and employment in areas of high inequality, including health inequality, Bridgewater also choses to recognise other vulnerable groups as needing extra support accessing services and employment opportunities. These are:

- Carers
- Military veterans
- The homeless and vulnerably housed
- Asylum seekers and refugees
- Those with ‘chaotic lifestyles’ – drug and alcohol abuse, and sex workers
- People living in areas of high social deprivation

For organisations providing public services the Equality Act introduced a Public Sector Equality Duty (Section 149 of the Act). The Public Sector Equality Duty has two duties:

- The Equality Duty (also called the General Duty). More information below.
- The Specific Duties

There are two parts to the Specific Duties:

- To publish at least annually evidence that shows compliance with the Equality Duty
- To publish at least every four years measurable and achievable equality objectives

This report is our 2022 compliance with the first of these two Specific Duties.

Our two actions plans, the second of the two Specific Duties, are on our website at http://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/

The Equality Duty

The Equality Duty requires public sector organisations to have due regard to three aims in all they do:

- To eliminate discrimination, harassment, victimisation, and other conduct prohibited by the Act
- To advance equality of opportunity between people who share a protected characteristic and people who do not, the Act states that this includes:
    - Removing or minimising disadvantages suffered by people due to their protected characteristics
    - Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
    - Encouraging people from protected groups to participate in public life or in other activities where the participation is disproportionately low
- To foster good relations between people who share a protected characteristic and people who do not, which includes promoting understanding of and between different groups and tackling prejudice, racism, homophobia, transphobia, religious hatred and disability harassment and hatred

Due regard means thinking about these three aims in all Trust business, for example in employment; in service design and delivery; and in corporate projects such as strategy and policy development, or engagement and event organisation. This consideration should be robust, timely, conscious, and carried out with an open mind as to the outcomes.

You will find within our 2022 a short overview of Bridgewater, the areas we serve, and our over-arching mission, values and objectives. These underpin all our work, both service delivery and employment, and the strategic objectives cascade in annual personal objectives from our Chief Executive Officer right through our workforce.

We have tried to give an overview of equality in the Trust, how it is managed and by who, the reporting arrangements to ensure effective oversight and governance, the links to different areas of the Trust, and what specific action plans exist. But it is important to note that we recognise that EDI is embedded throughout all business, a golden thread in all areas of work; there can't be quality without equality and this is why we believe that equality is everyone's every day, all staff have a role to play in ensuring our places are equitable and inclusive, cognisant and valuing diversity, and striving to improve every day for everyone.

We have given an overview of how we demonstrate due regard in employment, setting out some of the standard policies, processes and engagement that works to embed equality, and we have highlighted some specific areas that we have worked on this year.

A big project that commenced in 2021 was our Restorative Just Programme, as we call it Just and Learning Culture. This is being implemented alongside our Civility and Respect project, looking at values, behaviours, and the overall culture of the Trust. The two must run alongside each other as we believe you can't have one without the other, and both are built, or will be, on our Trust values.

Staff networks have now been running in the Trust for 18 months and continue to grow and mature. These networks provide two key purposes. Firstly, they are a safe space for staff to come together, to share and support each other. And secondly, they are a forum for staff voice, an opportunity to discuss experiences, issues, and ideas with members of the executive team who all sponsor a network. They are a key engagement tool with staff from protected characteristic groups, and a driver and support for equality improvement. The members are all enthusiastic, passionate, and considerate and we want to thank them through this report for their ongoing commitment and support to equality in Bridgewater.

In March 2022 we are delighted to have been successful in our self-assessment validation for Disability Confident Level Three: Leader. We were supported throughout by Shaw Trust who provided invaluable advice and guidance, and were a true critical friend as we reviewed our current recruitment and retention data, policy and feedback, and created our action plan for the next two years.

Menopause is a key workplace issue for Bridgewater with nearly half our staff likely to be affected by menopausal symptoms, of having lived experience of these. We were an early adopter of Menopause Friendly accreditation in March 2021, and we remain committed, hoping through the implementation of our action plan to become a Menopause Friendly Employer in 2022.

Our workforce equality standards for race, disability, and gender all provide ongoing data on equality progress, later in the report you will find our 2021 results for the Workforce Race and Disability Equality Standards and Gender Pay Gap. You will see that in some

areas we are improving, in others we are not seeing the significant change we would like to. In many indicators we are doing well, violence and aggression from patients for example is low when compared to other types of NHS provider trusts, but even one incident is a staff member suffering physical, emotional, or psychological harm, and that is one to many. It is in these areas that the engagement of the staff networks is vital, provided a narrative behind the figures.

In relation to service delivery and patients one of the major projects this year has been refresh of the Trust's Quality and Place Strategy, aligning the previous strategy to the changing landscape of the NHS, through the Covid 19 pandemic, and the emergence of integrated place systems or ICS's. The Trust's values, mission, and objectives remain the same, but have been moved into the future of health care services.

We have again provided some high level information on how we demonstrate due regard to patients and communities. One of the key elements to this is understanding who are communities are, and we have provided a very brief overview of borough socio-economic profiles. This is just a small picture however and we have also included information for example on how our pilot project for Community Health Workers is going to develop family level partnerships to address health inequality through supporting individuals with higher need to understand and access relevant service, whether they are health care, debt management, or many other sources of support and guidance.

We have given some small examples of how our services support diverse communities in their day-to-day work, but this is just a small example, so much more could be reported.

Of course corporate teams also support service delivery and we have included a brief overview of one piece of work of the Trust's safeguarding team, the specialists who guide and support staff in relation to protecting the most vulnerable children, young people, and adults accessing our services.

And finally we provide some data, and we are honest here, we have gaps that we are seeking to address through projects looking at improving self-reporting of equality information in the electronic staff records, at identifying and recording armed forces community members, and through identifying, recording and flagging reasonable adjustments for patients and their families with disabilities.

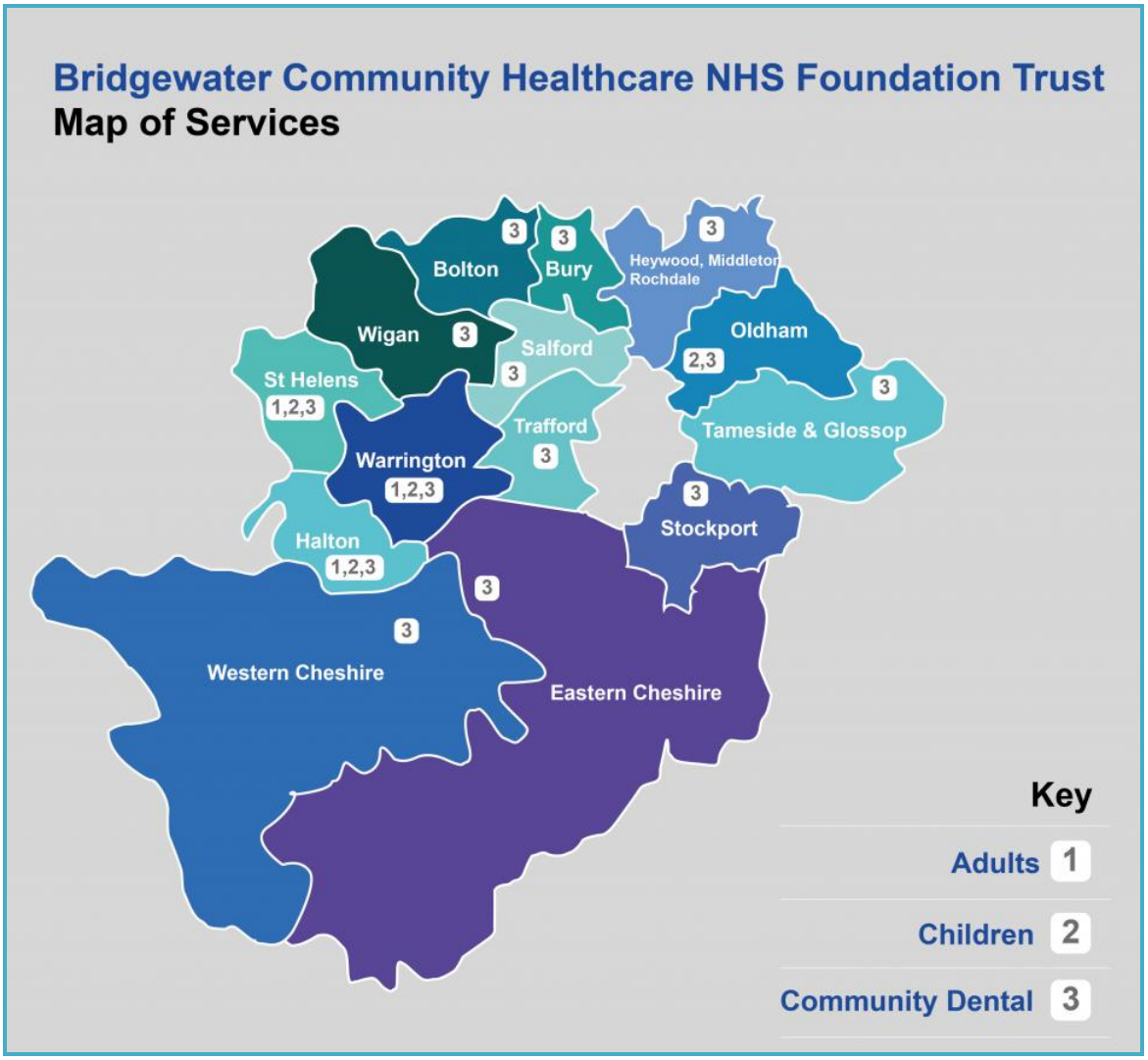
About Bridgewater

Bridgewater provides community services in Halton (Runcorn and Widnes), and Warrington, these services include:

- 0 – 19s services
- District nurses and community matrons
- Therapy services including physiotherapy and speech and language
- Specialist services such as palliative care and mental wellbeing

We also provide the 0 – 19s services in Oldham, and specialist community dental services for those who can't access high street dentists across a large area.

Figure 1: Bridgewater Map of Services



Trust Mission, Strategy and Objectives

The Trust's mission is '*to improve local health and promote wellbeing in the communities we serve*'.

To do this '*we will work closely with local people and partners to promote good health and to be a leading provider of excellent community healthcare services in the North-West*'.

This mission is underpinned by our People values:

- **P**erson centred
- **E**ncouraging innovation
- **O**pen and honest
- **P**rofessional
- **L**ocally led
- **E**fficient

Our overarching Trust Strategy, Quality and Place was refreshed in 2021. It details Trust plans for the next three years to deliver high quality, place-based care, as a key partner in local care organisations. Further details can be found on our website at https://bridgewater.nhs.uk/aboutus/qualityandplace/

Our Strategy Objectives, refreshed in 2020 to add our equality objective, are:

- **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs
- **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing, and independent living
- **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability
- **People** – to be a highly effective organisation with empowered, highly skilled, and competent staff
- **Equality, Diversity, and Inclusion** – to actively promote equality, diversity, and inclusion by creating the conditions that enable compassion and inclusivity to thrive.

The last objective is our mandated objective as per the Specific Duties of the Equality Act 2010. The actions to deliver it are set out in our two equality action plans, see page **.

Anti-Racism Statement and Commitment

Bridgewater is committed to improving race equality for our staff and our communities, and to being actively anti racist.

We are committed to improving awareness and understanding, from an individual to a Trust level, of the ways in which many of us have benefitted from privilege and systemic racial discrimination throughout our lives.

We will as a Trust demonstrate honestly and transparency; we will admit where we have gaps in knowledge, understanding, data, representation; we will be open and honest about where we believe we can do better; and we will actively facilitate and listen to the voices of our diverse workforce and communities, recognising that Black, Asian and minority ethnic groups are not a collective whole any more than 'White British' is a group with identical views, needs, aspirations and inequalities.

We will work in true partnership with our staff networks and with our wider communities to develop and deliver real and sustainable plans that address racism, discrimination, and inequality.

Equality, Diversity & Inclusion in Bridgewater

Our Equality, Diversity, & Inclusion Strategy 2020 - 2023, was built on the conversations we held with our staff networks and aligned to national actions such as the NHS People Plan.

The Strategy, signed off with the full commitment and active support of our Executive and Non-Executive Directors, recognises that every member of staff has a voice and a role, that it isn't just to leaders to deliver the Strategic Equality Objective and action plans for Bridgewater.

Our aim for equality is that it is totally embedded across the Trust, part of the everyday for every member of staff.

The strategy's vision, aims and principles remain the same as its predecessor. With the ultimate goal being a workplace and services that are compassionate, inclusive, representative, respectful, valuing diversity, and embedding respect and support for individual contributions, needs and aspirations.

The Strategy focuses on the future, on moving beyond data and compliance, (important though these are for monitoring and evaluating), to stretching ourselves, our services and our staff to be the best they can and should be.

More information can be found in the full Strategy on our **website**.

Our Strategy needs an action plan to deliver its aims, and we have two, both of which can be viewed on the website link above:

- Six High Impact Areas for Equality – workforce focused
- Equality Action Plan – Services and Communities

Day to day responsibility sits with the Equality & Inclusion Manager, with executive responsibility in the portfolio of the Director of People & Organisational Development.

A structure of governance is in place that provides challenge around the equality work of the Trust and provides assurance to Board. This structure includes committees involving staffside colleagues, senior leadership from both corporate and clinical services, executive and non-executive Board members, and of course subject matter experts from teams across the Trust.

The staff voice is heard through executive sponsorship and attendance at networks for protected characteristic groups; through network assurance in the above structure; and through involvement in small and specific working groups looking at areas such as anti-bullying and harassment and occupational health provision.

Our staff – due regard in employment

Due regard in employment requires us to consider the three aims of the Equality Duty in all workforce related issues, including for those potentially joining our Trust, and those who support our work through their invaluable volunteering contributions.

Data regarding our staff can be seen in Appendix 1, but here are the basic and everyday things we do that support due regard in our employment actions and decisions:

Due regard in employment

- Staff side colleagues work closely with corporate and clinical/medical leads through the Joint Negotiating and Consultation Committee and Local Negotiating Committee.
- Employment and human resources matters are underpinned by a suite of policies and procedures that undergo regular review by subject matter experts, clinical and corporate managers, and our staff side colleagues.
- All Trust policies related to staff are reviewed by the equality lead, with an equality impact assessment produced before being approved.
- The majority of job vacancies are advertised through the national NHS Jobs website with prospective candidates signposted to this.
- Staff are recruited on nationally agreed terms and conditions, either Agenda for Change or Medical and Dental. These T&Cs are agreed by our staff side colleagues nationally, with local colleagues supporting the Trust staff through panels that review job descriptions and person specifications for new posts and also those staff who have asked for a pay band review.
- All staff can access, or are referred to, occupational health services, who provide support and advice on health and wellbeing, including advice and support for staff with disabilities requiring reasonable adjustments. There is a range of other health and wellbeing support offers available, managed by the Trust's health and wellbeing co-ordinator's.
- Flexible working is open to all staff, within the needs of the service, and more than half of our staff work flexibly. Retire and return is also an option that many older staff have taken up in recent years.
- Employment and health and safety laws also underpin our employment practice, including providing protection and reporting processes for staff for discrimination, violence, bullying and harassment.

Eliminating Discrimination, Harassment, Victimisation, and other prohibited conduct

The actions stated above all support us in identifying and eliminating potential discrimination in our employment practices.

Annual data is provided by the NHS Staff Survey and through the Workforce Disability and Race Equality Standards. These provide us with a profile of progression across the years, and through engagement with our staff networks we are able to identify barriers, gaps, issues, and then agree actions to take to continue the work of eliminating any discriminatory practices, or behaviours witnessed or experienced by our staff.

We have in place policies that clearly highlight the Trust's approach in relation to these areas, both within structure and process, and the expectations we have from ourselves and from our staff and patients.

We have reporting systems that staff or patients/families can use if they are victims of or witnesses to these incidents.

We have a quality panel that looks at service changes and the potential impact on protected groups, including within the workforce, and of course equality impact and risk is included within this.

And we clearly set out our Trust strategy regarding racism and race equality, as seen on page 9.

But we know this is not enough. In 2021 and early 2022 we have seen reports regarding racism in cricket, the police, and the NHS, and we don't presume for a moment that everything in Bridgewater is perfect, that we have got everything right.

An important part of addressing these challenges is engagement with staff, and our five staff networks provide the opportunity for staff to both come together in a safe space to share their experiences and get support, and also to speak to senior leaders from the Board on issues of concern and ideas for improvement.

We also have a number of corporate functions who support staff from across the Trust in ensuring we identify and eliminate any discrimination etc.

There is of course the Equality & Inclusion Manager, who supports and advises in relation to both workforce and service delivery equality issues. This role sits within the wider HR team, many of whom are CIPD qualified, some to Masters level, and who support and advise staff within equality legislation every day.

Our staff side colleagues work alongside both their members and HR and provide a vital challenge and assurance in all matters related to workforce equality.

Our Policy Officer manages all aspects of corporate and clinical policies, ensuring new and reviewed documents go through robust processes, this includes an equality impact assessment, and library review of legislation, guidance, and best practice.

We ensure due regard through robust processes that are reported through governance structure to Board. This structure ensures that all areas of Trust business are under scrutiny, and are, importantly, interlinked, with issues arising in People Committee for example being flagged to Audit, or Finance and Performance Committees.

Advancing Equality of Opportunity

Our NHS Staff Survey results provide some key annual data on how we are doing in this in relation to employment.

We must report in relation to gender, disability, and ethnicity in the Gender Pay Gap report, and Workforce Disability and Race Equality Standards, see pages **. In the latter two standards we can see that staff from these protected groups report below that of their comparator groups, we can see improvements but there is still a way to go to eliminate that gap in experience.

We have been working with our staff networks to better understand experience, to share what is available to all staff, and to identify barriers to accessing opportunities. This has been led by our Organisational Development team, who have since undertaken individual talent management and leadership sessions with network members.

Our staff networks have also supported with projects such as procurement of a new occupational health provider and are involved in working groups for anti-bullying and zero tolerance, and for the new in 2022 reciprocal mentoring project.

Our policy states that opportunities, for career progression, learning and development, flexible working, and other areas, are open to all, fair, transparent, and inclusive, me must ensure that this correlates with experience on the ground. So, in 2022 we will continue to work with network members, and we will reach out to those not currently active in the networks, to understand and deliver in partnership actions to improve equality for all staff.

We make reasonable adjustments for staff with disabilities, but we try to ensure all staff have the support they need to thrive in the workplace, whether that is support for unpaid carers, people whose first language isn't English, people suffering difficult menopausal symptoms…. We are working hard to create an inclusive workplace where everyone is supported and has the opportunity to be involved and to progress.

Fostering Good Relations

Conversations with our staff network members have added real faces to the results in our NHS Staff Survey; results that tell us that some groups of staff are more likely to face discrimination, harassment, bullying and abuse in the workplace. This can be from patients, families, colleagues, and managers.

While as a community Trust we generally have lower overall numbers of these incidents the fact remains that staff who are disabled, who are from Black, Asian, or minority ethnic backgrounds, or who identify other than the hetero and binary norms for gender and sexual identity are more likely to experience these incidents than their comparator staff.

Our staff network members are involved in internal working groups looking at anti-bullying, harassment, and discrimination from the workforce; zero tolerance to racism and other harassment and discrimination from patients and families; and violence prevention through the national standard.

As can be seen these are all strands of the same thread, civility and respect and our expected standards in these. In 2022 we are looking to bring these together under the overall civility and respect workstream, ensuring that these action plans fit into the wider work being undertaken around organisational values, culture, and practice.

As well as recognising and challenging inappropriate behaviour, an important part of fostering good relations is building understanding and thereby awareness, empathy, and consideration.

We have undertaken awareness events for several years, but with our staff networks are focusing more clearly on just a small number of events every year, through communications, events, and bitesize equality learning sessions.

Awareness events in 2021/22 have focused on those areas identified by the staff networks as important to them – LGBT+ History Month, Black History Month, and Disability History Month. For each event we have tried to include a mix of celebration and education, raising awareness, and celebrating difference, something that is important to the network members.

Staff from the networks have supported these events by sharing ideas, their stories, and supporting events in their workplaces. And staff from teams across the Trust have joined in and supported the events

For Black History Month 2021 network members shared family recipes and stories, we shared a reading list, and hosted a, super difficult, quiz for staff.

In Disability History Month 2021 we talked about the importance of providing support and reasonable adjustments and shared information about or Employee Adjustment Passport. We shared information about bullying and harassment and what staff can do when facing or witnessing these behaviours. And we looked at hidden disabilities, asking staff if they would know a colleague had a disability.

In 2022 we have started the year looking at LGBT+ History Month, with the theme art in politics, looking at how artists and culture can highlight political issues and push for change.

We have chosen to look at Keith Haring and his work on AIDS in the 1980-90s.

We have talked about Section 28, AIDS, the hidden history of LGBTQ+ in the UK, and offered signposting to further resources and sources of support.

We have hosted an art class open to all staff looking at LGBTQ+

artists and given staff the opportunity to develop their own awareness or campaigning work of art.

And we have shared Alzheimer's Society guidance on living with dementia for people in the LGBTQ+ community, and supporting people from this community living with dementia.

In March we are hosting a Ramadan event, led by one of our non-executive directors this giving staff the chance to learn more about Ramadan and how they can support colleagues and patients as this important month in the Muslim calendar begins in April 2022.

As part of Ramadan every year we share resources about supporting patients in health care settings during the fast, raising awareness of what is and isn't permitted, who may be excluded, and how staff can better support both patients and colleagues.

Just and learning culture

Implementing a restorative just and learning culture is one of the actions of the national NHS People Plan.

A just and learning culture establishes processes and a culture whereby incidents that may have previously led almost immediately to formal investigations being started against staff are instead reviewed to look at contributory factors and learning.

A just and learning culture does not mean that where intent is clear, for example racist comments or deliberate negligence in patient care, there will not be formal processes instigated, but it instead recognises that most incidents arise from a set of circumstances, human or structural, that have led to a genuine mistake. The Trust and staff should be supported to understand and learn rather than be penalised and subjected to lengthy and distressing processes.

In autumn 2021 60 members of staff attended training to become ambassadors, this was led by Merseycare NHS Trust and Northumbria University. Following this a Just and Learning Culture Steering Group has been established, an action plan agreed, and small task and finish groups are just starting work on areas such as policy review, and development of a four step process to look at incidents and factors as they occur.

Part of the Just and Learning programme is civility and respect, this includes a review and refresh of Trust values to embed them across the Trust. Civility and respect and living by our values are fundamental building blocks of a Just and Learning Culture. The civility and respect workstream will bring together existing work on anti-bullying and harassment and zero tolerance.

EDI is a thread running throughout both Just and Learning and civility and respect as evidence shows that staff from minority groups are more likely to be in formal disciplinary processes, and are more likely to report bullying, harassment, and discrimination in the workplace. As such the Just and Learning lead has been assigned line management responsibility for equality, bringing two important areas of work together.

Just and Learning lead Ros said: *'The Trust are progressing with the implementation of our Just Culture programme recognising the centrality of EDI priorities to its successful assimilation and aim to incorporate the objectives of the range of EDI networks and initiatives into our Just Culture aspirations.*

The recently established steering group will oversee development and progress through four workstreams which focus on performance and monitoring, training, communication and policy review and development, perspectives of our staff with protected characteristics will help inform the direction of travel. Promotion of the Trust values will support a framework of civility and respect, behaviours which are pivotal to promoting inclusion'

Staff Networks

Staff networks are a really important part of the Trust.

As we have already referenced we have staff network members supporting the Trust and sharing their voice and experience in a number of areas.

We currently have five networks:

- (Dis)Ability and Wellbeing Network – name being discussed in March 2022 as members do not like the word disability
- Race Inclusion Network
- LGBTQ+ Staff Network
- Menopause Support Network
- Carers Support Network

We have also looked to establish an armed forces network but so far have been unsuccessful in this. We recognise that this may be because of low numbers, work related commitments, or just a hesitancy about why we want to establish a network. We hope that as we start to implement our action plan and really start to build communications the appetite for this network will grow.

In 2022 the networks are looking to develop their terms of reference and network objectives; all have chosen to take a hybrid approach of being both a safe space, and an activism network.

The networks are choosing which events they want to focus on this year. For example, in 2022 the Race Inclusion Network are planning to celebrate Black History Month once again in October, but are also looking at Gypsy, Roma, Traveller History Month in June – one of the largest but most marginalised minority ethnic groups in two of our boroughs. Two members are also hosting an EDI Bitesize session, a new series of events for 2022, with this particular lunchtime event focusing on understanding privilege and becoming an ally.

Each network has at least one Board level sponsor:

- (Dis)Ability and Wellbeing Network – Director of Finance (key as they enabled the centralisation of reasonable adjustments spend)
- Race Inclusion Network – Chief Executive, and Trust Chair
- LGBTQ+ Staff Network – Chief Operating Officer, and Trust Secretary
- Menopause Support Network – Medical Director (one of two in a joint role, the other Medical Director being Chair of the Race Inclusion Network)
- Carers Support Network – Director of People & Organisational Development

These sponsors are invited to attend network meetings, ensuring that staff voice is heard at the highest levels of the Trust.

All networks are currently discussing terminology, mirroring discussions that are being held nationally. We have yet to reach a conclusion, and know that this will be an ongoing process, but we have chosen to no longer use the terms BME and BAME, and to instead try to reference individuals or groups accurately, or to use the term Black, Asian, or minority ethnic.

Disability Confident

In early 2022 we have taken part in an NHS England/Improvement pilot project looking at Disability Confident in recruitment. We were one of only 14 Trusts selected to take part in this project.

As part of this a large review of recruitment and retention data and practices in the Trust was undertaken. This involved members of several corporate and clinical teams, along with members of the staff disability network (members of the other networks have also contributed as we felt this was an opportunity to look at our practices through a wider equality lens).

An action plan has been developed with some short and some longer-term actions to deliver. The task and finish group to deliver this will report to the wider Recruitment and Retention POD, itself part of a wider group that reports to People Committee and Board.

We were delighted to receive external validation to Disability Confident Level 3: Leader in March 2022 with the support of Shaw Trust.

Menopause Friendly

In 2021 we committed to becoming a Menopause Friendly Employer, recognising that just under half of our workforce fitted the profile (in relation to age and gender) of staff who are likely peri-menopausal or post-menopausal. And we know that while we can make some general estimates based on ESR data we can't exclude:

- Transmen
- Younger women going through early or premature menopause
- Staff who have had a medical menopause
- Staff from Black, Asian, or minority ethnic backgrounds whose peri-menopause, (evidence suggests), may be earlier and more difficult, or whose cultural background doesn't have a term for menopause, or whose menopause is not discussed openly
- And partners, male, female, or other gender identities who are impacted by menopausal symptoms and who want to support their loved ones but maybe aren't sure how

We have established a Menopause Support Network, a safe space for staff to come to talk, share, and just let their bra's loose, and their emotions out. A place for loved ones and allies to come and talk about their experiences, worries, and ideas about what those on the other side of menopause could benefit from in terms of understanding how to support. And also a network of ideas and action, of getting angry and saying this needs addressing.

Our new Menopause Support Policy was published in January 2022 and will form the basis of the action plan to be implemented throughout this year. Draft guides are almost completed, a workplace risk assessment is in development, Fresh Packs are being created for workplaces, and events are being planned that we hope to open out to partners across the boroughs.

Figure 2: Fresh Pack for Menopause Flyer

Armed Forces and Autism Action Plans

In 2022 we are also looking to implement two other action plans, armed forces friendly, and autism friendly.

Armed Forces Friendly crosses both employment and service delivery. Following the Royal Assent of the Armed Forces Bill 2021 the Trust must now evidence due regard to the armed forces community and military veterans.

For about a decade the Armed Forces Covenant has been embedded within the NHS Standard Contract, requiring Trusts to meet certain principles when delivering services to members of the wider armed forces community – the principle of no disadvantage in access, and priority treatment where applicable being the main one.

The new Bill provides the community with a similar protection to the characteristic groups protected under the Equality Act. We must evidence how we meet due regard in these principles.

We have signed Local Covenant agreements with partners in our boroughs, but the Bill and the work we are undertaking on recruitment and retention of staff has led us to the belief that we need a review and refresh of our practices in relation to the armed forces community in the boroughs we serve.

We are working in Cheshire and Merseyside in a collaborative group to ensure standardisation and sharing of best practice across the area.

The second action plan is about autism friendly workplaces, and while this is about employment it will offer mutual support to the Learning Disability and Autism Working Group looking at service delivery.

Autism friendly action plans will require a thorough review of every stage or recruitment and employment, and there will be some quite radical changes needing to be made, not least to awareness, understanding and culture in the Trust. But if we can get employment right for people with autism it can only benefit every other protected characteristic group, and it can support us to better deliver accessible and inclusive services to people with autism in our community.

We have recruited applicants with autism in the past, offering additional support if needed during the recruitment process and in the workplace, and they are now working successfully within their teams. And we are looking to work with these staff members to evaluate their recruitment and workplace experience, to build on this success and to develop in partnership our action plan so that future applicants can feel supported, included, and valued throughout their time with Bridgewater.

Workforce Equality Standards

Three mandatory workforce equality standards allow us to analysis our progress in relation to gender, race, and disability.

The Workforce Race Equality Standard was mandated by NHS England in 2015 and looks at the inequality in nine indicators of employment experience between Black, Asian, and Minority Ethnic and White staff. This is in recognition of the evidence that shows that nationally across most if not all areas of employment minority ethnic staff report worse experiences than their White colleagues. The table on pages 21 - 22 shows our 2021 results.

Pages 23 – 24 show the 2021 Workforce Disability Equality Standard results for Bridgewater. Mandated in 2019 this Standard looks at 10 metrics, comparing the experiences of Disabled and non-disabled staff. As with minority ethnic staff, nationally staff with disabilities report poorer experiences in the workplace and often difficulty finding and retaining employment.

The Gender Pay Gap reporting is a legal requirement set down by Government in recognition of the ongoing disparity in pay between men and women despite many years of equal pay legislation. Publishable by 30 March every year the data looks at a snapshot date of 31 March the previous year, giving time for detailed review of results and action planning to address identified issues. The table on page 25 details our gender pay gap for 2019 to 2021.

Full reports for all three Standards can be found on our **website**.

Finally, we also assess and grade our equality performance in relation to employment and service delivery in the Equality Delivery System 2 (EDS2) annual submission.

Generally, we use the NHS Staff Survey results from the previous autumn to review and grade our workforce indicators, however due to the later publication, 30th March, in 2022 we have been unable to use them this year for EDS2, we believe this has left a gap in quantitative data for our most recent submission however action plans will be focussed on the most recent set of results following publication. Our latest EDS2 results can be found on pages 28.

As a Trust we are also committed to the Disability Confident Employer scheme and we were very pleased to be validated as a Level 3 Leader in March 2022.

We are also committed to being an Age Positive employer, to the Equality and Human Rights Commission Working Forward charter for pregnancy and maternity equality, and to the Race At Work charter.

Workforce Race Equality Standard (WRES) 2021

We have provided in the table to follow a summary of our results against the nine indicators of the WRES. More information, including year on year comparisons, can be found in the detailed report on our **website**.

Table 1: Workforce Race Equality Standard Results 2021

Indicator						
1. Percentage of staff in each AfC Band 1 9 or Medical and Dental pay grades, compared with the percentage of staff in the workforce overall. Disaggregated by non clinical staff, clinical staff, and medical and dental staff						
	Non-clinical			Clinical		
	White	BAME	N/S	White	BAME	N/S
Under Band 1	0.35	0.06	0	0	0	0
AfC1	0	0	0	0	0	0
AfC2	6.01	0.17	0.12	1.50	0.06	0.06
AfC3	7.46	0.17	0.58	6.36	0.23	0.23
AfC4	2.20	0	0	8.73	0.46	0.81
AfC5	2.49	0.23	0.12	14.51	1.04	0.23
AfC6	1.73	0.06	0.12	19.65	0.87	0.87
AfC7	0.87	0.17	0.06	9.71	0.17	0.29
AfC8a	0.69	0	0.12	3.29	0.06	0.06
AfC8b	0.46	0.06	0	0.23	0	0
AfC8c	0.64	0	0.06	0.23	0.06	0
AfC8d	0.12	0	0	0	0	0.12
AfC9	0	0	0	0	0	0
VSM	0.17	0	0.06	0.06	0.06	0
	Medical and Dental Grades:					
Consultants	0.17	0.23	0.17			
(of which VSM)	0	0	0.06			
Non Consultant Career Grade	2.83	1.21	0.12			

Continued….

Table 2: Workforce Race Equality Standard Results 2021 Continued

Indicator	
2. Relative likelihood of being appointed from shortlisting across all posts	0.61 times more likely to be appointed if you are White
3. Relative likelihood of entering formal disciplinary processes	0.00 – no Black, Asian, or minority ethnic staff in new formal disciplinary processes
4. Relative likelihood of accessing non mandatory training/CPD	1.09 times more likely to access non-mandatory training if you are White
5. Percentage of staff experiencing bullying, harassment, and abuse from patients/relatives/public in last 12 months	BAME 30.3% White 18.2%
6. Percentage of staff experiencing bullying, harassment, and abuse from staff in last 12 months	BAME 15.6% White 17.8%
7. Percentage believing the Trust provides equal opportunities for career progression and promotion	BAME 84.6% White 91.7%
8. In the last 12 months personally experiencing discrimination from manager/team leader/other colleagues	BAME 12.1% White 4.4%
9. Percentage difference between Board membership and overall workforce Disaggregated by voting and non voting members	White -19.0% BAME 8.9% Not Stated10.1%
Overall Workforce	
White	1,565 (90.46%)
Black, Asian, and Minority Ethnic	93 (5.38%)
Unknown/Not Stated	72 (4.16%)

Workforce Disability Equality Standard (WDES) 2021

We have provided in the table to follow a summary of our results against the ten indicators of the WDES. More information, including year on year comparisons, can be found in the detailed report on our **website**.

Table 3: Workforce Disability Equality Standard Results 2021

Metric						
1. Percentage of staff in each AfC Band 1 9 or Medical and Dental pay grades, compared with the percentage of staff in the workforce overall. Disaggregated by non clinical staff, clinical staff, and medical and dental staff. *Note rounding up of numbers may mean a slightly higher figure than 100% is seen in the below.*						
	Non-clinical			Clinical		
	Disabled	Non-Disabled	N/S	Disabled	Non-Disabled	N/S
AfC1 4	0.40	13.35	2.95	0.23	12.54	5.66
AfC5 7	0.17	4.22	1.45	1.50	37.80	8.03
AfC8a 8b	0.06	0.87	0.40	0.23	1.85	1.56
AfC8c VSM	0.06	0.66	0.75	0	0.40	0.17
	Medical and Dental Grades:					
Consultants	0	0.29	0.16			
Non Consultant Career Grade	0.06	3.06	1.16			
Trainee Grades	0	0	0			

2. Relative likelihood of being appointed from shortlisting across all posts	1.53 times more likely to be appointed if you are Non-Disabled
3. Relative likelihood of entering capability processes	0.0 - no formal capability procedures in this period
4. A) Percentage of staff experiencing bullying, harassment, and abuse from patients/relatives/public in last 12 months	27.4% Disabled 16.6% Non-Disabled
Percentage of staff experiencing bullying, harassment, and abuse from managers in last 12 months	14.4% Disabled 7.2% Non-Disabled
Percentage of staff experiencing bullying, harassment, and abuse from staff in last 12 months	17.4% Disabled 11.6% Non-Disabled

Continued….

Table 4: Workforce Disability Equality Standard Results 2021 Continued

Metric	
B) Percentage staff reporting bullying, harassment, and abuse in last 12 months	60.3% Disabled 48.3% Non-Disabled
5. Percentage believing the Trust provides equal opportunities for career progression and promotion	87.0% Disabled 92.8% Non-Disabled
6. Percentage feeling pressure by manager to attend work even when feeling unwell	19.6% Disabled 19.5% Non-Disabled
7. Feeling valued by the Trust	41.0% Disabled 49.1% Non-Disabled
8. Satisfaction that reasonable adjustments made to support them in their work	75.8% Disabled
9. A) Staff engagement score (Disabled staff only)	6.8 Disabled 7.2 Non-Disabled 7.2 Overall Trust Result
B) Have you taken action to facilitate the voices of Disabled staff	Yes
10. Percentage difference between Board membership and overall workforce Disaggregated by voting and non voting members	Disabled -3% Non-Disabled -4% Not Stated 6%
Overall Workforce:	
Disabled Non Disabled Unknown	2.72% 75.03% 22.25%
A * means that numbers are below 10 and therefore remain confidential in line with information governance and data protection requirements	

Gender Pay Gap 2021

We have provided in the table to follow a summary of our results for the Gender Pay Gap reporting indicators. More information including action plans can be found in the detailed report on our **website**.

Table 5: Gender Pay Gap 2019 to 2021

	March 2019		March 2020		March 2021	
Percentage of male and female staff in quartiles						
	Female	**Male**	**Female**	**Male**	**Female**	**Male**
1	660	57	397	44	370	50
2	621	61	416	24	397	23
3	626	42	415	25	392	28
4	707	97	373	67	364	56
Average	**654**	**64**	**400**	**40**	**381**	**39**
Mean Gender Pay Gap						
Percentage %	22.38		25.35		16.14	
Cost £	4.53		5.56		3.26	
Median gender pay gap						
Percentage %	1.54		9.19		2.37	
Cost £	0.23		1.56		0.38	
Bonus pay						
Note	No bonus pay gap, all clinical excellence awards to female staff in relevant period					

2022/23 – Our Plans for Workforce Equality

To follow are some of the planned actions for 2022 – 23, developed in partnership with our staff networks:

- Develop the civility and respect work stream in partnership with the Just Culture programme, bringing together anti-bullying and harassment, and zero tolerance.
- Deliver EDI Bitesize training series.
- Deliver Disability Confident action plan, including:
    - Self-reporting guide and communications
    - NHS Jobs and Bridgewater webpage updates
    - Job description refresh
    - Accessible communications guidance
    - Establishment of workplace support process
    - Development of Disability Peer Support Volunteer programme
    - Delivery of reasonable adjustments policy and procedure for workforce
- Implement maturity actions for staff networks.
- Development of Race Equality Champions and anti-racism work.
- Delivery of action plan for Menopause Friendly Employer accreditation.
- Development and establishment of Paths to Parenthood project looking to develop awareness, deliver tools and evaluate Trust policy and process in relation to staff with fertility challenges or on different paths to becoming parents, e.g. LGBT+ parents to be.
- Delivery alongside Cheshire and Merseyside partners of military veterans action plan.
- Refresh and delivery of EDI training offer.
- Review Rainbow Badges offer for LGBTQ+ equality and inclusion.
- Continued working with Cheshire and Merseyside partners on real actions to improve Equality Delivery System 2 (EDS2) grades.
- Work with colleagues in developing an EDI focus in Leader in Me.
- Further train and embed EqIA across all Trust business.

Equality Delivery System (EDS) 2

EDS2 Collaborative

In 2018 we joined with colleagues in Merseyside and Cheshire a collaborative group facilitated by the Merseyside CSU. The intention of the collaborative is to support Trusts who are developing in relation to the EDS2 indicators agreed nationally. These are Trusts, like ourselves, who struggle to evidence improvement through data – often due to difficulties with diverse patient record systems in use across the organisation.

EDS2 is a nationally mandated equality toolkit that has 18 outcomes across four goals:

- Patient Access
- Patient Experience
- Staff Experience
- Leadership

The collaborative recognise that rightly or wrongly EDS2 can be just a tick box exercise, a gathering of 'evidence' to prove a Trust is doing well in relation to equality. Data in itself is not always proof that equality is achieved.

Across the protected characteristic groups there are challenges and inequalities, often related to poor or no access to services, or to challenges when in these services. The collaborative members have engaged with national, regional, and local groups representing different protected characteristics to gather both qualitative and quantitative evidence of inequality. From this an action plan was developed.

To date the group has worked in the following areas:

- Interpretation and Translation Quality Standard development
- Reasonable Adjustment Standard Operating Procedure: Patients
- Reasonable adjustments Standard Operating Procedure: Staff
- D/deaf Access Plan developed with Deaf patients across Merseyside

Work is currently underway on:

- Transgender Standard Operating Procedure
- Military veterans equality action plan

Through continued collaborative work, and engagement with external groups, Trusts can move to EDS2 achieving or excelling grades through real and sustained action rather than data. The EDS2 assessment documents can be viewed on our **webpage**.

Equality Delivery System 2 (EDS2) 2022

We have provided in the table to follow a summary of our grading following internal assessment against the Equality Delivery System 2 (EDS2) NHS toolkit in March 2022. More information and previous year's results can be found on our **website**.

Table 6: EDS2 Results 2022

Outcome	Grading 2022
1. Better Health Outcomes	
1.1 Service design and delivery	Developing
1.2 Meeting individual needs	Developing
1.3 Transitions between services	Developing
1.4 Patient safety	Developing
1.5 Screening, vaccination, and other health promotion services for all	Achieving
2. Improved Patient Access and Experience	
2.1 Accessible services	Developing
2.2 Information and support for decision making	Developing
2.3 People report positive experiences of the NHS	Developing
2.4 People's complaints about services are handled respectfully	Achieving
3. A Representative and Supported Workforce	
3.1 Recruitment and selection for a representative workforce at all levels	Developing
3.2 Equal pay	Achieving
3.3 Training and development	Developing
3.4 Abuse, harassment, bullying and violence	Developing
3.5 Flexible working	Developing
3.6 Staff report positive experiences of their membership of the workforce	Developing
4. Inclusive Leadership	
4.1 Equality commitment from Board and senior leaders	Achieving
4.2 Equality impact assessment of Board and other decision making papers	Developing
4.3 Middle managers and other line managers cultural competence	Developing

Due regard in service delivery

Due regard to our patients, their families, and carers requires us to consider the three aims of the Equality Duty in all service delivery and healthcare related issues. This includes looking at accessibility, experience, outcomes, and inequalities.

Data regarding our patients can be seen in Appendix 2, but here are the basic and everyday things we do that support due regard in our employment actions and decisions:

Due Regard in Service Delivery

- All Trust policies, procedures and guidelines related to patients and services are reviewed by the equality lead before being approved, with support provided as necessary to staff completing equality impact assessments of these documents and final sign off being undertaken by the Equality and Inclusion Manager.
- Many Trust services deliver specialist care to protected characteristic groups, for example people with disabilities, the elderly, and children and young people. These services are designed to meet the particular needs of the target demographic with staff automatically identifying and making the adjustments needed to support access and inclusion.
- All Trust staff must undertake mandatory training, some standard for all and some role specific.
- All services have access to interpretation and translation providers, this includes information and communication support in community languages, BSL, and other formats such as audio, easy read and Braille. See Appendix 3 for our language interpretation usage in 2021.
- The Trust's incident reporting systems and Freedom to Speak Up processes ensure that any issues in relation to patient experience are flagged, recorded, analysed and lessons learned and shared.
- Staff are supported by the internal Library Service who advise on updated NICE guidance, changes to legislation, current news, and who provide an invaluable source of support in developing the patient policies, procedures, and guidelines.
- The Trust's services are effectively supported by our Safeguarding teams, with staff and named nurses working collaboratively with outside agencies to ensure the most vulnerable in our communities and identified and supported.
- To help us to consider our equality impact, and to support us in meeting due regard to equality, we use borough health inequality documents; these provide local population demographics by protected characteristic, and inequalities information for protected groups.

Quality and Place – Our Refreshed Strategy 2021 - 23

Our Bridgewater aspiration is to be a key partner in a joined-up health and care system that supports people and families to live healthy lives, accessing health and wellbeing services when and where they need them.

Our mission is to improve local health and wellbeing in the communities we serve. We will do this by working closely with local people and partners.

Our Quality & Place (Q&P) strategy was originally developed and published in 2018, with a five-year vision. We engaged and gathered over 500 responses in 'Big Conversations' from our staff, communities and partners to shape and inform our strategic direction.

Based on events over the last 18 months, coupled with the publication of the White Paper, describing the formation of Integrated Care Systems (ICS) across the health and care, it was important to review and update the Q&P strategy.

We remain committed to Q&P and are able to deliver our strategic objectives with greater clarity. These are:

1. ***Quality*** – To deliver high quality, safe and effective care which meets both individual and community needs.
2. ***Innovation & Collaboration*** – To deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living.
3. ***Sustainability*** – To deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability.
4. ***People*** – To be a highly effective organisation with empowered, highly skilled and competent staff.
5. ***Equality, diversity and inclusion*** – To actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.

As integrated care systems (ICSs) and place-based partnerships develop, it will be essential for all local partners, including ICS staff, NHS provider organisations, local authorities and the voluntary, community and social enterprise (VCSE) sector, to come together to develop a better understanding of how patients and users experience integrated care. The advent of ICSs and place-based working offers a real opportunity to ensure staff and communities are at the heart of how services are developed.

So, what are the next steps in our refreshed Q&P strategy journey? Over the coming weeks and months you will get to know more about Quality & Place via the following channels:

- Staff engagement
- Public engagement
- Further integration and partnering with General Practice and Social Care
- Focus on delivering integrated services and pathways with partners
- Increased integration
- Increased local decision-making
- Increased financial autonomy in place
- Provider Collaborative delivering impact and benefit to place
- Developing and expanding our Dental Network

As we begin to plan our communication on our next steps, you can read the refreshed Quality & Place strategy by visiting: **bit.ly/bwstrategy.**

Eliminating Discrimination, Harassment, Victimisation, and other prohibited conduct

The actions on page 29 all support us in identifying and eliminating discrimination both as a structural or systemic and unconscious process, and as a behaviour along with harassment and victimisation.

We also look through the equality and human rights lens at how our day-to-day business may negatively impact on protected characteristic and vulnerable groups. And this has been so important throughout the pandemic.

Many of our services were stepped down in early 2020 to support priority one healthcare services, in Bridgewater and in our partnering Trusts. We also supported the safe discharge of patients to homes or intermediate care settings from hospital. And then many of our staff were redeployed to support the Covid 19 vaccination programme for our staff and then in school age children through our school nursing teams.

To ensure we undertook these mandated measures in a way that impacted as little as possible on vulnerable patients we established a quality panel that looked at the business continuity plans that every service produced. Every plan was reviewed by the panel and following discussions an agreed risk score was produced, this included looking at equality and human rights risks as a result of service changes.

All services undertook review of waiting lists and put in place actions to facilitate the prioritisation of treatment of urgent patients, the management and communications with those on the waiting list, triage of new referrals, signposting where appropriate to other services. Each service worked hard to ensure that no patient who needed urgent treatment was missed, and this included home visits for those who were unable to access primary care as they too changed their operating processes.

A panel was established, meeting daily, when there was a further Covid outbreak in Padgate House, our intermediate care unit, ensuring that all measures were taken to protect these vulnerable patients while minimising the impacts, including equality impacts, on them.

The quality panel has since developed, it still meets to discuss services that have been amber or red rated through the regular command meetings, but it also looks now at planned service changes.

Advancing Equality of Opportunity

To advance equality of opportunity effectively it is important to understand where inequality exists, what might be contributing factors, who isn't being heard or getting involved. And in our services this is about health outcomes and understanding the personal, external, structural, and systemic factors that impact and detriment on health.

Within our boroughs we have areas of high deprivation, and we have provided some brief information from the Office for National Statistics[1], below.

Halton

As at 2019 18.5% of the population of Halton was income deprived.

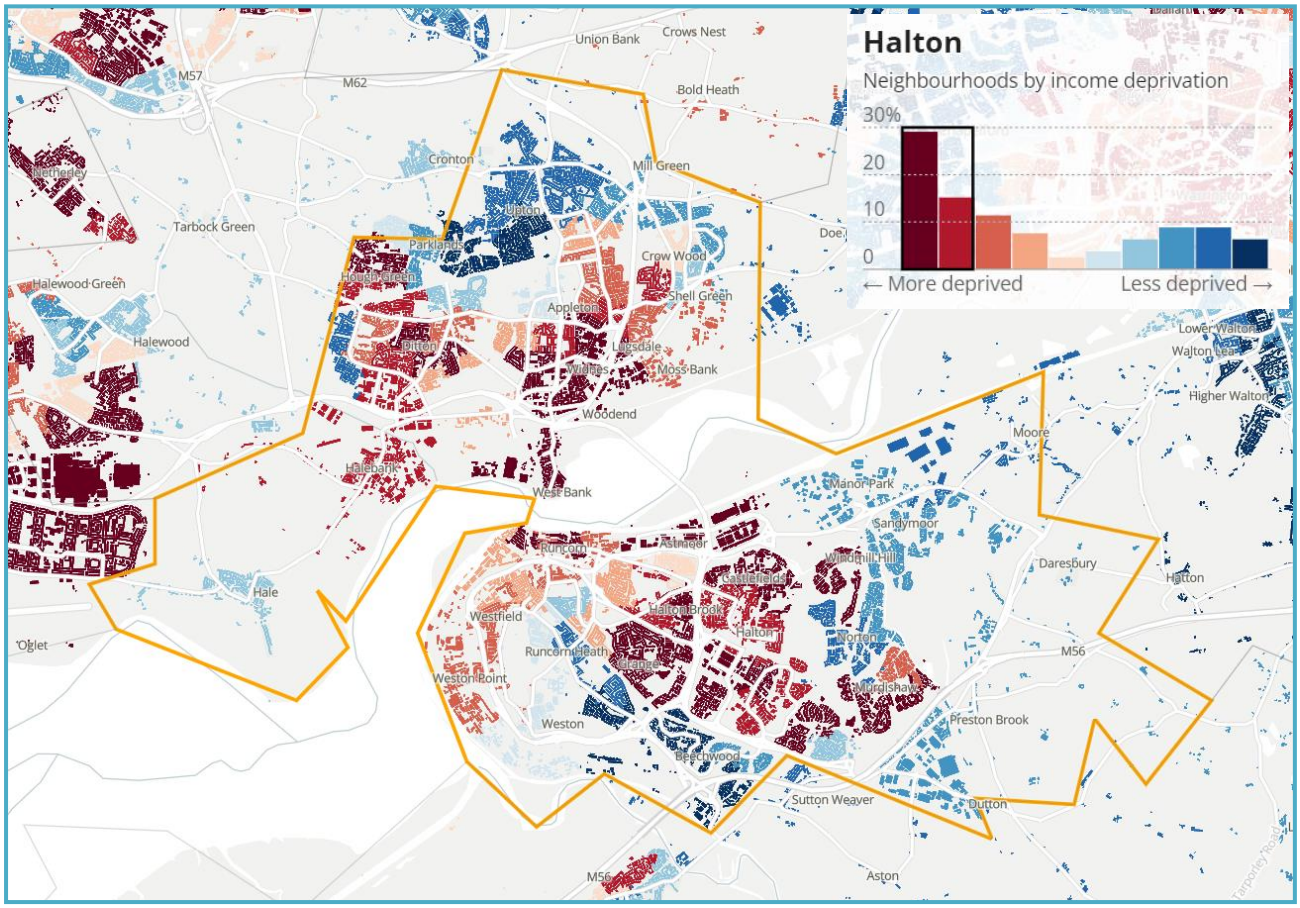
Halton was 31st in the table of most income deprived of the 316 English local authorities (1 being the most deprived, 316 the least).

Of the 79 individual neighbourhoods (lower super output areas) in the borough:

- 35 are among the 20% most deprived in England
- 12 are among the 20% least income deprived in England

The map below shows how these areas are often right next to each other, and this can be seen in primary school data where two primary schools less than four miles apart can be at opposite ends of the socio-economic deprivation scale:

Figure 3: Socio-Economic Deprivation Map of Halton (Widnes and Runcorn)



[1] https://www.ons.gov.uk/visualisations/dvc1371/#/E07000223

Warrington

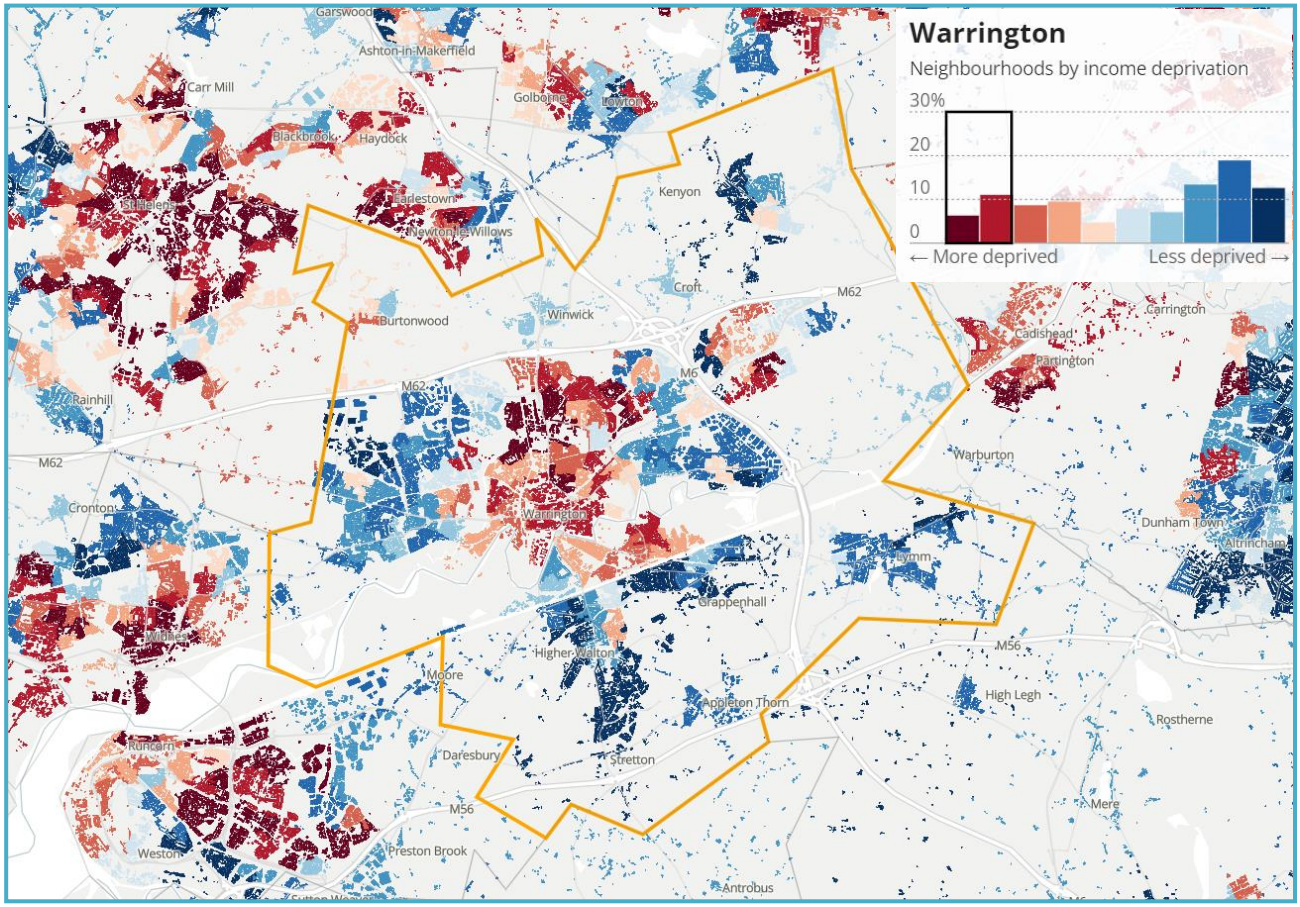
As at 2019 in Warrington 10.9% of the population was income deprived, and the borough was ranked 153 out of 316 on the local authority table of income deprivation.

In Warrington there are 127 neighbourhoods (lower super output areas) and of these:

- 20 were in the most income deprived in England
- 40 were in the least income deprived in England

You can see in the map below how in Warrington the areas of income deprivation (the red and orange areas) are clustered around the town centre, in Halton the areas are clustered around the river, generally areas of traditional or existing industry. The least deprived areas (the blue areas on the map) are moving out to more rural and less traditional built up areas.

Figure 4: Socio-Economic Deprivation Map of Warrington



Oldham

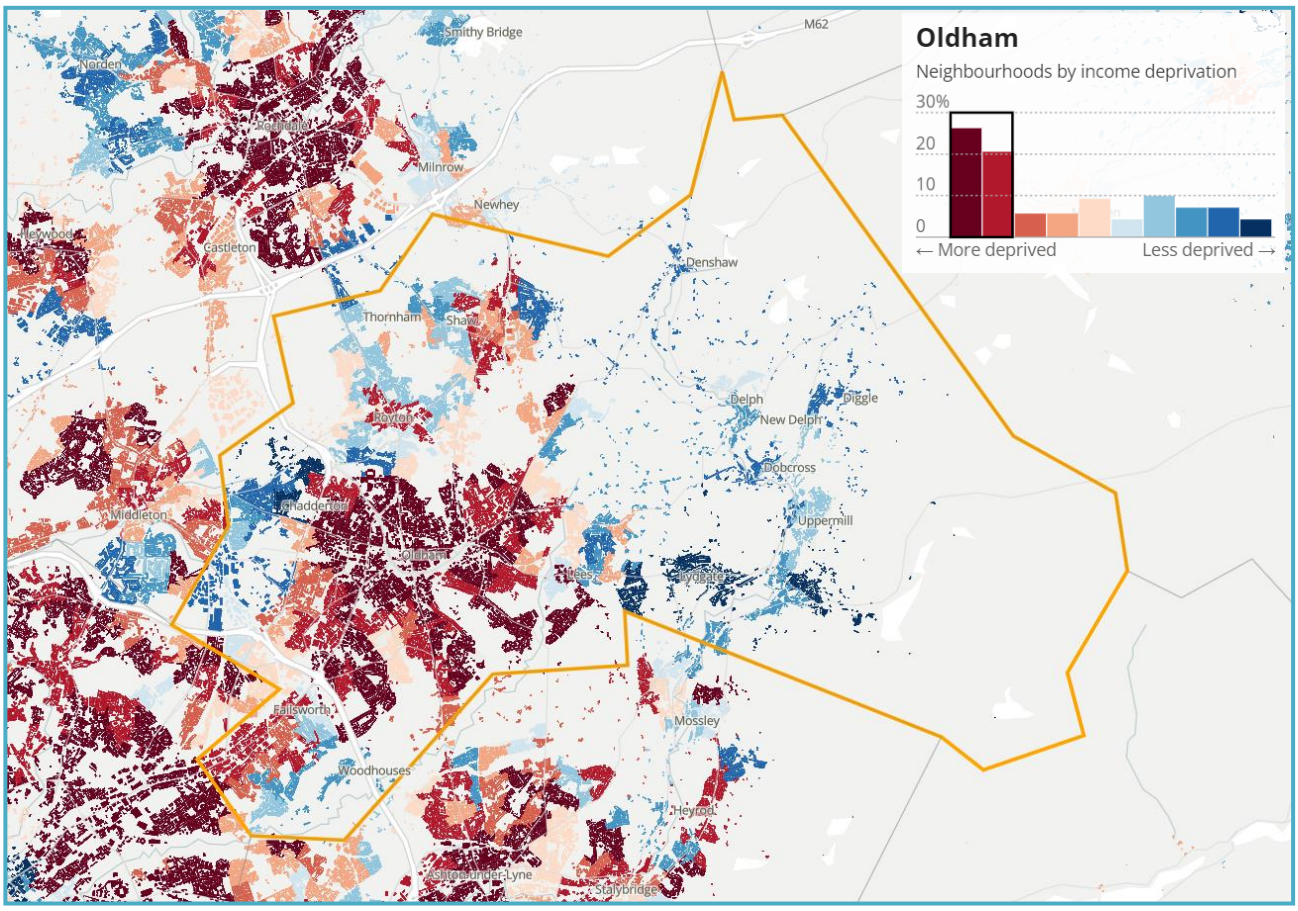
Oldham is the third borough where we provide community health services. In Oldham, as at 2019, 19.3% of the population were in the most income deprived in England, and the borough was ranked 21st out of 316 local authorities for income deprivation.

Of the 141 local neighbourhoods

- 66 were in the most income deprived in England
- 16 were in the least income deprived in England

The map of income deprivation in Oldham very starkly shows the high levels of income deprivation in the borough, again mostly densely clustered in more built up areas

Figure 5: Socio-Economic Deprivation Map of Oldham



As Professor Sir Michael Marmot highlights in his reports regarding the social determinates of health, socio-economic deprivation is one of the factors affecting health, life expectancy, and health life expectancy.

We know other factors can also lead to health inequality, these include employment status, housing, caring responsibilities, education, ethnicity, disability, and we have profiles for our local areas that detail this data about the population alongside research and evidence related to protected characteristic group. Much will be reviewed and refreshed as Census 2021 data is released.

Fostering Good Relations

Within our services individual teams do a lot of work around fostering good relations and raising awareness.

Our dental teams for example are undertaking Pride in Practice assessments in Greater Manchester, and teams also raise awareness in different communities through events such as Mouth Cancer Action Month.

The Trust has a zero tolerance strategy for racism, disablism, LGBQ+T phobia, sexual harassment etc. While this can be difficult to anticipate and manage we are clear that our staff, our patients and their families and friends have a right to work and access services that are inclusive and free from discrimination and hate. We have policies and processes, and reporting mechanisms to ensure that people are offered a clear message, a route to report, and support if such an incident does occur. This is an ongoing piece of work however and in 2022 we will be bringing all the work streams around these behaviours together in our work on values, culture, civility and respect.

Rainbow Badges were rolled out across the Trust in November 2019, the pandemic has rather slowed progress, particularly in relation to the training that we ask all staff to complete before committing to the badge, however to date approximately 200 staff have pledged to this message of inclusion and welcome for the LGBTQ+ community.

Every year we highlight religious and cultural events, whether that is a greeting of celebration for Diwali, a message of support or remembrance, or more in depth support such as that for Ramadan and supporting colleagues and patients at this time.

There is a lot more we can and plan to do but being conscious of diversity and embedded inclusion in the workplace and services is always at the centre of what we do.

Oldham 0 – 19s Service - SPOONS

‘As we are aware from recent reports Black, Asian, and minority ethnic women are at an increased risk of having a pre-term birth, stillbirth, neonatal death, or a baby born with low birth weight.

Our Black, Asian, and minority ethnic population here in Oldham is higher than the UK average and during the pandemic we have noticed an increased rate of neonatal births for our area of Glodwick and St Marys.

In order to improve the outcomes for the community we serve, we linked in with a local charity 'SPOONS' who offer support for families with a neonate both on the unit and following discharge.

SPOONS have also recently appointed a volunteer specifically for engaging with these communities who we invited to our children's centre to build links between ourselves and the charity. Shahnaz, the volunteer, has attended a team meeting here at Beever to discuss her role and how we can work together to achieve positive health outcomes for these families.

We are also in the early stages of planning to host a series of SPOONS messy play groups at the centre specifically targeted towards Black, Asian, and minority ethnic families where parents can not only encourage play and development for their child via SPOONS but can also access the Health Visiting service in terms of any health queries they may have.'

Covid 19 Vaccination Programme

As referenced above Trust staff have supported the Covid 19 vaccination programme for staff and school age children.

The vaccination is a personal choice and we are very aware of the potential equality and human rights implications in this decision-making. But equally we aware that access to the vaccine has been life changing for those more vulnerable to the virus, allowing them some feeling that they can safely start to meet family and friends again and resume some of the activities that have been so restricted for the last two years.

The following is from the Bridgewater Bulletin on 21st February and details what steps staff have taken to ensure every vaccine finds a place:

'Bridgewater staff save incredible £140,000 worth of vaccines

What to do when the power goes off and you have more than £100,000 worth of vaccine in fridges… you call a nurse of course who rolls up her sleeves and calls on her colleagues who collectively save the day.

Today we highlight the efforts of staff working in the school-aged immunisation team at Spencer House. At 3.30pm last Thursday, the electricity supply at Spencer House went off.

With only moments delay, the nursing staff in the centre took charge of the situation, assessed what needed to be done, made decisions, allocated tasks, and contacted their colleagues.

Calls were made to neighbouring trusts and vacant fridge space was located at Halton Hospital. Contact was made with the manufacturers of the vaccine to understand the timescales at play.

Staff alerted to the potential crisis, immediately reacted to the situation and offered their services in portering the vaccine from the fridges into waiting vehicles and nurses were then despatched up the M62 to the Widnes site.

"This was and is a fantastic example of staff thinking on their feet, using their knowledge, skills and contacts to best effect," said Chief Nurse Lynne Carter.

"Collectively all involved saved almost £140,000 worth of vaccine. That included the cancer preventing HPV vaccines, Meningitis ACWY, childhood boosters and COVID19 vaccines for the 12-15 year old programme.

“We can never thank all those involved enough. They prevented us having to dispose of the vaccine and so delay the whole process.

“The work that went on that day sums up the spirit of support and co-operation that has underpinned so much of the work in the NHS in the past two years.

“We are extremely proud of all those whose efforts on that day and in the days that followed undoubtedly made a huge difference to many thousands of people’s lives.

I would like to put on record my thanks to all the nursing staff who responded so brilliantly, to our colleagues in medicines management for providing professional guidance, our corporate colleagues for helping to shift the stock and our colleagues in Warrington & Halton Hospitals for locating and loaning vacant fridge space.”

Safeguarding

The children and adults safeguarding teams provide guidance and support to staff across the Trust, from ensuring the correct level of training is mandated based on job role, to guiding staff and providing support in difficult cases as they arise.

Communication and awareness raising is a key part of their role, ensuring safeguarding messages are in the workplace frequently, and that staff are kept up to date with any changes or updates.

The teams work with partners at a local borough level, ensuring that staff from all organisations work together for the welfare, safety, and best outcome for all concerned.

Examples of their work to advance staff awareness include briefings on perplexing presentation and fabricated induced illness, elder abuse, female genital mutilation, and child sexual exploitation.

Learning Disability and Autism Working Group

In 2021 we established our Learning Disability Working Group, looking at evidence and gaps in assurance based on the national Learning Disability Improvement Standard framework.

An action plan was developed with the group that includes representatives from Patient Experience, Adult and Children’s Safeguarding, EDI, Quality, Halton Community Matrons, and Allied Health Professionals.

One of the first pieces of engagement with the learning disability community was an art competition for Learning Disability Week in June 2021. The theme was ‘art and creativity’ and the online competition was undertaken by local individuals and groups, the winning entries can be seen below.

Figure 6: Showing Winning Entries From The Learning Disability Week Art Competition

A newsletter is planned for twice a year, providing a community update on the work of the Group, the first issue in February 2022 detailed the art competition, the development of new best practice guidance for services, and a new talk to us form designed to be accessible for people with learning disabilities.

Community Health Workers

This is a pilot project that is recruiting staff to work with individuals and families in Halton, offering advice, support, and interventions to hopefully improve long term health and wellbeing.

It is built on the principles of Marmots Fair Society, Health Lives, and Build Back Fairer: reports, with at its heart the intention to reduce local health inequalities through partnerships with local residents within a specified caseload.

The Community Health Worker will:

- Understand issues and health inequalities that impact the local area
- Make contact with each household in a defined area on a regular schedule of visits, face to face or virtually as appropriate, listening and discussing health needs on each visit
- Identify vulnerable households or individuals in conjunction with health care teams
- Identify health and/or social care needs in conjunction with health care teams
- Signpost to appropriate local services and resources
- Provide up to date messaging on COVID-19 immunisation, testing and social distancing measures following appropriate training
- Act as an advocate to help households navigate the health and social care systems, access appropriate services and remove blocks to accessing services and resources.
- Give healthy lifestyle advice including advice on immunisation and screening following appropriate training
- Deliver key messages on public health following appropriate training
- Collect, collate and share information about each visit with relevant partners in compliance with legislation using Trust digital systems
- Manage their time to ensure that visits are completed
- Work closely with volunteers who will support the Community Health Worker role once fully identified

It is planned that the Community Health Workers will make a positive contribution in a number of areas including:

- Provision of effective and accurate Covid 19 information
- Improve screening and immunisation rates
- Improve links between communities and voluntary sector organisations
- Improve early detection of severe mental and physical illness
- Support the management of long-term conditions

2022/23 – Our Plans for Service Equality

To follow are some of the planned actions for 2022 – 23 in relation to services and communities:

- Ratification of a standard operating procedure for identifying, recording, and meeting reasonable adjustment needs for patients with disabilities (Cheshire and Merseyside partnership project).
- Improvement of service and workforce offers for military veterans, reservists, regulars and their families (Cheshire and Merseyside partnership project).
- New language interpretation and translation contract based on locally produced and agreed Quality Standard (Cheshire and Merseyside partnership project).
- Learning Disability Improvement Standard working group and action plans.
- Patient and community engagement strategy and action plan through Trust working group.
- Review of communications accessibility and refreshment of Trust writing guidance.
- Ratification of gender reassignment patient support policy (Cheshire and Merseyside partnership project).
- Deliver of d/Deaf Action Plan (Cheshire and Merseyside partnership project).

Contact Details

If you have any questions or would like to receive this report in another language or format please contact:

Ruth Besford (Equality & Inclusion Manager)

ruth.besford@nhs.net

Appendix 1: Workforce Data and Governors Information

You can see below a basic breakdown of staff by protected characteristic group. ***N.B: * means figure below 10.***

Staff Equality Demographics By Clinical and Non-Clinical Staff Groups			
		Clinical Staff	**Non- Clinical Staff**
Age	Under 21	*	*
	21 – 30	154	40
	31 – 40	352	60
	41 – 50	389	111
	51 – 60	369	161
	61 – 70	91	58
	Over 70	*	10
Disability	No	1,013	332
	Yes	41	15
	Not Stated	306	97
Pregnancy and Maternity	Maternity and adoption (pregnancy not recorded on staff record except for sickness absence purposes)	40	*
Race/Ethnicity	Asian, Asian British (inc Indian, Pakistani , Bangladeshi, Sri Lankan, and other)	51	9
	Black British, Black African and Caribbean	12	*
	Chinese	*	0
	Mixed ethnicity	15	7
	Other Ethnicity	*	0
	White, (inc White British, Irish, European, and Other)	1,227	405
	Not Stated	50	20
We recognise that the figures above do not reflect the diversity of our multi-racial workforce. However figures for minority ethnic staff are too low to report when disaggregated into detailed individual identities, so we have aggregated them to provide reportable figures			
Religion/Belief	Christianity	711	227
	Islam, Buddhism, Hinduism, Sikhism	43	6
	No Religion	114	27
	Other	84	25
	Not Stated/ Do Not Wish To Disclose	408	159
Gender Identity	Male	92	70
	Female	1,268	374
Our Electronic Staff Record records gender as identified by the member of staff, however we recognise that at this time for gender identity, and also sexual identity, there is limited capability to record the full spectrum of identities and this is being reviewed nationally			
Sexual identity	Heterosexual	990	325
	LGB+	13	*
	Not Stated/Do Not Wish To Disclose	357	111

An important part of our status as a Foundation Trust is the work our governors do. Our governors are the public's voice within Bridgewater, and they each bring with them a wealth of knowledge, skills, and experience of working in the public and private sectors. In 2022 we will be undertaking recruitment of both staff and public/partner governors as a result of some existing vacant posts and the end of eligible period for others. We are working to engage with diverse groups in both the workforce and the community to encourage applications from a diversity of backgrounds and lived experience.

One of the key responsibilities of our governors is to hold their Non-Executive colleagues to account and at the Council of Governors meetings they report on their level of assurance that this responsibility is being fulfilled.

Governors sit on interview panels for the Trust Chair, Executive, and Non-Executive posts as they are advertised.

They are also an important part of the overview of quality in our services; while there have been changes due to the Covid pandemic Governors have remained an important part of sessions such as Time To Shine, and question and answer sessions with clinical services.

In addition to the formal bi-monthly meetings, governors meet within the constituencies they serve to understand the operational issues that are impacting on services and users / patients. When possible Governors have utilised events that are organised by our partners that are specifically aimed at the public, these have been curtailed over the last two years but plans will be developed as we resume face to face events in our boroughs.

In 2021 our Quality and Place Strategy was updated following the publication of the NHS Long Term Plan and White Paper. Our governors played a key role in the development of the original strategy and supported a series of public facing roadshows where members of the Trust and the public at large were invited and encouraged to share their views about what's working well and where we might do better. They have in the past year been active in the development of the Trust's community and patient engagement plans and strategy.

Appendix 2: Patient Data (As At February 2022)

Patient profile as at February 2022, (from SystmOne and EMIS record systems)		
Age	Under 10	14.00%
	Under 20	9.19%
	20 34	15.19%
	35 49	15.65%
	50 64	19.81%
	65 69	6.04%
	70 79	11.77%
	80 89	6.73%
	90+	1.60%
Gender	Female	55.55%
	Male	44.43%
	Unknown/Not Stated	0.01%
Ethnicity	Asian (Bangladeshi, British, Indian, Pakistani, Other)	0.37%
	Black (African, British, Caribbean, Other)	2.30%
	Chinese	0.09%
	Mixed (Asian & British, Black African & British, Black Caribbean & British, British Mixed)	20.08%
	White (British, Irish, Other)	19.01%
	Other	0.25%
	Unknown/Not Stated	57.90%
Disability	Unknown/Not Stated	100.00%
Religion or Belief	Atheism	1.39%
	Christianity	13.61%
	Other faiths	>0.1%
	Unknown/Not Stated	84.19%
Sexual Orientation	Unknown/Not Stated	100.00%
	Bisexual, Gay. Lesbian	>0.10%
Armed Forces	No	21.5%
	Unknown/Not Stated	78.25%

Appendix 3 – Language Interpretation/Translation Usage January 2021 – January 2022

Language Interpretation and Translation

The provision of language and communication support for people whose first language isn't English, or for people with disabilities or impairments with communication support needs, is very important for effective and safe provision of care and equity of outcome.

As a Trust through the EDS2 Collaborative we have implemented the use of the Language Interpretation Quality Standard, this is being used as part of procurement for a new language interpretation contract in early 2022.

Table 7: Showing language interpretation spend and bookings numbers for January 2021 to January 2022

DA Languages	Cost	Bookings
Total	£66,492	2,209
Face to Face	£47.243	1,418
Telephone	£13,050	632
Video	£2,278	119
Translation	£3,921	40

Biggest users of Language services are our Dental services in Pennine, Greater Manchester, and Cheshire and Merseyside. This is followed by our Oldham 0 – 19s services. Video interpretation has seen a big increase this year, and this is an area where we are still testing effectiveness as feedback suggests that in some services and for certain types of appointment it is very effective, but in others it simply can't replace face to face interpretation support.

Most frequently requested languages

- Urdu
- Bengali
- British Sign Language
- Polish
- Arabic
- Romanian
- Kurdish/Kurdish Sorani
- Mandarin

We have been working closely with our language interpretation provider throughout 2021 as we have worked through difficulties sourcing particularly face to face interpretation in some languages, especially Kurdish Sorani, Polish and Romanian. We believe there are several factors at play in relation to this shortage, Brexit and new rules in the Immigration Act, the Covid 19 pandemic and easing of restrictions on travel, and concerns in relation to face to face contact from the interpreters themselves. We have tried to ensure this hasn't impacted too greatly on patients during this time, and fill rate or bookings remains above 90% every month.

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Bridgewater Community Healthcare NHS FT

Organisation's Board lead for EDS2:

Paula Woods (Director of People & Organisational Development)

Organisation's EDS2 lead (name/email):

Ruth Besford (EDI Manager) ruth.besford@nhs.net

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Internal govenance
Staff networks

Organisation's Equality Objectives (including duration period):

One equality objective:
To actively promoted equality, diversity, and inclusion by creating the conditions that enable compassion and inclusivity to thrive.

This is underpinned by two action plans, one for workforce, one for services and communities. Both can be viewed at https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/
These action plans are reviewed annually following year end, and updated

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

Healthcare Support Worker Programme - winner of Nursing Times award in 2021 for innovative recruitment. Learning from the recruitment programme is being used to refresh recruitment and induction policy and process, as diversity of applicants and appointees was greatly increased, and feedback has been very positive from new starters in the programme.
Integration of services with the local hospital Trust, local authority, and third sector in Warrington and Halton through the pandemic has supported many patients to remain in their homes, and others to be rapidly and safely discharged to either their home or to an intermediate care setting.

Publication Gateway Reference Number: 03247

Date of EDS2 grading March 2022 **Date of next EDS2 grading** March 2023

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Quality Panel; Quality Impact Assessment policy and process; Equality Impact Assessment policy and process; LD Working Group; Bridgewater engagement groups; Warrington and Halton CQPG reports; Community Health Worker pilot project	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Prioritisation of services during the pandemic. Management of referrals and waiting lists to ensure those in urgent and priority need are seen. Ongoing support and communication with service users on waiting lists. Integration with health and social care partners. Support to local hospital Trusts.	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Policy	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Service user complaints, comments, and feedback. Incident reporting, including serious incidents,via the Quality and Safety Committee, and Bridgewater Engagement Group (where appropriate). Learning from deaths - reporting, review, and partnership working at place. Policy - Equal Opportunities, Dignity & Respect at Work, Violence	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Regular 0 - 19s imms and vaccs programme resumed and on target. Covid 19 vaccine messages issued via social media. Trust not part of national adults vaccination programme, but part of school vaccs programme, with staff support to deliver safely and effectively in short turn around time mandated. Guidance on religious and cultural appropriateness of Covid	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation Evidence drawn upon for rating: Quality Panel Quality Impact Assessment policy and process Equality Impact Assessment policy and process LD Working Group Bridgewater engagement groups Warrington and Halton CQPG reports Community Health Worker pilot project	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Language interpretation service. Policy and process, including MCA, safeguarding, consent and others. eLearning and other statutory training.	✓
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Talk to Us forms. Complaints and compliments including any formal escalation such as MP intervention.	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Policy and process, including timescales. All managed by Patient Experience team who report to Chief Nurse. Regular reporting of complaints to Quality & Safety Committee, and Bridgewater Engagement Group. Informal complaints managed and recorded at service level. All complaints included on business continuity plan/quality impact assessment for review as part of Quality Panel assessment.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** WRES; WDES; Gender Pay Gap; Disability Confident; Six High Impact Areas for Equality Action Plan; Race Disparity Ratio Action Plan; Disability Confident Action Plan	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** WRES; WDES; Disability Confident; Gender Pay Gap; Annual Equality Report; Agenda for Change and associated policy and procedure, inc panels supported by staffside colleagues	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** WRES; Disability Confident; Gender Pay Gap; Annual Equality Report; Six High Impact Areas for Equality Action Plan As for 3.1 we struggle with data in self-reported fields measuring	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** WRES WDES NHS Staff Survey 2021 Just and Learning Culture Civility & Respect - bringing together BABAH, zero tolerance, violence and aggression prevention, into one work stream looking at values, culture, and behaviours	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** NHS Staff Survey 2020 – awaiting publication of 2021 results for updated review by protected group Flexible Working Policy As per legislation, flexible working is available to all staff from start of service, this depends on needs of service but the workforce team is supporting services in workforce planning, including better understanding of flexible working and its benefits	✓
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ☐ Disability; ☐ Gender reassignment; ✓ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** In 2020 results across the NHS Staff Survey mostly improved, suggesting a more positive experience for staff, however those results are 15 - 18 months old so are not appropriate for this assessment. We are waiting for updated 2021 results due to be published 30th March 2022.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade:** Undeveloped / Developing / **Achieving** / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Five staff networks all have active executive sponsorship - Race Inclusion Network (CEO, Chair, Lead Governor) and network chair is Medical Director; DAWN (DoF); LGBTQ+ (Chief Operating Officer and Trust Secretary); Menopause (Medical Director); Carers (Director of People and OD) Day to day responsibility rests with Director of People and OD. Active support of awareness events, both those led by EDI	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** **Grade:** Undeveloped / Developing / **Achieving** / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** EqIA standard on all committee papers, but not fully embedded as a true analysis and decision making tool. EDI Manager sits on People Committee and contributes to decision making on workforce issues, including highlighting any equality impact.	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade:** Undeveloped / Developing / **Achieving** / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Varies by service - discrimination more established than cultural competency evidencing.	✓

EDS2 2022

Outcome	Protected Groups	Grading 2022	Evidence
Key to grades: *1 – 2 protected groups fairing as well as everyone else = undeveloped* *3 – 5 protected groups fairing as well as everyone else = developing* *6 – 8 protected groups fairing as well as everyone else = achieving* *9 protected groups fairing as well as everyone else = excelling*			
Better Health Outcomes			
1.1 Service design and delivery	Age Disability Pregnancy/maternity Race Sex	Developing	• Quality Panel • Quality Impact Assessment policy and process • Equality Impact Assessment policy and process • LD Working Group • Bridgewater engagement groups • Warrington and Halton CQPG reports • Community Health Worker pilot project
1.2 Meeting individual needs	Age Disability Pregnancy/maternity Race Sex	Developing	• Prioritisation of services during the pandemic. • Management of referrals and waiting lists to ensure those in urgent and priority need are seen. • Ongoing support and communication with service users on waiting lists. • Integration with health and social care partners. • Support to local hospital Trusts. • Signposting to other support. • Quality panel for business continuity plans and service changes, all risk assessed, including equality through risk review and attendance of EDI manager. • LD Working Group and action plan.

			• LD Healthcare Passport in Halton. • Language interpretation support. • Diverse volunteer programme in Oldham supporting service users. • Service user feedback, including talk to us, and patient complaints and compliments. • Mapping of local community, and local health inequalities - not yet complete.
1.3 Transitions between services	Age Disability Race Sex	Developing	• Policy
1.4 Patient safety	Age Disability Pregnancy/maternity Race Sex	Developing	• Service user complaints, comments, and feedback. • Incident reporting, including serious incidents,via the Quality and Safety Committee, and Bridgewater Engagement Group (where appropriate). • Learning from deaths - reporting, review, and partnership working at place. • Policy - Equal Opportunities, Dignity & Respect at Work, Violence and Aggression, and others. • Policy for key areas, e.g.. safeguarding, including domestic violence, FGM, honour based violence etc.; end of life care, including guidance re religious and cultural belief; ongoing review of all policies for inclusivity, particularly in relation to LGBTQ+ • Standard Operating Procedures for all clinical processes. • Strict Covid 19 measures across the Trust in clinical and corporate areas. • Mandatory eLearning and other statutory training. • Rainbow Badges (for LGBTQ+ service users

1.5 Screening, vaccination, and other health promotion services for all	Age Disability Pregnancy/maternity Race Religion/belief Sex	Achieving	• Regular 0 - 19s imms and vaccs programme resumed and on target. • Covid 19 vaccine messages issued via social media. Trust not part of national adults vaccination programme, but part of school vaccs programme, with staff support to deliver safely and effectively in short turn around time mandated. • Guidance on religious and cultural appropriateness of Covid vaccine available for all staff. • Non-Executive Director supported Covid vaccine uptake in local Muslim community through social media messages. • Community Matron in Halton leads District Nursing team on effective support for service users with LD, including support to attend screening and other services, and creation of resources to aid understanding and access. • Oldham 0 - 19s service undertake regular health promotion campaigns. • Dental services lead on oral health promotion and have worked to achieve Pride in Practice in Greater Manchester. • We know there is more work to do regarding public health and health promotion, we successfully bid for funding to deliver a community health worker pilot scheme in Halton, this is at the early stages but will engage with local families in identified areas to support healthy living choices, and access to appropriate screening.

Improved Patient Access and Experience			
2.1 Accessible services	Age Disability Race Sex	Developing	• Quality Panel • Quality Impact Assessment policy and process • Equality Impact Assessment policy and process • LD Working Group • Bridgewater engagement groups • Warrington and Halton CQPG reports • Community Health Worker pilot project
2.2 Information and support for decision making	Age Disability Pregnancy/maternity Race Sex	Developing	• Language interpretation service. • Policy and process, including MCA, safeguarding, consent and others. • eLearning and other statutory training.
2.3 People report positive experiences of the NHS	Age Disability Pregnancy/maternity Race Sex	Developing	• Talk to Us forms • Complaints and compliments including any formal escalation such as MP intervention.
2.4 People's complaints about services are handled respectfully	Age Disability Pregnancy/maternity Race Religion/belief Sex Sexual orientation	Achieving	• Experience team who report to Chief Nurse. • Regular reporting of complaints to Quality & Safety Committee, and Bridgewater Engagement Group. • Informal complaints managed and recorded at service level. • All complaints included on business continuity plan/quality impact assessment for review as part of Quality Panel assessment.
A Representative and Supported Workforce			
3.1 Recruitment and selection for a representative workforce at all levels	Age Disability Marriage/civil partnership Pregnancy/maternity Sex	Developing	• WRES • WDES • Gender Pay Gap • Disability Confident • Six High Impact Areas for Equality Action Plan

			• Race Disparity Ratio Action Plan • Disability Confident Action Plan We struggle to evidence, via data, for LGBTQ+ staff, staff from minority ethnic backgrounds, and staff from other religions. We have a lot of actions focusing in these areas that we are implementing.
3.2 Equal pay	Age Disability Marriage/civil partnership Pregnancy/maternity Race Sex	Achieving	• WRES • WDES • Disability Confident • Gender Pay Gap • Annual Equality Report • Agenda for Change and associated policy and procedure, inc panels supported by staffside colleagues • Recruitment and Retention POD and task and finish groups
3.3 Training and development	Age Marriage/civil partnership Pregnancy/maternity Sex	Developing	• WRES • Disability Confident • Gender Pay Gap • Annual Equality Report • Six High Impact Areas for Equality Action Plan As for 3.1 we struggle with data in self-reported fields measuring against take up of training and career development opportunities
3.4 Abuse, harassment, bullying and violence	Age Marriage/civil partnership Pregnancy/maternity Race Sex	Developing	• WRES • WDES • NHS Staff Survey 2021 • Just and Learning Culture • Civility & Respect - bringing together BABAH, zero tolerance, violence and aggression prevention, into one work stream looking at values, culture, and behaviours
3.5 Flexible working	Age Marriage/civil partnership Pregnancy/maternity Sex	Developing	• NHS Staff Survey 2020 – awaiting publication of 2021 results for updated review by protected group • Flexible Working Policy

			• As per legislation, flexible working is available to all staff from start of service, this depends on needs of service but the workforce team is supporting services in workforce planning, including better understanding of flexible working and its benefits
3.6 Staff report positive experiences of their membership of the workforce	Age Marriage/civil partnership Pregnancy/maternity Sex	Developing	• In 2020 results across the NHS Staff Survey mostly improved, suggesting a more positive experience for staff, however those results are 15 - 18 months old so are not appropriate for this assessment. We are waiting for updated 2021 results due to be published 30th March 2022.
Inclusive Leadership			
4.1 Equality commitment from Board and senior leaders	Age Disability Gender reassignment Pregnancy/maternity Race Religion/belief Sex Sexual orientation	Achieving	• Five staff networks all have active executive sponsorship - Race Inclusion Network (CEO, Chair, Lead Governor) and network chair is Medical Director; DAWN (DoF); LGBTQ+ (Chief Operating Officer and Trust Secretary); Menopause (Medical Director); Carers (Director of People and OD) • Day to day responsibility rests with Director of People and OD. • Active support of awareness events, both those led by EDI Manager and networks, and those run in services, for example Dental and Oldham 0 - 19s. • Director of Transformation and Integration leading on community engagement and in reach at ICS level. Medical Director leading on engagement in relation to health inequalities.
4.2 Equality impact assessment of Board and other decision-making papers	Age Disability Race Sex	Developing	• EqIA standard on all committee papers, but not fully embedded as a true analysis and decision making tool.

			• EDI Manager sits on People Committee and contributes to decision making on workforce issues, including highlighting any equality impact.
4.3 Middle managers and other line managers cultural competence	Age Disability Race Sex	Developing	• Varies by service - discrimination more established than cultural competency evidencing.

NHS

NHS NorthWest

Anti-Racism Framework

Published October 2021

INCLUSION CENTRE OF EXCELLENCE
inspiring change together

NHS North West
Black, Asian and Minority
Ethnic Assembly

Contents

Foreword from Evelyn Asante-Mensah OBE Chair NW BAME Assembly and Anthony Hassall NHS North West Regional Chief People Officer

We have made a commitment as a region to embrace the intentionally inclusive language and approach of becoming actively anti-racist organisations. We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities we still see across our society.

This document has been produced by the North West Black, Asian and Minority Ethnic Assembly, the Northern Care Alliance's Inclusion Centre of Excellence and NHS England and NHS Improvement North West. It provides a framework for all our regional NHS organisations to embrace both the spirit of those commitments but to also put into action quickly the steps needed to turn powerful words into the actions needed to reduce the inequalities we still see everyday across our workforce.

From higher rates of bullying & harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting all these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

As intentionally inclusive leaders it is vital that we look at each of the areas set our in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do but is seen as mission critical to all that we stand for and that messaging is backed up by senior colleagues across the region being clear that actions to tackle inequalities are a priority in all that we do.

In using the framework leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long term inclusion strategies you may have. While there is not a one size fits all solution to advancing equality within any one organisation we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

Why does an intentionally anti-racist approach matter?

- Racism is very real both in society and across our NHS organisations. Yet despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need, anchors the NHS is social egalitarianism and makes equal rights part of our core business.

- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. Its more important than ever that as public sector organisations we are contributing to ensuring racism has no place in our society and is addressed across the communities we serve.

- Racism and discrimination are major drivers behind the health inequalities we still see today. Its our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not contributing further to the problems we see.

Our Anti-Racism Journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you as both an individual and an organisation to consider honestly where you are on that path to become more anti-racist.

Anti-Racist Zones	Approaches to move through the zones
Fear	- Provide clear factual information that challenges and supports the overcoming of any fears.
Learning	- Consider more development building on any existing learning. - Steps and opportunities that increase confidence with existing learning
Growth	- Empower inclusive leaders through allyship programmes and activities

INCLUSION CENTRE OF EXCELLENCE
inspiring change together

Five Anti-Racist Principles

1. Prioritise Anti-Racism – What does this mean?

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However prioritising Anti-Racism work is more than simply caring about equality or stating support for inclusion its about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it is both time and resources. When equality activity is seen as an add on or a nice to do other mission critical work is seen as more important, time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and ensure leaders see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that by investing the time and resources needed to tackle the inequalities that exist across their workforce and in services in the long term is more effective and will support them in meeting their other long term goals.

A good check to see how much you are personally prioritising this work is to consider asking yourselves as leaders how much of your time have you actually spent on anti-racism work in the last month?

Prioritise Anti-Racism – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are p rioritising Anti-Racism across all that they do:

1. **Leading from the front**
   Leadership matters and while being a leader often involves the management of multiple priorities the amount of dedicated timewe give to an issue is a key indicator of how much we have prioritised that area of work.

2. **Dedicated EDI Resource**
   The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. EDI Professionals are experienced experts who can support leaders with this work. They must however be considered an important part of the organisations leadership for their activity to be impactful and transformational over the longer term.

3. **Mission Critical**
   Anti-Racism activity need to be at the heart of all work across an organisation, not simply a central equality action plan. Orga nisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

4. **Actions Not Words**
   Organisations that are committed to anti-racism do more than the minimum ask, their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.

Prioritise Anti-Racism – Making it happen

Key Drivers	Direct deliverables	Resources
1. Leading from the front	- Executive EDI Lead has a clear role description including annual PDP goals - Executive EDI Lead must Chair/Co-Chair an EDI committee at least quarterly	Change the Race Ratio - Guidance from KPMG Board Diversity – More Action Less Talk
2. Dedicated EDI Resource	- Dedicated EDI Lead in place and as a minimum must report into a direct report of an Executive Director. - Must be considered part of the wider senior leadership team to support and enable change.	Why companies need a chief diversity officer Competency Framework for Equality & Diversity Leadership CIPD Diversity Management that works
3. Mission Critical	- Evidence of how the organisation has acted to make anti-racism work mission critical must be published annually within the organisational annual report	Embed anti-racism in the NHS
4. Actions Not Words	- An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	CIPID – Go Beyond Legal Compliance Fact Sheet

2. Understand Lived Experience – What does this mean?

It is everyone's reasonability to tackle racism not just Black, Asian & Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and consider what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian & Minority Ethnic communities its important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have weathering effect on people's wellbeing and any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

2. Understand Lived Experience – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are understanding the lived experience of their workforce:

1. **Listen and Learn**
   Leadership matters and while being a leader often involves the management of multiple priorities the amount of dedicated timewe give to an issue is a key indicator of how much we have prioritised that area of work.

2. **Empowering Your Talent**
   As well as hearing the lived experiences of staff it's important that the under utilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. Where can you diversify the decision makers in a space and how can you ensure the full talent potential of your diverse workforce is being used.

3. **Growing Cultural Competency**
   Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

4. **Data Plus**
   Organisations need to be intentional about understanding the experiences of Black, Asian & Minority Ethnic staff and serviceusers.

2. Understand Lived Experience – What does this look like?

Key Drivers	Direct deliverables	Resources
1. Listen and Learn	- An executive director must attend BAME staff Network Meeting at least four times a year	CIPD – Guide to establishing staff networks
2. Empowering Your Talent	- Set up a local BAME leadership council within your organisation - Ensure BAME talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles.	NHS England WRES Board Briefing - BAME Leadership Council Case Study
3. Growing Cultural Competency	- At least 50% of all Executive Directors and their direct reports have been part of a race equality reverse mentoring programme over the last 3 years.	Leadership Academy Reciprocal Mentoring Programme
4. Data Plus	- A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually including the involvement of BAME staff network members to ensure more than just data is presented.	Building Narrative Power for Racial Justice and Health Equity Kings Fund lived experiences of ethnic minority staff in the NHS

3. Grow Inclusive Leaders – What does this mean?

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities they see across their workforce and services.

Where an organisation has a mature inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and one where colleagues feel they belong and are included at work. On that journey growing an inclusive leadership culture it's vital that there is an approach and strategy for reducing inequalities not just at the top of the hierarchy but also a commitment to increase diversity and reduce inequalities across middle leadership too.

Too often the focus around developing Black, Asian & Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder, which reenforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted around going around the bias and prejudice that has led to ethnic minority colleagues not been given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a detitanation but a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make and to ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

3. Grow Inclusive Leaders – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are p rioritising Anti-Racism across all that they do:

1. **Visibility Matters**
   Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility helps build communities' trust in our institutions and also leads to better decision making overall.

2. **Where is Your Talent?**
   Understanding your talent trajectory in respect to Black, Asian & Minority Ethnic colleagues helps an organisation know wereactions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

3. **Levelling Up Middle Leadership & Inclusion**
   If we only focus development on our most senior leaders, commitment to change is often not followed through my those leaders tasked with implementing decisions across the organisation

4. **Real Opportunities**
   We have seen for a long time sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. But so often that development doesn't lead to an opportunity for promotion and centres the idea that Black, Asian & MinorityEthnic colleagues need to work harder and learn more in order to achieve the same as their white peers.

3. Grow Inclusive Leaders – What does this look like?

Key Drivers	Direct deliverables	Resources
1. Visibility Matters	- An organisations Board of Directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include 1 Black, Asian or Minority Ethnic member (which ever figure is higher).	NHS England a case for diverse boards NHS Confederation Taskforce on increasing Non-Executive Director Diversity in the NHS
2. Where is Your Talent?	- Must have set targets and a published talent trajectory for BAME representation across every level of the organisation.	CBI - develop a strong talent pipeline from entry level to executive roles CBI – Practical Guide Bridging the Gap
3. Levelling Up Middle Leadership & Inclusion	- All leaders at Band 8A and above must have a PDP goal agreed around equality, diversity & inclusion and a process to report annually the percentage of these goals that have been met.	Deloitte Six traits of inclusive leadership Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model
4. Real Opportunities	- An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian & Minority Ethnic colleagues the chance to gain experience to support with career progression.	Personnel Today – Black Jobs Matter

4. Act to Tackle Inequalities – What does this mean?

Let my actions speak for themselves is a famous saying but that represents the mantra by which an organisation truly committe d to anti-racism needs to run by. Words alone can often become a shield through which organisations are able to justify either consciously or unconsciously their inaction over time, whether they have followed through with meaningful actions or not to tackle an inequality.

Initiatives like the Workforce, Race Equality Standards, Model Employer plans and others are not a solution in themselves, bu t can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collective ly in partnership to tackle their main causes. Building a critical mass of activity built around neighbourhoods, localities and our region as a whole is key to seeing the numerous health inequalities and social injustices that harm so many being relegated to history instead of being a painfu l reality of today many are forced to live with.

The amount of action needed to tackle inequalities is large it reflects the generations of institutional racism and injustice developed over decades in this country. But when viewed as mission critical and delivered through embedded priorities across all areas of an organisations structure the task is not insurmountable and the outcomes will be transformation for our communities as a whole.

4. Act to Tackle Inequalities – What does this look like?

We have highlighted four key drivers that organisations should consider taking more action around to ensure they are tackling inequalities:

1. **More Than a Tick Box**
   While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this doesn't have to be the case. Tools like the Workforce Race Equality Standards and others can be used to prioritise, leverage and monitor real change. Anti-Racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.
2. **Zero Tolerance Matters**
   Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone including colleagues and service users. It's vital that organisations consider how they are handling these types of incidents and are constantly learning to do more to tackle racist abuse.
3. **We Do This Together**
   Many inequalities are too big to tackle on your own as a single organisation. It's vital organisations work in partnership to tackle racial inequalities we see across our communities. When looking at Health inequalities NHS organisations should be working with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.
4. **Fair and Just**
   The processes which exist across an organisation that look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case the outcomes experienced by colleagues lead to mistrust and a clear weathering affect on the wellbeing of Black. Asian & Minority Ethnic Staff.

4. Act to Tackle Inequalities – What does this look like?

Key Drivers	Direct deliverables	Resources
1. More than a tick box	- The organisation must be able to demonstrate two years of consecutive improvements against at least five Workforce Race Equality Standard Measures.	NHS England WRES Team Best Practice Case Studies
2. Zero Tolerance Matters	- The organisation must of communicated clearly that it takes a zero tolerance approach to racist abuse from service users or staff members. - A sample audit must be carried out of reported racist incidents annually with key learning identified on how the organisation can better response to racist incidents.	BME Charter for medical schools to prevent and address racial harassment BBC News Hospital CEO on zero tolerance
3. We do this together	- The organisation can demonstrate progress over the last 12 months of reducing an an identified health inequality. - The organisation can demonstrate working in partnership to reduce a specific health inequality.	Kings Fund – Addressing Race inequalities needs engagement NHS England Health Inequalities Hub
4. Fair and Just	- The organisation can evidence diverse representation within their disciplinary and grievance processes.	NHS England WRES Best Practice Case Studies

5. Review Progress Regularly – What does this mean?

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach. However when it comes to anti-racism and wider equality, diversity and inclusion activity this has often lacked the same rigour in monitoring performance as other areas of our organisations.

Research from the USA (Why Diversity Programmes Fail Prof. Frank Dobbin and Prof. Alexandra Kalev Harvard Business Review July-August 2016) has shown us that one of the most important aspect to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it's vital that the same consideration is taken when reviewing an organisations overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by more than simply the people that have led or commissioned any activity and that there is intentional consideration to the diversity of those involved in reviewing and monitoring progress.

As an NHS we are the biggest employer in the country but yet as we are split up into 100s of separate organisations we often look inward for ideas and feedback around change. As a North West region through the work of the BAME Assembly we have an opportunity to collaborate and ensure reviewing organisational progress is a task we support each other with, with ideas, success and failure shared in equal measure to support our anti-racism journey.

5. Review Progress Regularly – What does this look like?

We have highlighted four key drivers that organisations should consider reviewing and taking more action to ensure they are p rioritising Anti-Racism across all that they do:

1. **How are we performing?**
   It's vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should have an understanding of how their area is doing in relation to key targets.

2. **What's our approach?**
   Becoming and anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a pro longed period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

3. **Our Voices Matter**
   The voices of Black, Asian & Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure that actions that have been meaningful and had an impact are prioritised and where progress hasn't been made this isn't hidden by positive activity and behind the detail of a report.

4. **Open and Transparent**
   To have credibility around a statement that an organisation is anti-racist its vital the label is not just coming from the organisation themselves but that the statement is supported by the community it serves.

5. Review Progress Regularly – What does this look like?

Key Drivers	Direct deliverables	Resources
1. How are we performing	- An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub group of the board and include performance against the race disparity ratio, WRES and other race specific targets. - Organisation should record and publish their ethnicity pay gap annually	Health Education England Diversity Performance Dashboard Civil Service Diversity & Inclusion Dashboard
2. What's our approach	- Organisation should review progress against each of the key drivers and direct deliverables within the NHS North West Anti-Racism Framework at least annually.	NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group
3. Our Voices Matter	- The organisation should bring together annually Black, Asian & Minority ethnic staff to review EDI progress and any learning be built into the following years plans.	HPMA Newsletter - The Value of Lived Experience
4. Open and Transparent	- The organisation should submit an application to the BAME Assembly to receive feedback against their Anti-Racism framework at least every two years.	PWC – Diversity and the Case for Transparency

The BAME Assembly Anti-Racist Accreditation

The North West BAME Assembly's mission is to support NHS organisations from across the region to become Anti-Racist and to be at the forefront of challenging racism and tackling inequalities by people in our communities and our workforce.

To achieve this mission the assembly recognises that there will need to be intentional and sustained actions by all NHS organisations to turn the commitment to become an anti-racist organisation into a reality. So often in the past many communities have felt that pledges and commitments to equality haven't been followed through and the assembly feel it has a role to ensure that when we use the phrase "anti-racist" organisation here in the North West our communities and workforce can have confidence in what that means.

Recognising the number of assurance and compliance mechanisms that already exist, the BAME Assembly Anti-Racist Organisation Accreditation has been developed to be both clear on what's needed to implement and simple to apply when an organisation is ready to receive their assessment. Following the completion of a short application form that asks for examples of evidence across each of the five principles of our anti-racism framework. A panel of assessors brought together by the BAME assembly will judge whether an organisation has delivered against the minimum direct deliverables for each domain.

The make up of the assessment panel:

- Four BAME Assembly Members
- One NHS Provider or ICS EDI Lead
- Two BAME Staff Network Chairs
- Head of Equality from NHS England Northwest

Process for The BAME Assembly Accreditation

Self Assessment

- ❑ Review organisation against each of the dirt deliverables under the five principles of the anti-racism framework. If happy all have been completed move to application stage.

Application

- ❑ Complete application form downloaded from the BAME Assembly internet page. Each of the direct deliverables will require written evidence how they have been delivered by your organisation.

Assessment Panel

- ❑ The assessment panel will meet twice a year to review applications from organisations wanting to receive the BAME Assembly Anti-Racism Accreditation.

Publish & Review

- ❑ Organisations that are successful in receiving will have their name published on the BAME Assembly internet page, case studies shared via NHS England events and be able to use an Anti-Racism graphic on their website and email signatures.

Additional Anti-Racism Resources

National Education Union Anti Racism Framework – Click Here
NHS Leadership Academy Allyship Toolkit – Click Here
NHS Leadership Academy Resources on Racism – Click Here
NHS Employers Resources to Tackle Racism – Click Here
NHS England WRES 2020 Data Analysis Report – Click Here
NHS England Patient Carer Race Equality Framework – Click Here
NHS Race and Health Observatory – Click Here
NHS Confederation BME Leadership Network – Click Here

Produced by the Northern Care Alliance

Equality@nca.nhs.uk

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date 7 April 2022

Board Part Public

Agenda item 25/22i

Title	Russian / Belarussian Interests
Sponsoring Director	Colin Scales, Chief Executive
Authors	Jan McCartney, Trust Secretary
Presented by	Jan McCartney, Trust Secretary
Exec Summary/Purpose	To update the Board on the Trust's position in relation to Russian / Belarussian interests
Previously considered at	N/A
Related Trust Objective/ Intentions ***Delete as applicable***	**Quality** – to deliver high quality, safe and effective care which meets both individual and community needs **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability. **People** – to be a highly effective organisation with empowered, highly skilled and competent staff **Equality, Diversity and Inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
Which CQC domains are supported by this report?	***Responsive*** ***Well-led***

Which BAF risks are addressed in this report?	**BAF 1** - Failure to implement and maintain sound systems of Corporate Governance
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	N/A
Equality Impact assessment	N/A
Explanation of any acronyms in the report	N/A
Next steps	N/A
Recommendations	**The Board is asked to note the report.**

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board

Title	Russian / Belarussian Interests
Author	Jan McCartney – Trust Secretary
Date	7 April 2022
Purpose	To update the Board on the Trust's position in relation to Russian / Belarussian interests
Audience	Board

1.0 BACKGROUND

1.1 In light of the conflict in the Ukraine and the UK Government sanctions imposed on Russia and Belarus the Secretary of State for Health instructed Trusts to 'undertake an urgent review of your supply chains and identify contractual relationships you have with Russian and Belarussian suppliers.

1.2 The Trust also was advised, via the Company Secretary network, to review under Fit and Proper Persons whether any Director had any relevant interest or investment to declare.

2.0 CONTRACTS

2.1 The Deputy Director of Estates and the Head of Procurement has undertaken a review to identify any Russian / Belarussian contracts. They identified 3 freehold sites which is supplied with gas from the Russian company Gazprom. This information was submitted to the emergency planning department at NHSE/I.

2.2 The Trust has worked with the Crown Commercial Services to end the contract and identify an alternative supplier. This new contract will commence on 1 May 2022.

3.0 FIT AND PROPER PERSONS TEST

3.1 Whilst the Board of Directors had recently reviewed and resubmitted their annual declarations of interest, a separate additional request was made of them to confirm if they had any Russian interests or investments.

3.2 The whole Board of Directors confirmed that they had no interests or investments to declare.

4.0 RECOMMENDATIONS

4.1 The Board is asked to note the report.

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date 7 April 2022

Board Part Public

Agenda item 25/22ii

Title	Review of Board of Directors Terms of Reference
Sponsoring Director	Colin Scales, Chief Executive
Authors	Jan McCartney, Trust Secretary
Presented by	Jan McCartney, Trust Secretary
Exec Summary/Purpose	To approve the updated Terms of Reference
Previously considered at	N/A
Related Trust Objective/ Intentions	**Quality** – to deliver high quality, safe and effective care which meets both individual and community needs **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability. **People** – to be a highly effective organisation with empowered, highly skilled and competent staff **Equality, Diversity and Inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive.
Which CQC domains are supported by this report?	***Responsive*** ***Well-led***

Which BAF risks are addressed in this report?	**BAF 1** - Failure to implement and maintain sound systems of Corporate Governance
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	N/A
Equality Impact assessment	N/A
Explanation of any acronyms in the report	ToR – Terms of Reference
Next steps	N/A
Recommendations	**The Board is asked to approve the Terms of Reference**

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board

Title	Review of Board of Directors Terms of Reference
Author	Jan McCartney – Trust Secretary
Date	7 April 2022
Purpose	To review and update the Board of Directors Terms of Reference
Audience	Board

1.0 BACKGROUND

1.1 The terms of reference (ToR)for Board and its committees should be reviewed annually to ensure they remain fit for purpose. The last time these were reviewed was October 2020 so are overdue a review.

2.0 PROPOSED CHANGES

2.1 The proposed updates are minor and set out as below, these are also highlighted as tracked changes in the attached draft document.

Summary of changes	
Section 3	Update to basis of authority to include the legal basis of the Board
Section 4	Membership now specified in detail
Section 6	Frequency of members specified
Section 9	Chairman removed and replaced with 'Chair'

3.0 RECOMMENDATIONS

3.1 The Board is asked to approve the proposed changes.

Appendix A – Draft Board Terms of Reference

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

1 NAME

The Board of Directors

2 PURPOSE

The Trust exists to "provide goods and services for any purposes related to services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and the promotion and protection of public health."

The Trust has a Board of Directors which exercises all the powers of the Trust on its behalf, but the Board may delegate any of those powers to a Committee or to an Executive Director. The Board consists of Executive Directors, one of whom is the Chief Executive, and Non-Executive Directors, one of whom is the Chair.

The Board leads the Trust by undertaking three key roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the organisation.

The general duty of the Board and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the public it serves and for its staff.

3 BASIS OF AUTHORITY

These terms of reference describe the role and working of the Board and are for the guidance of the Board, for the information of the Trust as a whole and serve as the basis for the terms of reference for the Board's own Committees.

The Trust is required to establish a Board of Directors in accordance with the requirements of the NHS Act 2003 (as amended by the Health and Social Care Act 2012) and the Trust's constitution. All members of the Board shall act collectively as a unitary Board with each member having equal liability.

4 MEMBERSHIP

All Executive and Non-Executive Directors of the Trust are members of the Board of Directors.

Directors entitled to vote are Executive and Non-Executive Directors only. All questions put to the vote shall, at the discretion of the Chair, be decided by a show of hands. A paper ballot may be used if a majority of the Board of Directors present and entitled to vote so request. In the event of a tied vote, the Chair can exercise a casting vote. In the event of a vote Non-Executive votes must always outnumber Executive votes.

Board membership shall be as follows

- An independent Non-executive Chair
- Six other independent Non-executive Directors (including the Vice Chair and Senior Independent Chair)

Up to six Executive Directors, currently comprising:

- Chief Executive Officer (also the Accounting Officer)
- Deputy Chief Executive Officer / Chief Nurse
- Director of Finance
- Chief Operating Officer
- Medical Director
- Director of People & Organisational Development

Role of the Chair

The Chair is responsible for leading the Board and for ensuring that it successfully discharges its overall responsibilities for the Trust as a whole.

The Chair is the guardian of the Board's decision-making processes and provides general leadership of the Board.

Role of the Chief Executive

The Chief Executive (CEO) reports to the Chair and to the Board directly. All members of the management structure report either directly or indirectly, to the CEO.

The CEO is the Trust's Accountable Officer and is responsible to the Board for running the Trust's business and for proposing and developing the Trust's strategy and overall objectives for approval by the Board.

The CEO is responsible for implementing the decisions of the Board and its Committees, providing information and support to the Board.

Attendance

The Trust Secretary will be a regular attender at the Board but does not have voting rights.

The Board shall be supported administratively by the Trust Secretary whose duties in this respect will include:

- Agreement of agenda for Board and Board Committee meetings with the Chair and CEO.
- Collation of reports and papers for Board meetings
- Ensuring that suitable minutes are taken, keeping a record of matters arising and issues to be carried forward
- Advising the Board on governance matters.

5 CONNECTIVITY

Committees reporting to the Board:

- Audit Committee
- Nominations and Remuneration Committee
- Quality and Safety Committee
- Finance and Performance Committee
- People and Organisational Development Committee
- Any other ad-hoc Committee established by the Board

6 FREQUENCY OF MEETINGS

Ordinary meetings of the Board of Directors shall be held at regular intervals, at such times and in such places as the Board may determine from time to time.
Meetings will normally be bi-monthly however the Board may agree to vary the frequency

These meetings will be structured in two parts with Part I being open to members of staff, the public and the media to attend and with Part II being held in private.

In addition the Board of Directors will hold an Annual General Meeting to which members of staff, the public and the media will be invited to attend. This will be in combination with the Council of Governors' Annual Members Meeting.

7 DUTIES AND RESPONSIBILITIES

7.1 General Responsibilities

The general responsibilities of the Board are:

- To work in partnership with service users, carers, local health organisations, local government authorities and others to provide safe, accessible, effective and well governed services for the population it serves

- To ensure that the Trust meets its obligations to its patients, stakeholders and its staff in a way that is wholly consistent with values and probity and with established Codes of Conduct.

- To exercise collective responsibility for adding value to the Trust by promoting its success through direction and supervision of its affairs in a cost effective manner.

7.2 Leadership

The Board provides active leadership to the organisation by:

- Ensuring there is a clear vision and strategy for the Trust that people know about and that is being implemented, within a framework of prudent and effective controls which enable risk to be assessed and managed.

- Ensuring the Trust is an excellent employer by the development of a people strategy and its appropriate implementation and operation.

7.3 Strategy

The Board:

- Sets and maintains the Trust's strategic vision, aims and objectives ensuring the necessary financial, physical and human resources are in place for it to meet its objectives.

- Monitors and reviews management performance to ensure the Trust's objectives are met.

- Oversees both the delivery of planned services and the achievement of objectives, monitoring performance to ensure corrective action is taken when required.

- Develops and maintains an annual business plan and ensures its delivery as a means of taking forward the strategy of the Trust to meet the expectations and requirements of stakeholders.

- Ensure that national policies and strategies are effectively addressed and implemented within the Trust.

7.4 Culture

The Board is responsible for setting values, ensuring they are widely communicated and that the behaviour of the Board is entirely consistent with those values.

7.5 Governance

The Board:

- Ensures that the Trust has comprehensive governance arrangements in place that guarantee that the resources vested in the Trust are appropriately managed and deployed, that key risks are identified and effectively managed and that the Trust fulfils its accountability requirements.

- Ensures that the Trust complies with its governance and assurance obligations in the delivery of clinically effective, personal and safe services taking account of patient and carer experiences.

- Ensures compliance with the principles of corporate governance and with appropriate codes of conduct, accountability and openness applicable to NHS Foundation Trusts.

- Formulates, implements and reviews standing orders and standing financial instructions as a means of regulating the conduct and transactions of Trust business.

- Ensures that the statutory duties of the Trust are effectively discharged.

7.6 Risk Management

The Board:

- Ensures an effective system of integrated governance, risk management and internal control across the whole of the Trust's clinical and corporate activities.

- Ensures that there are sound processes and mechanisms in place to ensure effective user and carer involvement with regard to development of care plans and pathways, the review of quality of services provided and the development of new services.

- Ensures there are appropriately constituted appointment arrangements for senior positions.

7.7 Communication

The Board:

- Ensures an effective communication channel exists between the Trust, the Council of Governors, members, staff and the local community.

- Ensures the effective dissemination of information on service strategies and plans and also provides a mechanism for feedback.

- Ensures that those Board proceedings and outcomes that are not confidential are communicated publically, primarily via the Trust's website.

- Publishes an annual report and annual accounts.

7.8 Financial and Quality Success

The Board:

- Ensures that the Trust delivers high quality safe and effective care.
- Ensures that the Trust operates effectively, efficiently, economically.
- Ensures that the Trust strives to achieve the targets and requirements of stakeholders within the available resources.
-

- Reviews performance, identifying opportunities for improvement and ensuring those opportunities are taken.

8 Outputs

An agenda and any supporting papers shall be sent to each Director in electronic form so as to arrive with each Director normally no later than five days in advance of each meeting. Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item.

9 QUORUM

The quorum for a meeting will be six Directors including not less than three Executive Directors (one of whom must be the Chief Executive or the Deputy Chief Executive), and not less than three Non-Executive Directors (one of whom must be the Chair~~man~~ or the Vice Chair~~man~~ of the Board).

10 OTHER MATTERS

E-Governance Process

In order to facilitate the Board undertaking the business required of it, there will on occasion be a need for this to be conducted outside of its scheduled meetings in circumstances where it would not be practical to hold a meeting on a face to face basis.

In such circumstances the Board is authorised by its Terms of Reference to conduct business via a process of "E-Governance". The rules to be observed when conducting business in this manner are as follows:-

- The business to be conducted must be set out in formal papers accompanied by the usual cover sheets which clearly set out the nature of the business to be conducted and the proposal which Members are being asked to consider.

- The papers will be forwarded by the Trust Secretary via e-mail to all Members of the Board who, subject to their availability, are expected to respond by e-mail to the same distribution list with their views within three working days of receipt of the papers.

- For the conclusion of the Board to be valid, responses must be received from a quorate Board membership and in instances where the approval of the Board is sought, all such responses should support the proposal.

- In the event that there is not a unanimous agreement of all responding Members, the proposal shall be considered not to be approved.

- The Trust Secretary will summarise the conclusions reached for the agreement of the Chair and this summary will be presented to the next scheduled meeting of the Board following which it will be appended to the minutes of that meeting and included in the Board Action Log as necessary.

Process for monitoring compliance with terms of reference	The Board shall self-assess its performance following each meeting and shall conduct an annual review of its effectiveness. These Terms of Reference will be reviewed by the Board at least annually.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Bridgewater Board Date	7 April 2022
Board Part	Public
Agenda item	25/22iii

Title	Annual Effectiveness Review – results from online survey
Sponsoring Director	Karen Bliss, Chair
Authors	Jan McCartney, Trust Secretary
Presented by	Jan McCartney, Trust Secretary
Exec Summary/Purpose	To provide a summary of the results of the recent Board effectiveness review.
Previously considered at	N/A
Related Trust Objective/ Intentions	• **Equality, Diversity and Inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive. • **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living • **People** – to be a highly effective organisation with empowered, highly skilled and competent staff • **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs • **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability.
Which CQC domains are supported by this report?	***Well-led***
Which BAF risks are addressed in this report?	**BAF 1** - Failure to implement and maintain sound systems of Corporate Governance
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	

Equality Impact assessment	N/A
Explanation of any acronyms in the report	N/A

Next steps	The results will inform / assure the Board of its effectiveness.
Recommendations	The Board is asked to note the results of the survey for assurance.

Bridgewater Community Healthcare NHS Foundation Trust

Board of Directors

Title	Annual Effectiveness Review – results from online survey
Author	Jan McCartney, Trust Secretary
Date	07 April 2022
Purpose	To report on results of the annual Board effectiveness questionnaire
Audience	Board of Directors

1.0 EXECUTIVE SUMMARY

1.1 As part of the annual review of Board and committee effectiveness, a statement questionnaire was distributed to 16 members or invited attendees who regularly attend the Board, via Survey Monkey for anonymous response in March 2022.

1.2 The purpose of this evaluation is to assess the effectiveness of the Board, the Chair and the work plan.

1.3 13 returns were received; 12 were Non-Executive or Executive members and 1 was an invited attendee.

1.4 This information provides a point in time review of the functions of the Board and can be used to inform the work plan and provide assurance to the Council of Governors of its effectiveness.

2.0 SUMMARY

2.1 Each of the 16 statements had the response options of Strongly Agree, Agree, Disagree and Strongly Disagree. Responders also had opportunity to make comments or observations.

2.2 The majority of responders either agreed or strongly agreed to the statements, demonstrating a high level of satisfaction with the effectiveness of the Board. In 6 instances, 1 or more responder disagreed with the statements.

2.3 The comments received recognised that agendas were complex and on occasion papers were too lengthy which impacted on timings. Whilst minutiae was avoided wherever possible, it was necessary for all members to develop their understanding.

2.4 The Board was commended for ensuring robust governance took place during the pandemic, including feedback from Board committees. The use of the BAF ensured key risks were focused on.

2.5 Members interacted well and in a balanced manner. The minutes of the meetings were commended for their excellent quality.

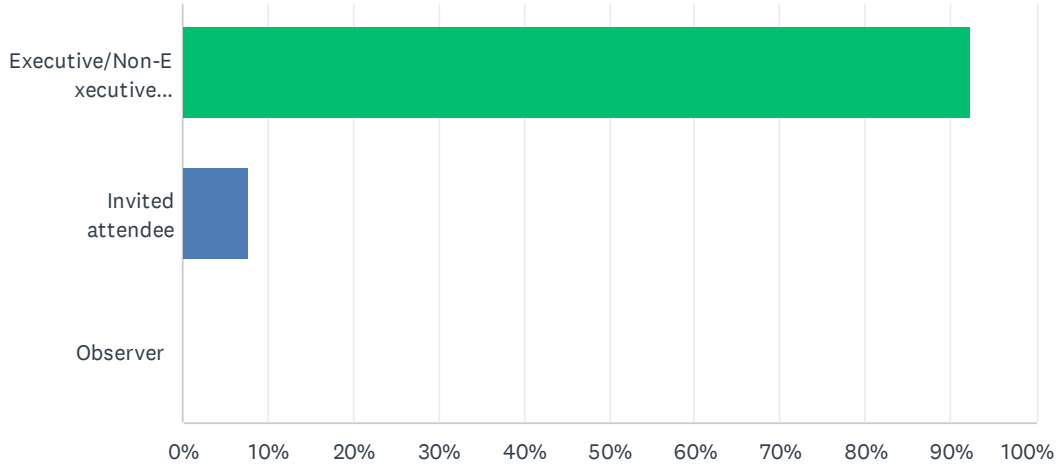
2.6 Overall, responders felt the Board was focused on its business, well chaired and well attended by colleagues with the appropriate mix of skill and experience.

3.0 RECOMMENDATIONS

3.1 The Board is asked to note the detailed results of the effectiveness questionnaire attached to this report.

Q1 Completed by:

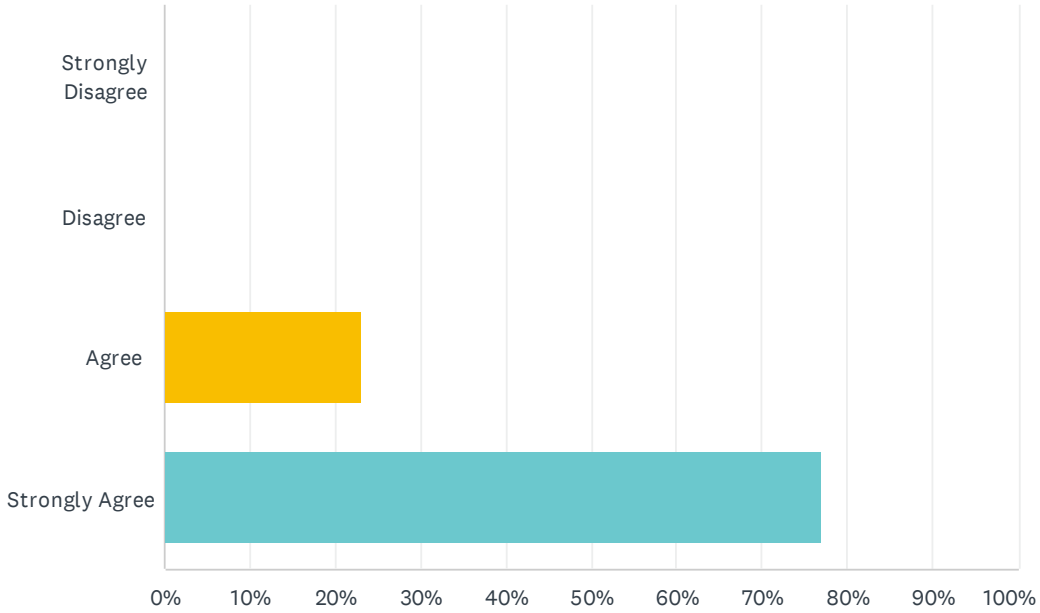
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Executive/Non-Executive Director member	92.31%	12
Invited attendee	7.69%	1
Observer	0.00%	0
TOTAL		13

Q2 There are clear terms of reference and clarity in the role vis a vis the trust as a whole:

Answered: 13 Skipped: 0

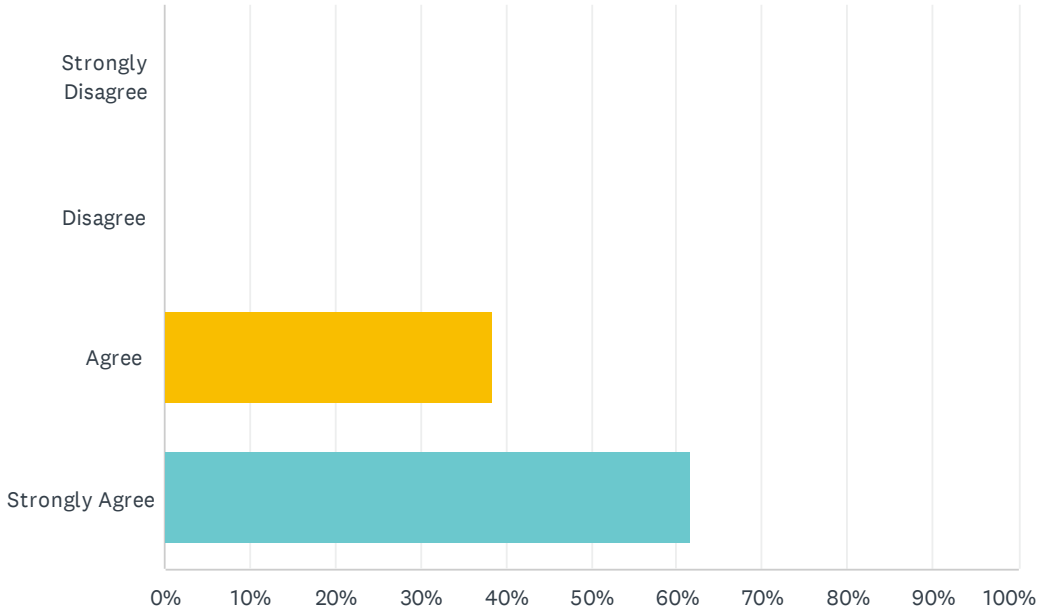


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	23.08%	3
Strongly Agree	76.92%	10
TOTAL		13

#	COMMENTS:	DATE
1	Use of BAF at the beginning of each Board Meeting ensures key risks and areas are covered	3/23/2022 10:47 AM
2	Karen is really focused, mindful of others opinions and is thoughtful in how she applies decisions and actions	3/10/2022 12:39 PM

Q3 The number and length of meetings is sufficient to allow the role to be discharged:

Answered: 13 Skipped: 0

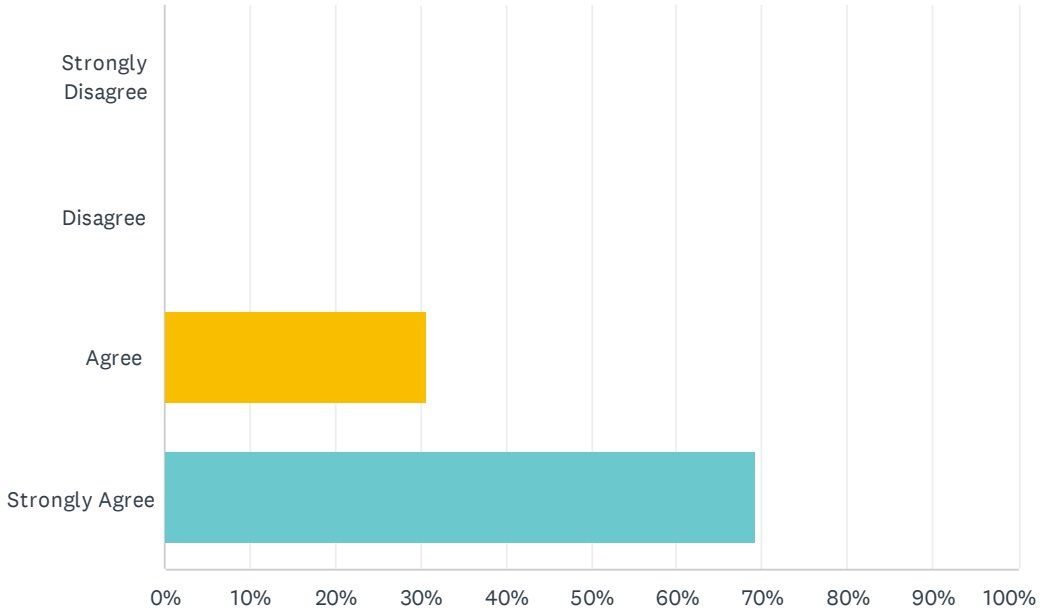


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	38.46%	5
Strongly Agree	61.54%	8
TOTAL		13

#	COMMENTS:	DATE
1	Just need to keep an eye on e governance items circulated in between boards.	3/23/2022 1:25 PM
2	Even through the pandemic, when agendas were streamlined, the Board ensured all business-critical issues were dealt with effectively	3/23/2022 10:47 AM
3	We have a range of meetings that vary in length and I think this is helpful and allows sufficient time for discussion and debate	3/14/2022 4:35 PM
4	Was challenging during the pandemic but the regular Board briefings were very useful	3/10/2022 1:50 PM
5	Recognising this could have been impacted by the current pandemic, any interim arrangements have been appropriate and have taken into account the essential nature of Board meetings.	3/10/2022 12:52 PM

Q4 The forum comprises members with an appropriate mix of skills and experience:

Answered: 13 Skipped: 0

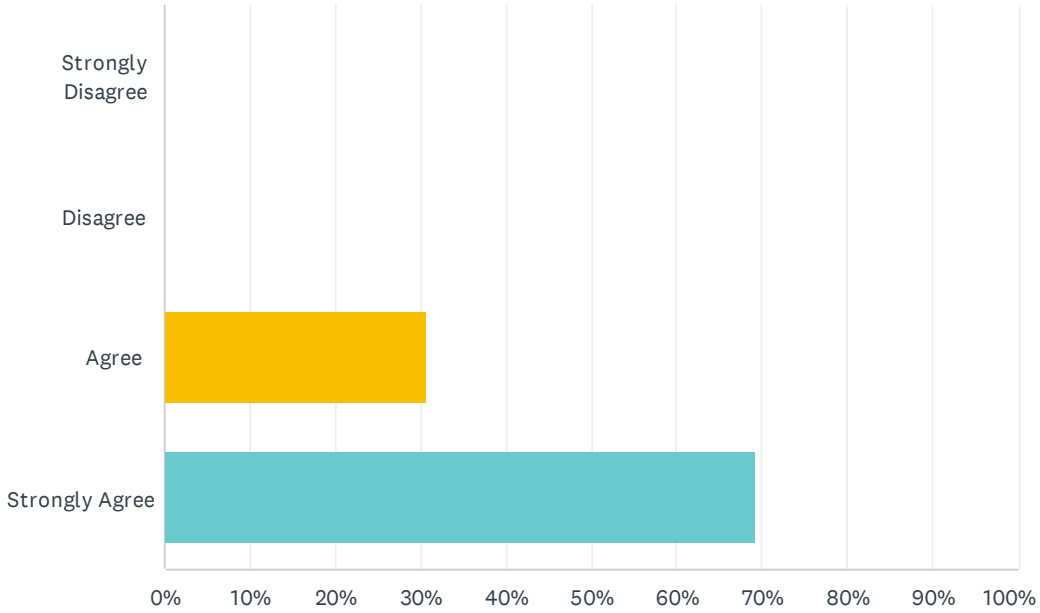


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	30.77%	4
Strongly Agree	69.23%	9
TOTAL		13

#	COMMENTS:	DATE
1	Still a number of relatively new board members but on the whole an appropriate mix of skills.	3/23/2022 1:25 PM
2	There is a blend of "older hands" and more newly-appointed members which promotes healthy challenge.	3/23/2022 10:47 AM
3	The Board is diverse and provides a strong mix of skills and experience	3/14/2022 4:35 PM
4	really good mix of skills and experience	3/10/2022 3:22 PM

Q5 Members understand the key work streams and what needs to be escalated:

Answered: 13 Skipped: 0

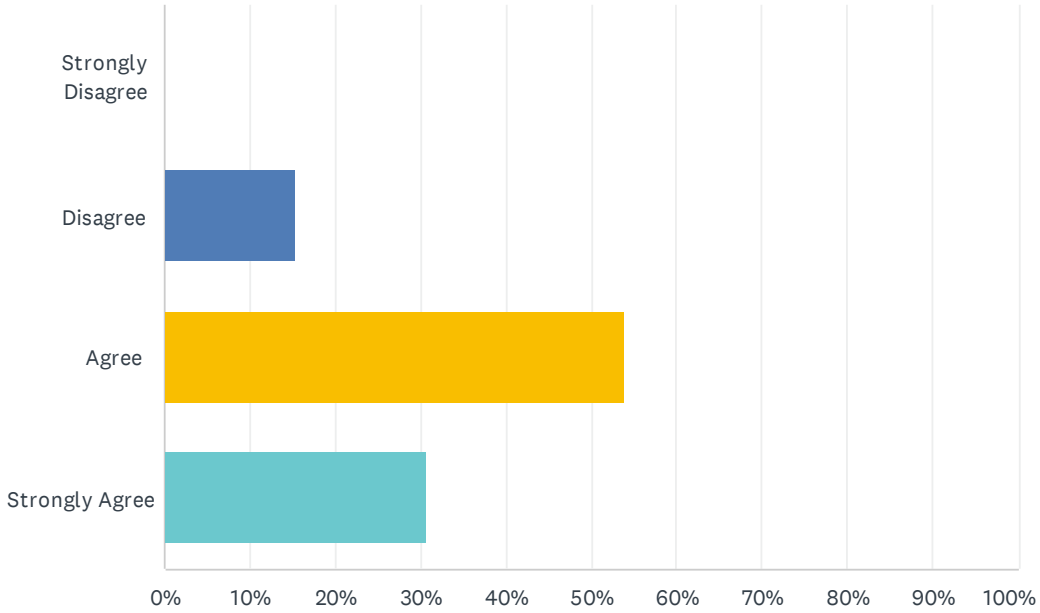


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	30.77%	4
Strongly Agree	69.23%	9
TOTAL		13

#	COMMENTS:	DATE
1	The feedback from board committees is clear	3/23/2022 1:25 PM
2	The committee reporting structure is clear and escalations are routinely reported when appropriate.	3/23/2022 10:47 AM

Q6 The agenda is clear, focuses on the right questions and avoids minutiae:

Answered: 13 Skipped: 0

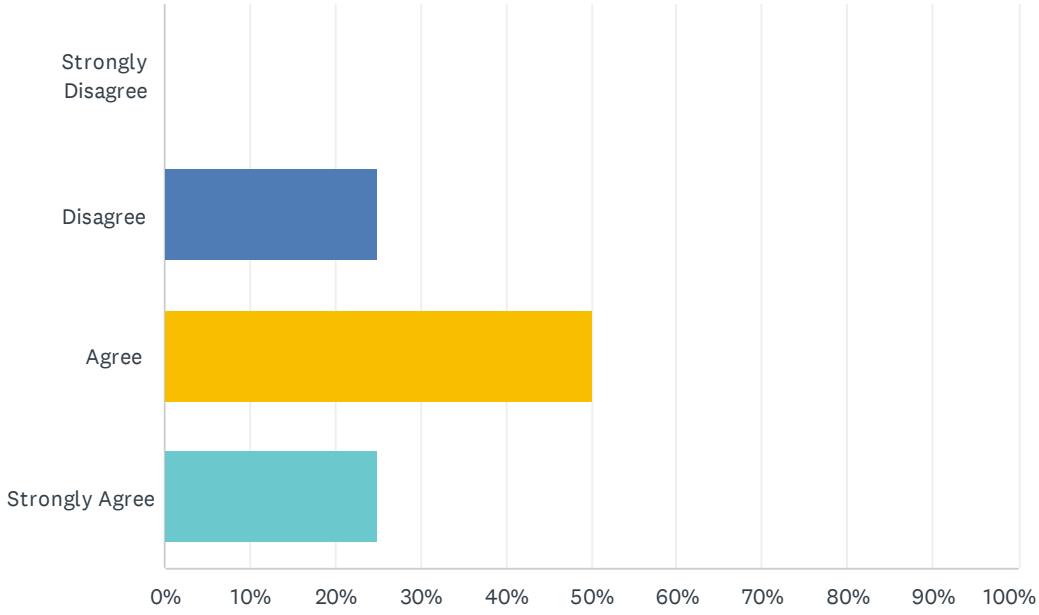


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	15.38%	2
Agree	53.85%	7
Strongly Agree	30.77%	4
TOTAL		13

#	COMMENTS:	DATE
1	Can get a little bogged down by minutiae. It sometimes feels we require assurance on the assurance.	3/23/2022 6:13 PM
2	On the whole	3/23/2022 1:25 PM
3	The need to focus on essentials during the pandemic has facilitated improvements in this area.	3/23/2022 10:47 AM
4	Occasionally there is minutiae, but only when needed	3/10/2022 3:22 PM
5	This continues to evolve and develop recognising new Board members and the need to get everyone up to speed.	3/10/2022 12:52 PM

Q7 Meeting papers are concise, relevant and received in a timely fashion:

Answered: 12 Skipped: 1

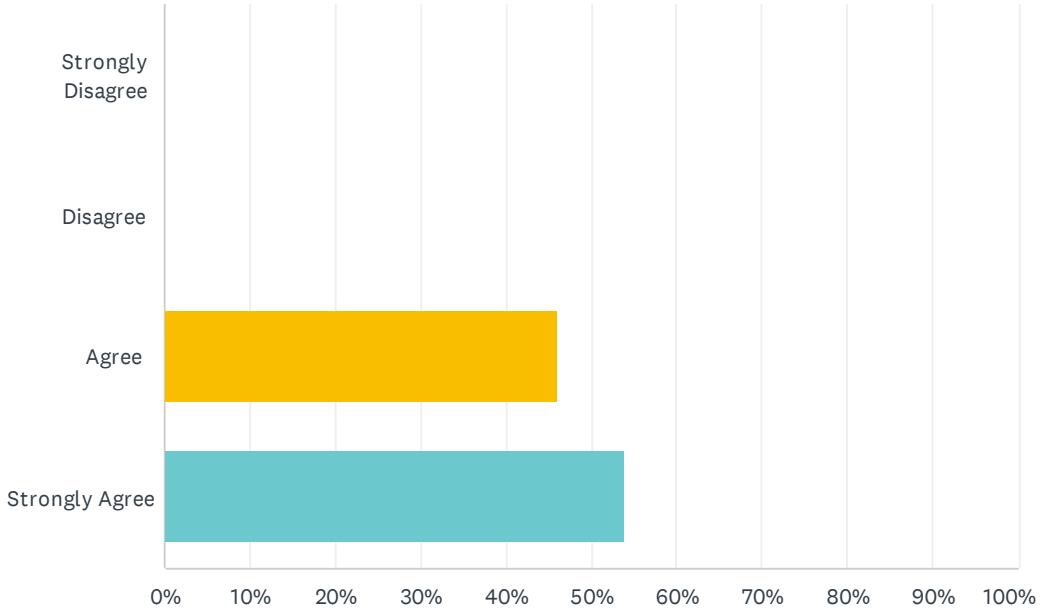


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	25.00%	3
Agree	50.00%	6
Strongly Agree	25.00%	3
TOTAL		12

#	COMMENTS:	DATE
1	Concise - often no, relevant -- mostly, received in a timely fashion - yes	3/23/2022 6:13 PM
2	Some exceptions but sometimes out of the direct control of the team	3/23/2022 1:25 PM
3	Some improvements still needed in report writing, but on the whole papers are clear and concise.	3/23/2022 10:47 AM
4	There has been a real improvement in the quality of papers over the last few years and indeed most recently	3/14/2022 4:35 PM
5	variable, some papers too lengthy	3/10/2022 3:22 PM
6	Care needed re too much in the papers, to avoid not being able to see the "wood for the trees"	3/10/2022 2:28 PM
7	Papers tend to come after close of play on a Friday giving limited time to read.	3/10/2022 1:50 PM
8	The timeliness of papers has been impacted by the pandemic and the focus on service delivery.	3/10/2022 12:52 PM

Q8 The standard of delivery of reports is good with appropriate presenters:

Answered: 13 Skipped: 0

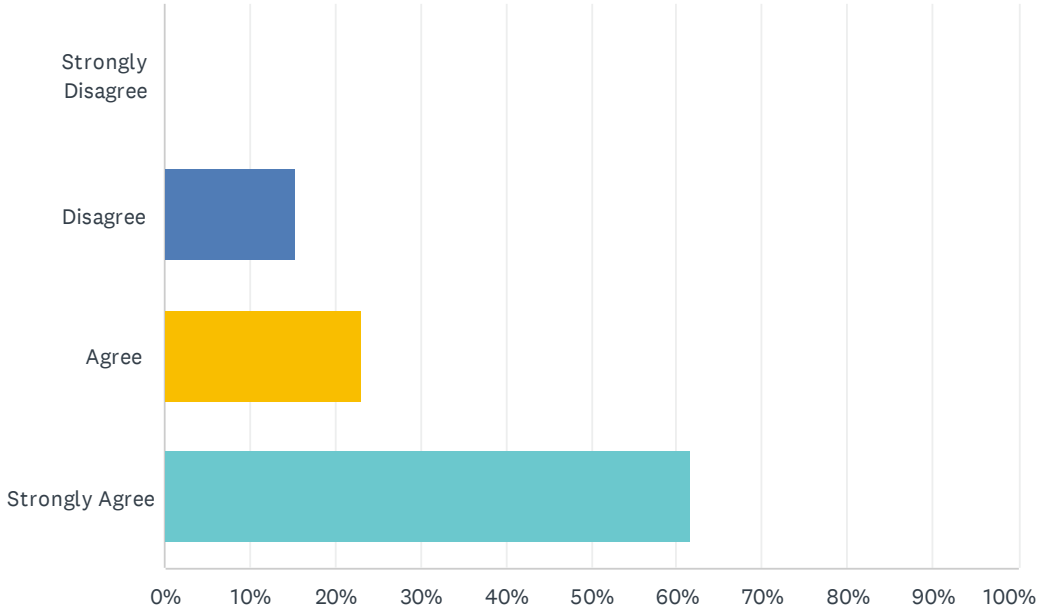


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	46.15%	6
Strongly Agree	53.85%	7
TOTAL		13

#	COMMENTS:	DATE
1	Board reports have been developing and improving during the previous 12 months.	3/23/2022 4:07 PM
2	Agreement is to take papers as read and summarise the key issues. This works well in the main.	3/23/2022 10:47 AM
3	More papers could be introduced more succinctly and taken as read then a focus on key highlights or lowlights that require Board discussion	3/10/2022 1:50 PM

Q9 Adherence to agenda, topics and timeframes is good:

Answered: 13 Skipped: 0

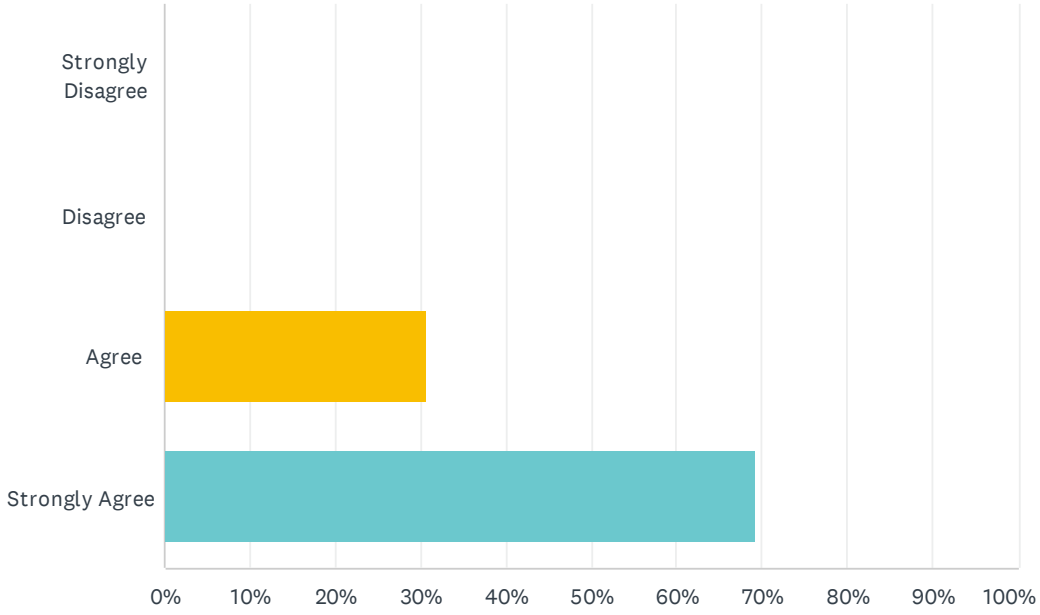


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	15.38%	2
Agree	23.08%	3
Strongly Agree	61.54%	8
TOTAL		13

#	COMMENTS:	DATE
1	Generally good, although it is sometimes a difficult balance between allowing adequate debate and contributions from all and keeping to agenda times!	3/23/2022 10:47 AM
2	Really good chairing always allowing for breaks and keeping to time whilst ensuring there's an opportunity for everyone to contribute	3/14/2022 4:35 PM
3	Timekeeping sometimes poor	3/10/2022 3:22 PM
4	Timing can at times be a challenge although we are getting better at building in breaks and finishing on time	3/10/2022 1:50 PM
5	We do go over at times but that’s when it’s really important to have the discussions and include everyone’s opinions	3/10/2022 12:39 PM

Q10 Members interact well and meeting participation is balanced:

Answered: 13 Skipped: 0

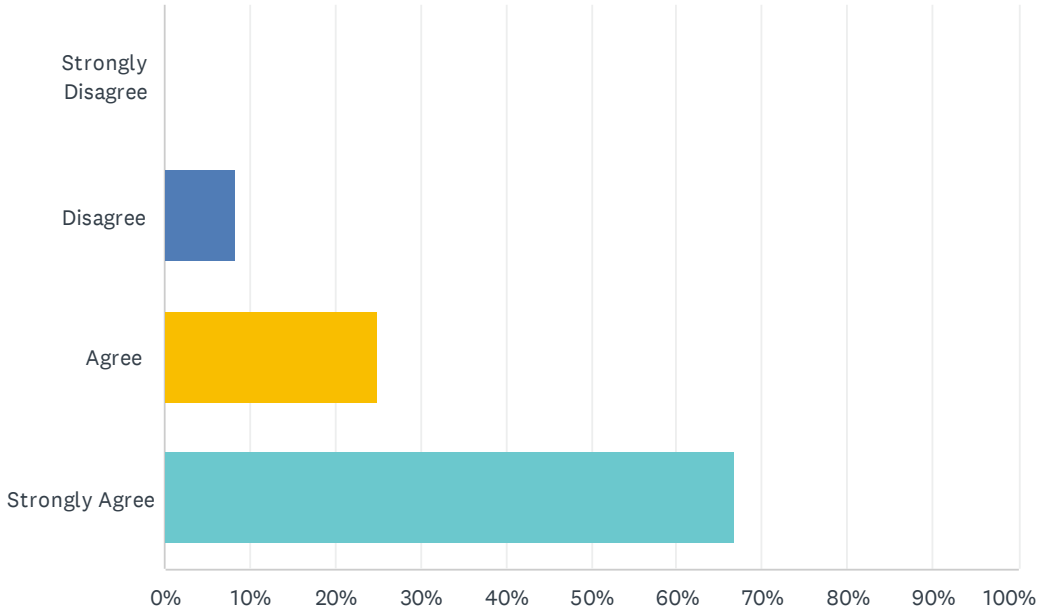


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	30.77%	4
Strongly Agree	69.23%	9
TOTAL		13

#	COMMENTS:	DATE
1	The majority of meetings have been on Teams therefore Teams tools such as hand raising indicates who wants to contribute and everyone keeps their cameras on unless they are having wifi issues.	3/23/2022 4:07 PM
2	On the whole although some members contribute more than others	3/23/2022 1:25 PM
3	observed respectful but firm challenge	3/10/2022 3:22 PM
4	Everyone is heard on the board, this is a strong point	3/10/2022 12:39 PM

Q11 There is good rigour of debate with probing discussions and appropriate challenge:

Answered: 12 Skipped: 1

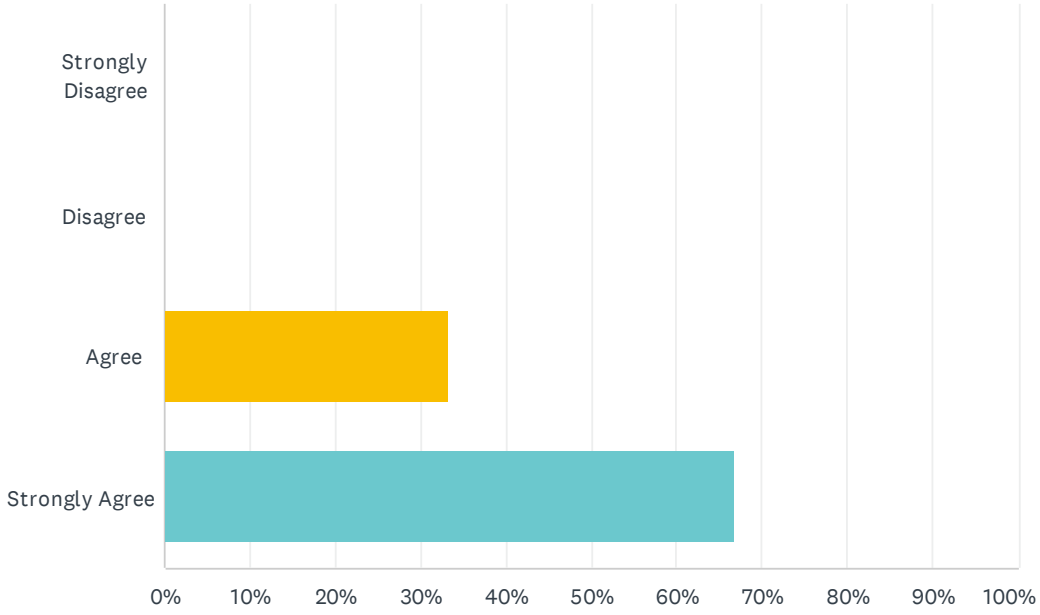


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	8.33%	1
Agree	25.00%	3
Strongly Agree	66.67%	8
TOTAL		12

#	COMMENTS:	DATE
	There are no responses.	

Q12 Meeting Chair is effective in controlling the meeting:

Answered: 12 Skipped: 1

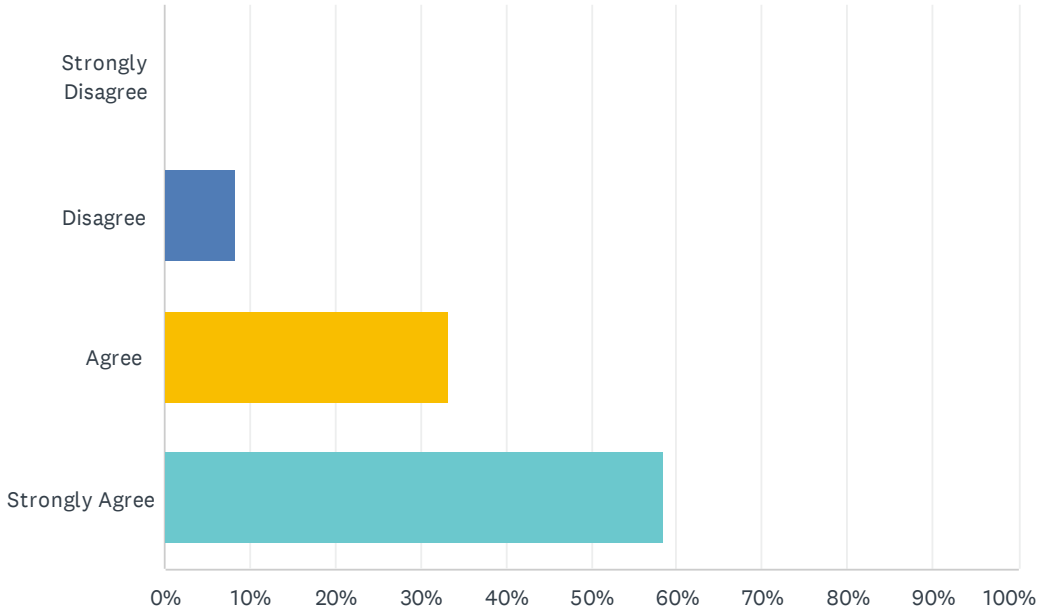


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	33.33%	4
Strongly Agree	66.67%	8
TOTAL		12

#	COMMENTS:	DATE
1	except for timekeeping	3/10/2022 3:22 PM
2	Most certainly, ensure time for appropriate discussion and debate but also managing time effectively	3/10/2022 2:28 PM
3	Despite the interim change from face to face to remote teams meetings.	3/10/2022 12:52 PM

Q13 There is a good decision-making process and clarity of outcome of each issue discussed:

Answered: 12 Skipped: 1

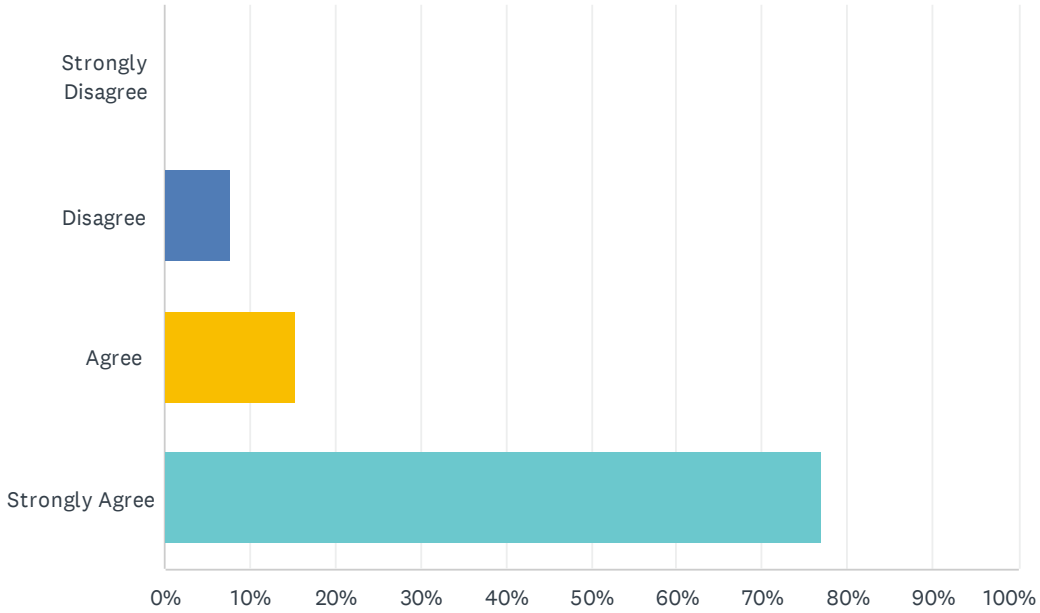


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	8.33%	1
Agree	33.33%	4
Strongly Agree	58.33%	7
TOTAL		12

#	COMMENTS:	DATE
1	Usually	3/23/2022 1:25 PM
2	Good summary of the discussions and actions that have been agreed	3/10/2022 1:50 PM

Q14 The minutes of meetings accurately capture decisions taken and constructive challenge:

Answered: 13 Skipped: 0

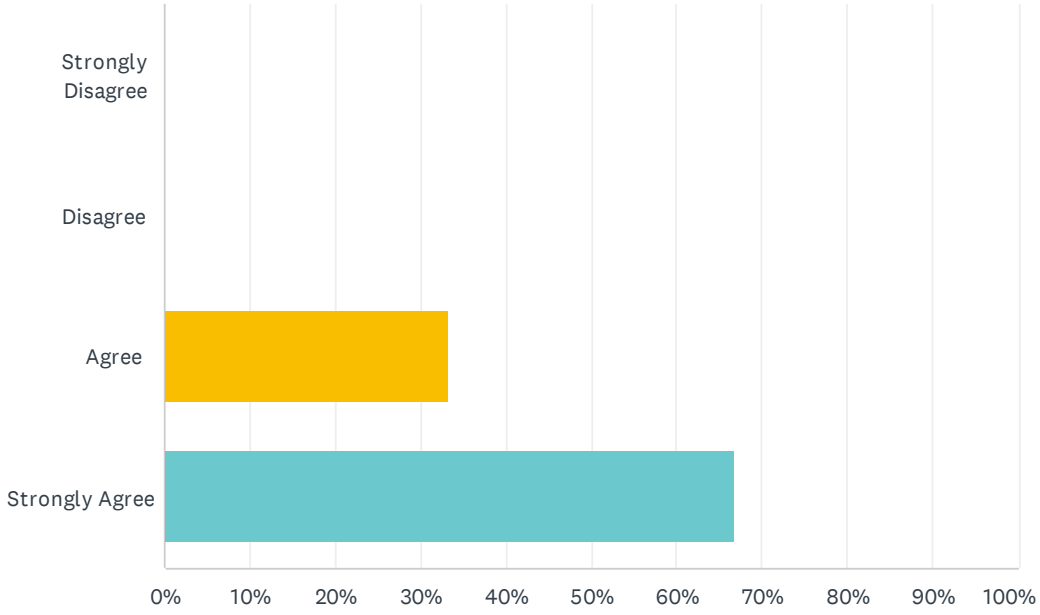


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	7.69%	1
Agree	15.38%	2
Strongly Agree	76.92%	10
TOTAL		13

#	COMMENTS:	DATE
1	The quality of minutes is excellent	3/23/2022 10:47 AM
2	We have really good quality minute taking	3/14/2022 4:35 PM
3	minutes excellent	3/10/2022 3:22 PM

Q15 At the end, the meeting is briefly evaluated:

Answered: 12 Skipped: 1

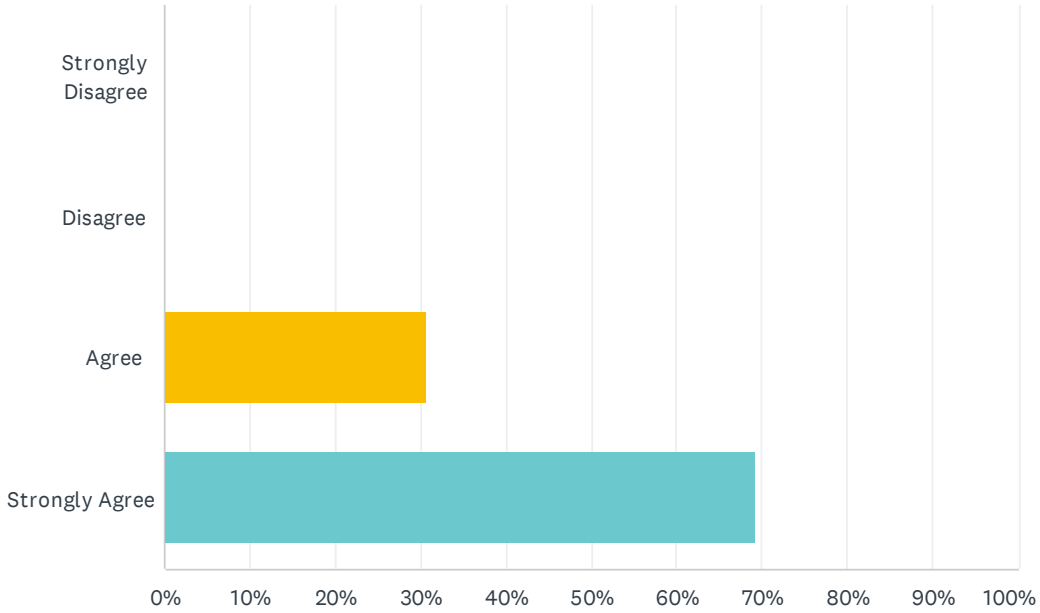


ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	33.33%	4
Strongly Agree	66.67%	8
TOTAL		12

#	COMMENTS:	DATE
1	Any updates to the BAF are noted and the meeting is routinely evaluated.	3/23/2022 10:47 AM
2	Yes and observer feedback obtained, which is good practice	3/10/2022 2:28 PM

Q16 Overall the meetings is a success and is perceived to have positive impact:

Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Strongly Disagree	0.00%	0
Disagree	0.00%	0
Agree	30.77%	4
Strongly Agree	69.23%	9
TOTAL		13

#	COMMENTS:	DATE
1	Board meetings are effective and allow ample opportunity for challenge and debate	3/23/2022 10:47 AM

Q17 Any further comments or observations?

Answered: 1 Skipped: 12

#	RESPONSES	DATE
1	.	3/10/2022 2:28 PM

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board Date	7 April 2022
Board Part	Public
Agenda item	25/22iv

Title	Application of the Trust Seal
Sponsoring Director	Colin Scales, Chief Executive
Authors	Jan McCartney, Trust Secretary
Presented by	Jan McCartney, Trust Secretary
Purpose	To record the use of the Trust seal from 30 April 2021 to 31 March 2022
Previously considered at	n/a
Related Trust Objective/ Intentions	BAF 1 - Failure to implement and maintain sound systems of Corporate Governance
Patient Safety and Quality	n/a
Care Quality Commission Outcomes support by this paper	Well-led
How does the paper address strategic risks identified in the BAF?	Failure to implement sound systems of Corporate Governance

Legal implications/ regulatory requirements	
Finance and resources Impact assessment	n/a
Equality Impact assessment	n/a
Next steps	n/a
Recommendations	Board is asked to receive the report for information

Board

Title	Application of the Trust Seal
Author	Jan McCartney, Trust Secretary
Date	March 2022
Purpose	The Board is asked to note the application of the Trust Seal from 30 April 2021 to 31 March 2022
Audience	Trust Board

1.0 EXECUTIVE SUMMARY

1.1 Documents signed on behalf of the Trust, which must be executed under deed, are sealed as set out within the Trust's Standing Orders at section nine "Custody of the Seal and Sealing of Documents", and section 10 "Signature of Documents". This is normally confined to land deals, including purchases, transfers, tenancy agreements, and acquisitions.

2.0 APPLICATION OF THE TRUST SEAL

2.1 In the period from 30 April 2021 to 31 March 2022 there were three applications of the Trust Seal applied by the Board and Committee Administrator on behalf of the Trust Secretary:

Table 1 Application of the Trust Seal

Seal Number/Reference	Application of the Trust Seal	Date	Signed (Authorised officers)
01/22	Underlease for part of Orford Jubilee Park Health Centre, Jubilee Way, Warrington, Cheshire, WA2 8HE between Community Health Partnership and Bridgewater Community Healthcare NHS Foundation Trust	23 February 2022	Nick Gallagher, Director of Finance and Lynne Carter, Chief Nurse/Deputy Chief Executive
02/22	Bury, Tameside and Glossop Community Solutions Limited LIFT, Underlease for part of Ashton Primary Care Centre, 193 Old Street, Ashton Under Lyne, OL6 7SR between Bridgewater Community Healthcare NHS	23 February 2022	Nick Gallagher, Director of Finance and Lynne Carter, Chief Nurse/Deputy Chief Executive

	Foundation Trust and Community Health Partnerships Limited		
03/22	Lease of land at Caldwell Road (car park), Widnes. Between Halton Borough Council and Bridgewater Community Healthcare NHS Foundation Trust	23 February 2022	Nick Gallagher, Director of Finance and Lynne Carter, Chief Nurse/Deputy Chief Executive

3.0 RECOMMENDATION

3.1 The Board is asked to note the use of the Trust Seal as set out in table one.