NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

Thursday 9 June 2022, 10am
Karalius Suite, Halton Stadium

A G E N D A

Item	Time	Item Title	BAF Reference	Action
29/22	**10.00**	**APOLOGIES FOR ABSENCE – Sarah Brennan** **DECLARATION OF INTEREST IN ITEMS ON THE AGENDA**		**Information** **Assurance**
30/22	**10.00**	**MINUTES OF THE LAST MEETING:** (i) **BOARD MEETING HELD ON 7 APRIL 2022**		**Assurance/ Approval**
31/22	**10.05**	**MATTERS ARISING FROM THE ACTION LOG**		**Action/ Assurance**
32/22	**10.10**	**ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE CHAIR**		
33/22	**10.10**	**SPOTLIGHT ON SERVICES – Talent for Care Team**		**Information**
34/22	**10.30**	**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**

35/22	**10.45**	**KEY CORPORATE MESSAGES**	**BAF1**	**Information**
36/22	**11.00**	**QUALITY - To deliver high quality, safe and effective care which meets both individual and community needs**		
		(i) IQPR month 12 – presented by Executive Leads	**ALL**	**Assurance**
		(ii) Covid-19 Update presentation - presented by the Deputy Chief Operating Officer	**BAF2,3,6**	**Assurance**
		(iii) Ockenden II Report Update – presented by the Chief Nurse	**BAF2,3,6**	**Assurance**
		(iv) Report from the Quality and Safety Committee held on 21 April 2022 – presented by the Committee Chair	**BAF2,3,6**	**Assurance**
		(v) Independent Inquiry into Child Sexual Abuse (IICSA) - presented by the Chief Nurse	**BAF2, 3**	**Information**
10 minute break				
37/22	**12.00**	**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) Reports from the Finance and Performance Committee held on 28 April 2022 and 19 May 2022 – presented by the Committee Chair	**BAF4, 7, 8**	**Assurance**
		(iii) Report from the Audit Committee held on 27 April and 19 May 2022 - presented by the Committee Chair	**BAF1**	**Assurance**
38/22	**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 Director of Integration and Collaboration	**BAF7**	**Assurance**

39/22	**12.45**	**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 11 May 2022 – presented by the Committee Chair	**BAF5, 6**	**Assurance**
40/22	**1.00**	**OVERARCHING CORPORATE GOVERNANCE ITEMS** (i) Compliance with Provider Licence - presented by the Trust Secretary (ii) Terms of Reference – presented by the Trust Secretary	**BAF1**	**Assurance** **Approval**
41/22	**1.15**	**REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK**	**ALL**	**Information**
42/22	**1.20**	**OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE CHAIR**		**Information**
43/22	**1.25**	**DATE AND TIME OF NEXT MEETING** **Thursday 4 August 2022, 10am, in person meeting – venue details to be provided.**		**Information**
44/22	**1.25**	**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 7 April 2022, 10am
Meeting held virtually via Microsoft Teams

Present
Karen Bliss, Chair
Colin Scales, Chief Executive
Linda Chivers, Non-Executive Director
Nick Gallagher, Director of Finance
Abdul Siddique, Non-Executive Director
Martyn Taylor, Non-Executive Director (from item 22/22)
Tina Wilkins, Non-Executive Director
Paula Woods, Director of People and Organisational Development
Sally Yeoman, Non-Executive Director
Ted Adams, Medical Director
Lynne Carter, Chief Nurse
Sarah Quinn, Chief Operating Officer

In Attendance
Rob Foster, Programme Director of Integration and Collaboration
Jan McCartney, Trust Secretary
Jilly Wallis, Allied Health Professionals Lead (for item 18/22)
Lynda Richardson, Board and Committee Administrator

Observers/members of the Public
Rita Chapman, Lead Governor
Diane McCormick, Public Governor, Halton

14/22 (i) APOLOGIES FOR ABSENCE
Aruna Hodgson, Medical Director
Gail Briers, Non-Executive Director

The Chair welcomed all to the meeting.

ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

There were no declarations of interest made.

15/22 MINUTES OF THE LAST MEETING:

3 February 2022

Page three, amendment to a sentence within the second paragraph: '*he advised that an event had taken place with the Chief Executives involved in the provider collaborative* ***that*** *had discussed the setting of stretch targets for community health services…*'

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

16/22 MATTERS ARISING FROM THE ACTION LOG

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

64/21i Finance Report (use of cash balance)

The Director of Finance advised that formal guidance was still awaited by the treasury team. **The Board agreed that the best course of action for this item was deferral to the Finance and Performance Committee.** A report would be taken to that forum when guidance was available. This action would be removed from the Board action log on this basis.

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

77/21 Board Assurance Framework
07/22 IQPR
10/22 Policies for ratification
11/22 Board Assurance Framework

17/22 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.

18/22 SPOTLIGHT ON SERVICES – AHP Workforce Strategy

The Board received a presentation from Jilly Wallis, Allied Health Professionals (AHP) Lead which set out the current national and Trust wide picture for AHPs. The Trust commenced the project, commissioned by Health Education England, in October 2021 with the appointment of the AHP Lead, initially for one year. The AHP Lead provided an update on the progress of the project including the work that had been undertaken during the pandemic to date leading into the development and the first draft of an AHP strategy which would be imminently available for circulation. The strategy would act as a framework to support AHPs to be embedded within the Trust and support people and families to live healthy lives, in line with the NHS Long Term Plan, NHS People Plan and the national AHP strategy and would help to grow AHPs further in Bridgewater.

The Chief Nurse highlighted that the work undertaken including apprenticeships and advanced practice would improve the services that the Trust could offer for patients. The Chief Operating Officer added that encouraging the use of AHPs within the delivery of clinical services and in place would enable the Trust to have a wider offer.

Following a series of questions from Non-Executive Director, Tina Wilkins, the AHP Lead advised that timescales between the workforce strategy for 2022-24 and the Trust AHP strategy with an 18-month timescale mandated by Health Education England were misaligned, as there would need to be time to bring staff on board and to train them over a longer period of time. However Health Education England would take all of the individual organisational strategies and collate them into one wider strategy. She advised that patients would be included in the work to drive elements of the strategy and there were links with the Trust's Patient Experience Team who would provide support to include aspects such as patient's lived experiences and feedback.

Medical Director, Ted Adams asked whether any research elements had been included within the Trust's AHP strategy. The AHP Lead advised that the project was connected to the University of Central Lancashire and was reviewing areas such as back pain and physiotherapy. The Trust was working with the University to explore any other areas that the Trust could link into. She highlighted that there was a piece of culture changing work to take place around research to encourage staff to become more involved.

The Director of People highlighted that there were a number of strategies in place within the Trust including the Quality and Place and People Strategies, alongside regional and national nursing and midwifery strategies. She noted that it would be important to recognise those strategic plans and reference them in the Trust's own overall people strategy, which was currently being refreshed, going forwards. Work would be progressed on this via the Trust People Operational Delivery groups (PODs).

The Board welcomed the high impact work undertaken to date and recognised its importance as a key element of Trust workforce transformation.

19/22 BOARD ASSURANCE FRAMEWORK

The Trust Secretary reported that the Board Assurance Framework was reviewed in detail by the Board Committees during their previous cycle to ensure that this was contemporary. She noted that the Audit Committee would be reviewed at the Audit Committee during April 2022 and that BAF8 would be reviewed further by the Finance and Performance Committee in May 2022.

The Director of Finance highlighted that the key controls for BAF4 would require update following the finalisation and approval of the plan.

Following a point made by Non-Executive Director, Linda Chivers **it was agreed that the Board Assurance Framework would record audits from 2019/20 onwards for consistency, with others prior to that period being removed. It was also agreed that BAF1 would reflect information from the staff survey results concerning reported improvements in staff confidence levels regarding reporting risks and concerns.**

20/22 KEY CORPORATE MESSAGES

The Board received a report from the Chief Executive which detailed Non-Executive and Executive Director activity, Executive and senior team engagement, feedback from recent Time to Talk sessions with services and external publications and reports.

The Chief Nurse reported that discussion had taken place at the Executive Management Team and Senior Leadership Team meetings concerning Time to Talk sessions and leaders at directorate levels would be rolling out a similar approach to interact and engage with teams. She informed the Board that there would also be 'tea and talk' sessions held with individual directors over the coming months. This would help to counteract the challenges of engaging with staff in person over the pandemic. The Chair asked that the Non-Executive Directors were involved in this as they would be keen to take part and interact with staff.

21/22 QUALITY - To deliver high quality, safe and effective care which meets both individual and community needs

(i) IQPR

The Board received the report for assurance noting the key areas of performance for the Trust for month 10 across operations, quality, people and finance, and welcomed the inclusion of the dental data within the circulated report which provided a further level of understanding on performance.

(ii) Covid-19 Update Report

The Chief Operating Officer presented a report to the Board to provide an update concerning the current actions being taken to manage the impact of the pandemic. The report highlighted that over the last few weeks, staff absence levels had decreased from the levels of absence recorded in January 2022 but were on an increasing trend with a notable rise in absence related to Covid-19. She reported that several services remained escalated at amber and this was being monitored via a daily operations huddle, the Command and Control structure and Quality Impact Assessment (QIA) panels which reviewed the quality impact on service delivery.

The Chief Operating Officer reported that there had been changes to the isolation and testing guidance and policies and procedures had been updated to reflect this. In addition, Vaccination as a Condition of Deployment (VCoD) was revoked on 15 March 2022.
The Board received the report recognising the pressures of the management of increasing numbers of positive covid-19 cases and noted the actions that were being taken to continue to support staff to deliver safe and effective care.

(iii) Report from the Quality and Safety Committee held on 17 February 2022

Non-Executive Director, Sally Yeoman as Deputy Committee Chair presented a report from the last meeting of the Quality and Safety Committee on behalf of the Committee Chair, Gail Briers. The Board received the report and agreed that this provided a high level of assurance. Non-Executive Director, Tina Wilkins commented that the relationship between the Quality and Safety Committee and the Finance and Performance Committee was working effectively, with sharing of key items and ensuring cross linkages.

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

(i) Finance Report

The Board received the report for assurance and acknowledged the Trust's continued achievement against the Better Payment Practice Code as well as the achievement of a break-even position and savings in view of current challenges.

(ii) Report from the Finance and Performance Committee held on 24 March 2022

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

23/22 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

The Director of Integration and Collaboration presented an update to the Board to provide oversight on the progress with integration and collaboration development and opportunities across the Trust. The Board noted that appointments had been made to the key leadership roles on the ICS/ICB board and to the nine Place Director roles across Cheshire and Merseyside. The report also provided an update regarding current developments across Warrington, Halton and Dental along with an update concerning the Provider Collaborative.

The Board received the report and welcomed the direction of work. Non-Executive Director, Linda Chivers commented that it would be important for the Trust to ensure it held an active role in collaborative or integrated projects to keep Bridgewater at the forefront as the community services go to provider. It was also acknowledged that the Trust's strategies would need to dovetail with those in Place and with those of the ICS/ICB.

24/22 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 16 March 2022

The Board received a report from the latest People and Organisational Development Committee from the Committee Chair, Abdul Siddique. It finally endorsed the Public Sector Equality Duty for Workforce and Services Annual Report and the Equality Delivery System 2 report which were recommended for Board approval by the People Committee.

(ii) Staff Survey Report

The Director of People provided a verbal report noting that a written report had been circulated with the closed board agenda due to an embargo being placed on the results of the survey, ahead of their national publication, until 30 March 2022 which was following the date of issue for the board agendas.

The Director of People reported that at the Board time out session held early March 2022, Board members were provided with an overview of the significant changes made to the Staff Survey and how this was now aligned to the NHS Our People Promises, of which there were seven. Two themes remained from the previous survey: 'morale' and 'staff engagement'. This gave a total of nine areas that were measured. The nine areas were scored 1 to 10 with 10 being the highest score.

The benchmarking results provided information for the Trust as a whole and by Directorate. The Director of People explained that overall, the survey results were pleasing. She noted that the areas for improvement and further development related to 'we are always learning' and 'we work flexibly'. The Trust had maintained its 'staff engagement' score of 7.2 which was the national average. This is pleasing taking into consideration the survey was completed during the second year of the pandemic and whilst staff were continuing to work under ongoing significant pressures. Staff engagement would remain as an area of focus for the Trust with the ambition to ensure that this score was improving going forwards.

The Trust was at the national average for being compassionate and inclusive, safe and healthy and for team working. With the exception of 'we are always learning' the Trust's scores were not statistically significant in terms of being below the national averages for being recognised and rewarded, having a voice that counts and working flexibly. The Director of People highlighted that the Trust had sustained a staff survey response rate of 50% for a second year running. The 2021 Survey changed significantly in terms of its questions and the Trust would be changing its approach to action planning accordingly.

The Director of People advised that the areas of improvement and further development would be worked on via the Trust's People Hub and PODs whose primary focus was the delivery of the NHS People Plan and the seven People Promises. There would also be a focus on the Staff Friends and Family Test (SFFT). The two questions with regards to recommending the Trust as a place to work and receive treatment to family and friends would also be considered as above. There would be focused actions by directorates for Dental, Halton Children's Services and Warrington Adult Services. The Oldham Children's Services, which transferred to a new provider on 1 April 2022, had achieved positive survey results which were above Trust scores except for staff engagement which was .01 away from the Trust score and therefore this was not statistically significant as such.

The NHS People Pulse Survey would provide a temperature check as to progress. The Director of People advised that updates would be formally provided to the Board, People Committee, Executive Management Team and other forums as part of the Trust governance structure. A detailed report from the output of the staff survey, including action plans, would be taken forwards via the People Committee in May 2022.

The Director of People highlighted that since the original report was written it had been noted following an analysis of the national dashboards that the Trust's position was favourable nationally beyond benchmarking with community trusts. The Trust performed well in seven of the nine categories within this dashboard. There had also been some key headlines noted with a recent Health Service Journal (HSJ) with the Trust's performance against the SFFT test mentioned which was favourable in comparison with some other community organisations. She advised that action plans would include a focus on this and a variety of communication and engagement activities.

The Director of People added that NHS Employers would be developing a staff covenant to build on the principles in the People Promise and the NHS Constitution and there would be a consultation period. Further information was expected on this in the near future.

The Board received the report and acknowledged that whilst further work was required to be undertaken that the results for Bridgewater were positive overall.

(iii) North West Anti-Racist Framework

The Director of People presented the framework for the Board's consideration following a request from the regional people board. The Trust would be assessing itself against this framework with a self-assessment exercise to be undertaken. She explained that there would be an accreditation process including the self-assessment with a review panel. If the Trust was successful it would receive a recognition via the BAME assembly website. The Chief Executive advised that the framework would be considered via the Executive Management Team in detail and the Trust would ensure that its activity towards becoming an anti-racism organisation would be prominent both internally and with partner organisations. The framework included a set of ambitions that would be taken through the People Committee and updates provided via that forum to the Board to ensure visibility. It was noted that there had been delays in reciprocal mentoring, but the Trust would ensure that it was taking part in this programme.

The Board welcomed the framework and committed to sign up to this. Following a suggestion from Non-Executive Director, Linda Chivers it would include reference to anti-racism as part of the Equality, Diversity and Inclusion strategic objective.

25/22 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Russian/Belarussian Interest

The Trust Secretary report that 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 supply chains and identify contractual relationships with Russian and Belarussian suppliers. She advised that the Trust also was advised, via the NHS Providers Company Secretary network, to review under Fit and Proper Persons whether any Director had any relevant interest or investment to declare.

Following a review by the Deputy Director of Estates and the Head of Procurement, it was identified that three freehold sites were supplied with gas from the Russian company Gazprom. This information was submitted to the emergency planning department at NHS Improvement/England. The Trust had worked with the Crown Commercial Services to end the contract and identify an alternative supplier. This new contract would commence on 1 May 2022. The Trust Secretary reported that whilst the Board had recently reviewed and resubmitted annual declarations of interest, a separate additional request was made to confirm any Board members held any Russian interests or investments. All Board members had confirmed that they held no interests or investments to declare.

The Director of Finance confirmed to Non-Executive Director, Martyn Taylor that there was a minimal cost for the exiting of the Gazprom contracts. Concerning the future cost of gas, he confirmed that this was not included in the planning guidance and there was no current funding for energy price increases, however an excess inflation impact cost pressure had been recognised. Trusts would plan for the expected costs pressures with feedback to be provided to NHS Improvement/England and to the Treasury. The Director of Finance advised that the Board would receive feedback in the event of any further information on funding or any national solution.

The Medical Director noted that a review had been undertaken of the Trust's medical devices and the organisation did not hold any Russian made devices.

The Board received the report for assurance.

(ii) Board Terms of Reference

The Board noted that this item had been deferred. A review of the full suite of Board and Committee Terms of Reference would be undertaken by the Head of Corporate Governance after which the amended documents would be presented for approval. Board members were invited to provide any comments in relation to the review directly to the Head of Corporate Governance.

(iii) Board Annual Effectiveness Review

The Trust Secretary presented a report received by the Board for assurance detailing feedback from the recent annual Board self-effectiveness review. A statement questionnaire was distributed to 16 board members or invited attendees who regularly attended the Board via Survey Monkey for anonymous response in March 2022. 13 returns were received; 12 were Non-Executive or Executive members and one was from an invited attendee. The majority of responders either agreed or strongly agreed to the statements, demonstrating a high level of satisfaction with the effectiveness of the Board. However in response to six of the questions, one or more responders had disagreed with the statements.

Whilst the results were positive overall, it was noted that further work was required regarding the size of agendas, time keeping and the conciseness of papers. The Trust Secretary advised that any further comments with reference to board effectiveness could be provided on a confidential basis to herself or Non-Executive Director, Sally Yeoman as the Senior Independent Director.

Non-Executive Director, Linda Chivers highlighted the response rate noting that it was clear from this that not all Board members had responded to the self-effectiveness survey. She commented that it was important that all Non-Executive and Executive Directors engaged with this and completed the responses to the Board and Committee effectiveness surveys. Non-Executive Director, Martyn Taylor referred to the importance of responders providing commentary against their feedback as this was valuable information.

(iv) Trust Register of Seals Report

The Board received a report from the Trust Secretary which set out that the Trust Seal had been applied on three occasions from 30 April 2021 to 31 March 2022.

26/22 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

As discussed earlier in the meeting, all sections of the Board Assurance Framework would record audits from 19/20 onwards for consistency. BAF1 would reflect information from the staff survey results concerning reported improvements in staff confidence levels regarding reporting risks and concerns.

27/22 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.

28/22 DATE AND TIME OF NEXT MEETING

Thursday 9 June 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	**BLUE**	07.04.22 It was agreed that his action would be deferred to the Finance and Performance Committee and removed from the Board action log.
07.04.22	19/22	Board Assurance Framework	**All BAF sections to record Audits from 19/20 onwards for consistency.** **BAF1 to reflect information from the staff survey results concerning reported improvements in staff confidence levels in reporting risks and concerns.**	Jan McCartney	**BLUE**	Item completed – BAF now updated
07.04.22	24/22iii	NHS North West Anti-racism Framework	**The Board committed to sign up to the framework and to include reference to anti-racism as part of the EDI strategic objective.**	Paula Woods	**BLUE**	27th April 2022 The framework, its principles, key drivers and direct deliverables are being mapped out. Our commitment was communicated in April's Team Brief and a Director Blog issued in May. Progress will be reported to the People Committee

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
07.04.22	25/22ii	Board Terms of Reference	**All Board members were asked to feedback any comments on any of the suite of Board and Committee Terms of Reference to the Head of Corporate Governance who would be undertaking a review of all ToR.**	All	**BLUE**	Review now completed.
07.04.22	25/22iii	Board Effectiveness Review	**Survey feedback demonstrated that there would be further work required concerning the size of the agendas, timekeeping of items during meetings and conciseness of papers.**	Jan McCartney	**GREEN**	Workplan currently being updated

Bridgewater Community Healthcare
NHS Foundation Trust

Bridgewater Board Date	9 June 2022
Board Part	Public
Agenda item	34/22

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	9 June 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.

2.0 CHANGES TO THE BAF

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

The Audit Committee met on 27 April at which a thorough review of this BAF was conducted. The following changes are recommended.

Principle Risk – a minor amend inserted on the third paragraph to add the words 'including those'. Reference to CQC rating removed.

Rationale for Current Score – updated to reflect delay in Well Led actions.

Prevent Controls – update wording to reflect the management structure is now complete and add 'risk register' as a prevent control.

Detect Controls – The line on staff survey to be updated.

Assurances - update the date on the Internal Audit plan.
Remove Moving to Good Programme, this had been discontinued.
Add MIAA governance registers.

Gaps in Controls – This was updated to reflect the current approach by the CQC in relation to inspections.

After considering the updates listed above and the fact the Well Led actions are yet to be implemented, the Committee recommended a change in the current risk rating to increase the likelihood to 3, thus increasing the risk to a 12 (high) rating.

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

The Quality & Safety Committee met on 21 April 2022 and the following changes are recommended.

Audits – the Quality Spot Check was added with its finding of significant assurance

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 21 April 2022 and no changes were recommended.

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 28 April 2022, as this was an extra meeting a thorough review of the BAF did not occur and no updates were required.

The Committee also met on 19 May 2022. The rationale for current score was updated to reflect the planned deficit and the removal of Covid-19 funding. The Gaps in Control section has been updated to show the current position. The risk rating remained the same.

2.5 **BAF5 – Staff engagement and morale**

The People & OD Committee met on 11 May 2022 and the following change was agreed:

Assurances – Staff survey to be added as the Trust has retained the score for staff engagement.

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 21 April 2022 and no changes were recommended.

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

The People & OD Committee met on 11 May 2022 and no further following changes were proposed:

2.7 **BAF7 – Strategy and organisational sustainability**

The Finance & Performance Committee met 28 April 2022, as this was an extra meeting a thorough review of the BAF did not occur and no updates were required.

The Committee also met on 19 May 2022 when 'Warrington Discharge Mandate' was added to the assurance section and references to the STP removed.

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

The Finance & Performance Committee met 28 April 2022, as this was an extra meeting a thorough review of the BAF did not occur and no updates were required.

The Committee also met on 19 May 2022 when this BAF was discussed at length. The Director of Finance was asked to return with a full update of this risk.

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 30 May 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 3 (L) = 12, **high** 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) May 2022 – V0.1

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 3 (L) = 12, **high** Target risk rating: 4(C) x 2 (L) = 8, **medium**12	**CAUTIOUS**

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Executive Officer Deputy CEO / Chief Nurse Last reviewed: April 2022 Audit Committee Last reviewed: April 2022 Risk Ratings reviewed: April 2022	**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 including those caused by the pandemic. **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 Well Led actions not fully implemented.	**Prevent Controls** • Trust Board • Governance structure approved by the Board, SFIs and Scheme of Reservation and Delegation • Operational management structure and policies and procedures are in place • Board Assurance Framework & Risk Register **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 • Staff Survey – improving position in relation to raising concerns and those being addressed **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 22/23 • Leader in Me • CQC Well Led programme • External independent Well Led review • Daily automated data reporting • Governance Structure • Declarations of Interests Register • MIAA governance registers • 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 (2021/22) • DSPT Audit – substantial / moderate assurance (2021/21)

Gaps in controls and assurance: (and mitigating actions)
2018 CQC rating 'requires improvement' remains due to changes to inspections. CQC not due to inspect as no concerns have been raised in relation to the Trust.

Board Assurance Framework (BAF) May 2022 – V0.1

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: April 2022 Quality & Safety Committee Last reviewed: April 2022 Risk Ratings reviewed: April 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	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 – Significant 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) May 2022 – V0.1

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 Absence Management Audit – Significant Assurance (2019/20)

Gaps in controls and assurance: (and mitigating actions)
Controlled re-deployment to support priority 1 services

Board Assurance Framework (BAF) May 2022 – V0.1

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: May 2022 Finance & Performance Committee last reviewed: May 2022 Risk Ratings reviewed: May 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 due to be removed. Planned deficit for 2022/23. System pressures may result in increased deficit.	**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)

The plans for 2022/23 have been submitted to both HCP and NHSE/I. The deficit plan submitted is driven by restoration and recovery costs for services that do not qualify for additional funding from the Elective Recovery Fund in 2022/23. There is a further submission due in mid-June and further changes to the plan may be required to reflect the organisational impact of the underlying ICS financial deficit.

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 and the Trust is utilising the HfMA best practice guide -" Improving NHS financial stability – are you getting the basics right?" to benchmark against best practice.

Board Assurance Framework (BAF) May 2022 – V0.1

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: March 2022 People Committee Last reviewed: March 2022 Risk Ratings reviewed: March 2022	**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 • Staff Survey – sustained score for staff engagement **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) May 2022 – V0.1

BAF 6: Staffing levels	TRUST OBJECTIVES: • Equality, diversity and inclusion • People • Quality	RISK RATING: 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**	RISK APPETITE: CAUTIOUS - OPEN

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Operating Officer Last review: April 2022 Quality & Safety Committee Last review: April 2022 People Committee: March 2022 Risk Ratings reviewed: April 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) May 2022 – V0.1

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) = 12, **high** 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: May 2022 F&P Committee Last reviewed: May 2022 Risk Ratings reviewed: May 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 the development of the Integrated Care Boards 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 • Warrington Support Discharge Mandate
Gaps in controls and assurance: (and mitigating actions) None			

Board Assurance Framework (BAF) May 2022 – V0.1

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: May 2022 F&P Committee Last reviewed: May 2022 Risk Ratings reviewed: May 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	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

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) May 2022 – V0.1

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 9 June 2022

Board Part Public

Agenda item 35/22

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	9 June 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, joined the Chief Executive on his visit to the dental team based at the Fountains in Chester in April. Karen also joined the Chief Executive on his Time to Talk session with the team at Padgate House.

Karen attended the meeting with Amanda Doyle, North West Regional Director on her visit to the Trust on 14 April.

During the months of April and May, Karen attended various Cheshire & Merseyside meetings – Trust Chairs, Shadow ICB and ICS Finance Committee. In May, Karen also attended the NHS Providers North West Regional meeting and the Race Inclusion Network.

As part of the annual appraisal process, Karen completed these for all the Non-Executive Directors, the Chief Executive and the Trust Secretary.

1.2 Non-Executive Director, Linda Chivers attended the Trust's Council of Governors meeting, which was followed by an informal session for Governors and NEDs on clinical governance complaints. Linda also attended a Good Governance NED session on NHS Estates and a MIAA Cheshire & Merseyside Audit Chairs' Forum.

1.3 Non-Executive Director, Tina Wilkins attended the Just Culture Board session held on 25 April as well as the Board Time-Out session with the Good Governance Institute on 5 May. Tina also attended the last Council of Governors meeting and also the development session on 13 April. A Voice of the Child Forum meeting took place on 26 April which Tina also attended.

1.4 Non-Executive Director, Gail Briers attended the Warrington and Halton Governors meeting. As Chair of the Quality & Safety Committee meeting, Gail had an introductory meeting with Suzanne Mackie, Director of Quality Governance, and she took part in the interview for the Medical Appraisal Lead with the Medical Directors.

2.0 EXECUTIVE UPDATE

2.1 On 14 April, Amanda Doyle OBE, North West Regional Director took time out of her busy schedule to visit the Trust, which took place at Widnes Health Care Resource Centre. Presentations were given by staff on the work being undertaken in respect of health inequalities and place-based service delivery and partnership. Amanda then met the clinical teams in the Urgent Treatment Centre and the Halton Intermediate Care & Frailty Service. Amanda confirmed that she was very impressed by what she had heard and particularly by the passion and commitment shown by the teams.

2.2 The Chief Executive accepted a kind invitation received from Andy Carter MP for the Trust to be a sponsor at the Warrington Apprenticeship, Training & Jobs Fair, which took place on 29 April. This was a community-based event, alongside other local businesses to encourage and support people into work. This is a key priority for the Trust, having received national recognition for the work undertaken in offering apprenticeship opportunities to the communities we serve.

2.3 On 4 May the Chief Executive gave a presentation to the Directors' of Nursing, Midwifery and AHP Event on the Cheshire & Merseyside Mental Health, Learning Disability and Community Provider Collaborative.

2.4 The Chief Executive commenced the 2022 Executive Team appraisal process at the beginning of May. As part of the process, each director was asked to seek feedback from Board members and a selected number of governors and staff to inform their appraisal.

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.

The following Time to Talk sessions were held in April and May:

2.4.2 The Chief Executive met with the team based at Padgate House on 10 May. In addition, the Chief Executive and the Chair undertook a visit to The Fountains Dental Clinic on 11 April.

2.4.3 On 6 April, the Director of Finance accompanied the Chair to meet with the Equipment Services Team based at Europa Point. He also held a virtual meeting with the St Helens Audiology Team on 11 May.

2.4.4 The Chief Operating Officer met virtually with the Warrington Family Nurse Partnership on 17 May.

2.4.5 Medical Director, Ted Adams held a virtual meeting with the IT Services team on 20 April.

2.4.6 Medical Director, Aruna Hodgson met via Teams with the Dental Team based at Bath Street on 17 May.

2.4.7 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 A Board Time-Out took place on 5 May. The session focused on how the Trust adds value to the lives of the population and serve the system in which it works; how the Trust can continue to provide quality services and continuously develop the ways in it works specifically focussing on clinical leadership by empowering the frontline.

3.0 DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

3.1 During April and May 2022, seven time to talk sessions took place.

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

"Dedicated team with high level of clinical expertise. Great team spirit. Good leadership, staff happy to feedback on strong support they get from the Clinical Director, and vice versa. Mutual appreciation of each other roles, support each other, strong team bonding. Proud of what they do as a team. Keen to support younger dentists to develop specialist skills through training, mentoring & on the job learning. Flexibility/ adaptability during Covid -several staff redeployed to other roles e.g. swabbing, vaccination, & have seen this as positively as an opportunity to learn new skills, work with different colleagues & understand more about different parts of the Trust."

"Team were open and frank with challenges they face. However I was most impressed with the way they looked after each other, and demonstrate true compassion amongst the team."

4.0 EXTERNAL PUBLICATIONS AND REPORTS

4.1 **Integration and Innovation in action: provider collaboration**
An in-depth look has been published by NHS Confederation into how collaborations between providers at neighbourhood, place and system level are making a positive impact on patient care.
Integration and innovation in action: provider collaboration | NHS Confederation

4.2 **Provider collaboratives: explaining their role in system working (King's Fund)**
This article by the King's Fund looks at provider collaboratives in England, the opportunities they provide and the unresolved questions to consider when thinking about their role in the changing health and care landscape. It describes different models used for collaboratives that have been developed.
Provider collaboratives: explaining their role in system working | The King's Fund (kingsfund.org.uk)

4.3 **ICS Engagement with the Adult Social Care Sector in Decision Making**: a report by GGI, Care England and the Homecare Association.
ICS Engagement with the Adult Social Care Sector in Decision Making: a report by

GGI, Care England and the Homecare Association | Good Governance (good-governance.org.uk)

4.4 **NHS Providers responds to Royal College of Physicians poll on cost-of-living impact on health.**
NHS Providers responds to Royal College of Physicians poll on cost of living impact on health - NHS Providers

4.5 **Next steps for integrating primary care: Fuller Stocktake report**
https://www.england.nhs.uk/wp-content/uploads/2022/05/next-steps-for-integrating-primary-care-fuller-stocktake-report.pdf

5.0 RECOMMENDATIONS

5.1 The Board is asked to note the report.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Bridgewater Board Date 9 June 2022

Board Part Public

Agenda item 36/22i

Title	Integrated Quality Performance Report – Month 12
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 12 March 2022
Previously considered at	Finance and Performance Committee – May 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?	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: March 2022 (Month 12)

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 March 2022.

Within this report

Bridgewater Community Healthcare NHS Foundation Trust

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.

Trust Overview

Executive Summary

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

Responsive (Operations)

There are new red indicators in month in relation to the Widnes Urgent Treatment Centre, these have been green throughout the pandemic and so close monitoring will be required moving forwards.

The dermatology service continues to be a significant challenge in terms of operational 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 more effectively manage the referrals into the service and there has been some improvement in the dermatology indicators in month.

There is some improvement in the position around the 104+week dental waiters and there is a plan in place to have these cleared during July. The number of patients waiting for minor oral surgery has continued to increase.

All operational red indicators are being monitored by the operational teams and plans are in place to improve the performance of these indicators.

Safe, High-Quality Care (Quality)

There is no significant change in the quality indicators in month. There is one new indicator reporting as red indicators which is in relation to the family and friend's test.

People

Four of the five people indicators are red in month. All the red indicators have deteriorated slightly in month.

Making Good Use of Resources (Finance)

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

Operations

Executive Summary

Of the 19 Operations indicators which are reported; ten are red and eight are green and one is no longer being measured as the service is not provided in the Trust.

The indicators that have changed from green to red in month are:

- Cancellations by patient
- A&E: Total time in A&E (% of pts who have waited <= 4hrs).
- Total time in A&E - 95th Percentile.

The indicators that have changed from red to green in month are:

- Warrington Dermatology Cancer 31-day 2nd treatment comprising surgery.
- Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment.

The remaining seven indicators which were also red in March are as follows:

- 28-day Cancer Faster Diagnosis – improvement in month
- Referrals to Plan – improvement in month
- Cancellations by service – deteriorated in month
- Percentage of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway) – improvement in month
- Warrington Audiology - Number of 6 weeks diagnostic breaches – deterioration in month
- Warrington Activity Variance – slight improvement in month
- Halton Activity Variance - slight improvement in month.

Overall, there is not a significant change in the position in relation to the operational indicators reported against, however the performance in relation to the Widnes Urgent Treatment Centre will be monitored closely as these indicators have deteriorated for the first time in month.

Operations

Actions:

Indicator	Action	Target date	Responsible Committee
% of patients waiting under 18 weeks	Only two 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 / Finance and Performance Committee

Operations

Bridgewater Community Healthcare NHS Foundation Trust

Trust Scorecard

Operations															
Code	KPI Name	Target	Trend Line	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93.00%		100% (▲)	100% (►)	100% (►)	100% (►)	98.85% (▼)	97.07% (▼)	95.22% (▼)	98.08% (▲)	94.01% (▼)	96.58% (▲)	97.97% (▲)	95.98% (▼)	93.97% (▼)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94.00%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	66.67% (▼)	100% (▲)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96.00%		100% (▲)	88.24% (▼)	100% (▲)	92.86% (▼)	87.5% (▼)	100% (▲)	83.33% (▼)	100% (▲)	92.86% (▼)	76.92% (▼)	93.33% (▲)	52.94% (▼)	100% (▲)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85.00%		100% (▲)	85.71% (▼)	83.33% (▼)	86.96% (▲)	100% (▲)	100% (►)	91.3% (▼)	80% (▼)	91.67% (▲)	86.96% (▼)	100% (▲)	92% (▼)	86.67% (▼)
OP22	28 day faster diagnosis	75.00%		71.23% (▲)	65.71% (▼)	58.24% (▼)	77.18% (▲)	68.42% (▼)	60.14% (▼)	71.43% (▲)	58.26% (▼)	59.22% (▲)	62.02% (▲)	52.33% (▼)	54.59% (▲)	60.21% (▲)
OP06	Referrals to plan	95.00%		74.03% (▲)	77.12% (▲)	80.84% (▲)	80.31% (▼)	78.83% (▼)	77.97% (▼)	77.7% (▼)	78% (▲)	77.89% (▼)	78.73% (▲)	77.74% (▼)	77.93% (▲)	76.51% (▼)
OP07	Cancellations by service	5.00%		9.02% (▼)	7.69% (▲)	9.07% (▼)	8.36% (▲)	9.23% (▼)	8.82% (▲)	7.77% (▲)	11.92% (▼)	12.99% (▼)	14.06% (▼)	9.27% (▲)	8.7% (▲)	4.04% (▲)
OP08	Cancellations by Patient	5.00%		2.84% (▼)	5.81% (▼)	6.12% (▼)	6.64% (▼)	6.93% (▼)	4.91% (▲)	5.01% (▼)	4.83% (▲)	5.06% (▼)	5.06% (▼)	4.66% (▲)	4.66% (▼)	5.9% (▼)
OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92.00%		57.5% (▼)	59.13% (▲)	72.87% (▲)	86.17% (▲)	88.46% (▲)	81.65% (▼)	76.32% (▼)	67.19% (▼)	60.74% (▼)	56.49% (▼)	53.79% (▼)	54.5% (▲)	60.01% (▲)
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		100% (▲)	99.95% (▼)	99.92% (▼)	100% (▲)	99.96% (▼)	99.96% (►)	99.29% (▼)	97.93% (▼)	98.85% (▲)	99.05% (▲)	99.23% (▲)	97.61% (▼)	94.16% (▼)
OP12	Total time in A&E - 95th Percentile	4 Hrs		01:27 (▲)	01:27 (▼)	01:48 (▼)	01:41 (▲)	01:47 (▼)	01:53 (▼)	02:07 (▼)	03:12 (▼)	02:59 (▲)	02:56 (▲)	02:47 (▲)	03:19 (▼)	04:07 (▼)
OP13	A&E Time to treatment decision (median) <=60 mins	60 Mins		00:03 (▲)	00:03 (▼)	00:04 (▼)	00:04 (▲)	00:05 (▼)	00:05 (▲)	00:05 (▼)	00:07 (▼)	00:06 (▲)	00:05 (▲)	00:05 (▼)	00:06 (▼)	00:18 (▼)
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% (▲)	0.02% (▼)	0% (▲)	0.1% (▼)	0.02% (▲)	0% (▲)	0% (►)	0.11% (▼)	0.1% (▲)	0.14% (▼)	0.07% (▲)	0.03% (▲)	0.13% (▼)
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches	0		73 (▲)	49 (▲)	47 (▲)	27 (▲)	49 (▼)	6 (▲)	8 (▼)	0 (▲)	0 (►)	2 (▼)	14 (▼)	1 (▲)	2 (▼)
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score	95%		95.2% (▼)	95.41% (▲)	94.97% (▼)	94.9% (▼)	94.81% (▼)	94.81% (▲)	94.78% (▼)	99.53% (▲)	99.52% (▼)	99.53% (▲)	99.53% (▲)	99.52% (▼)	99.67% (▲)
OP18	Halton Maternity Dashboard - Number of red rated areas	0		0 (▲)	0 (►)	1 (▼)	0 (▲)	1 (▼)	2 (▼)	2 (►)	2 (►)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)
OP19	Warrington Activity Variance	3%		-28.24% (▼)	-26.41% (▲)	-23.21% (▲)	-24.02% (▼)	-24.84% (▼)	-24.33% (▲)	-24.28% (▲)	-24.87% (▼)	-23.58% (▲)	-23.72% (▼)	-23.17% (▲)	-23.2% (▼)	-23.17% (▲)
OP20	Halton Activity Variance	3%		-21.74% (▲)	-10.9% (▲)	-6.24% (▲)	-4.17% (▲)	-5.18% (▼)	-5.9% (▼)	-5.43% (▲)	-5.27% (▲)	-5.81% (▼)	-3.46% (▲)	-7.87% (▼)	-8.27% (▼)	-91.49% (▼)

Operations: Exception Reporting

Flagged Indicators

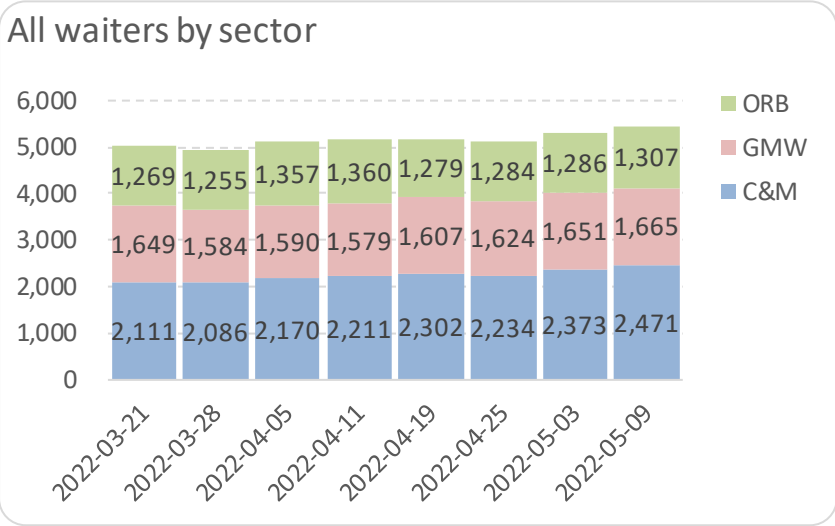
Operations			
OP07	Cancellations by service		Points above upper control limit
OP08	Cancellations by Patient		Points above upper control limit
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)		Points below lower control limit
OP12	Total time in A&E - 95th Percentile		Point above upper control limit
OP13	A&E Time to treatment decision (median) <=60 mins		Point above upper control limit
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches		Point above upper control limit

Operations: Exception Reporting

OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score		Point below lower control limit
OP19	Warrington Activity Variance		Points below lower control limit
OP20	Halton Activity Variance		Points below lower control limit

Operations: Exception Reporting

SPC Charts – Dental



Issue

Dental - Patients waiting by Sector

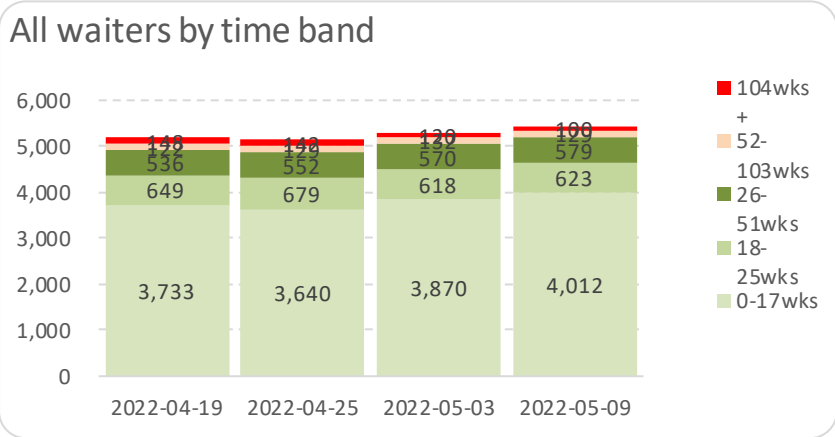
The number of patients waiting for dental treatment has increased in all sectors but most significantly in Cheshire and Merseyside.

During the pandemic referrals in Cheshire and Merseyside were put on hold and only urgent activity was managed. Now the referral pathways are open the number of referrals has increased and the number of patients waiting to be seen in Cheshire and Merseyside has increased by 17% since March.

Waiting list numbers in Greater Manchester West and Oldham, Rochdale and Bury have only increased slightly.

Operations: Exception Reporting

SPC Charts - Dental



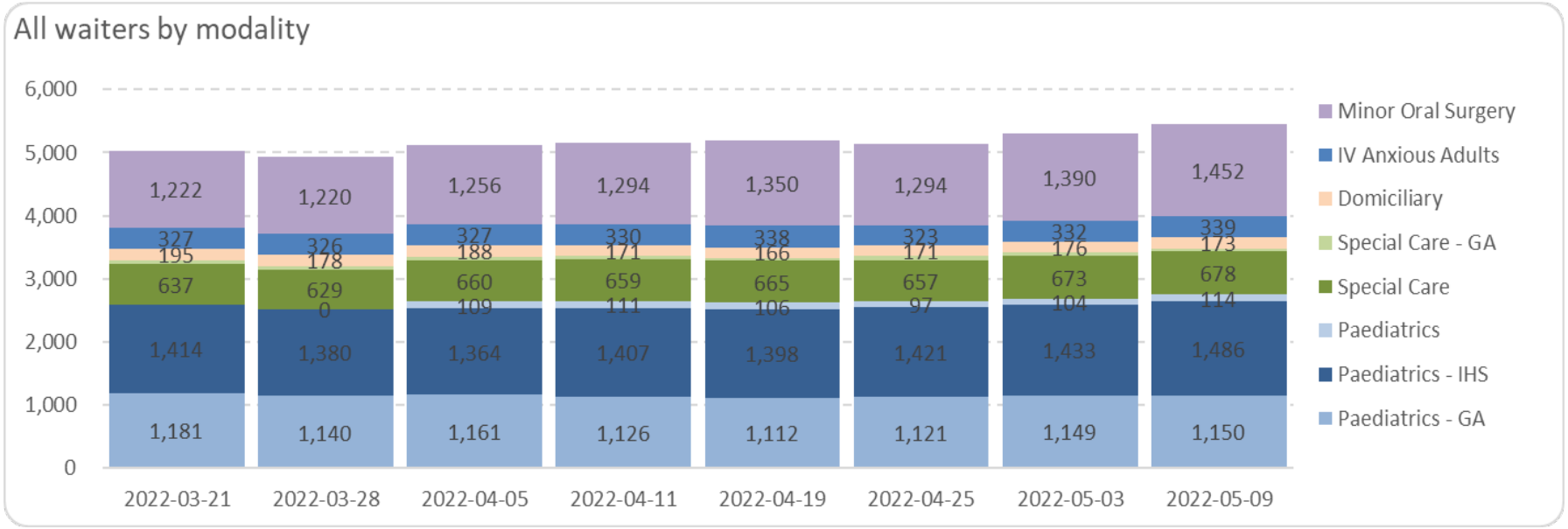
Date	0-17wks	18-25wks	26-51wks	52-103wks	104wks+
2022-03-21	3,572	653	434	131	239
2022-03-28	3,498	653	444	124	206
2022-04-05	3,661	642	493	124	197
2022-04-11	3,685	646	520	124	175
2022-04-19	3,733	649	536	122	148
2022-04-25	3,640	679	552	129	142
2022-05-03	3,870	618	570	132	120
2022-05-09	4,012	623	579	129	100

Issue – **Waiters by time band**

The number of patients waiting 104 weeks plus has fallen steadily over the last few months to 100. There are plans in place to clear all of the 104 week waiters by the end of July.

Operations: Exception Reporting

SPC Charts - Dental



Issue

Dental - Patients waiting by treatment

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

3 Quality

Executive Summary

There are eight Quality indicators reporting as red in March 2022. This is an increase of one red indicator from the previous month.

The new red indicator in month is:

- Friends and Family Test

The remaining seven indicators which were red in March are as follows:

- Percentage of Incidents Low impact Level 1-2 – deterioration in month
- Information Governance Training – improvement in month
- Safeguarding Children Level 2 Training – improvement in month
- Safeguarding Children Level 3 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 – remains the same

Actions:

Indicator	Action	Target date	Responsible Committee
Safeguarding Level 3 – Children's and Adults	Staff to be supported to participate in training.	June 2022	Borough/Directorate Director and Clinical Managers

Quality: Exception Reporting

Trust Scorecard

Quality															
Code	KPI Name	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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		171 (▼)	149 (▲)	157 (▼)	165 (▼)	165 (►)	148 (▲)	134 (▲)	167 (▼)	141 (▲)	121 (▲)	170 (▼)	129 (▲)	141 (▼)
QU03	% of incidents High impact Level 3-5	7.88%		2.34% (▼)	1.34% (▲)	0.64% (▲)	1.21% (▼)	1.82% (▼)	2.03% (▼)	3.73% (▼)	0.6% (▲)	0.71% (▼)	2.48% (▼)	1.76% (▲)	0.78% (▲)	2.13% (▼)
QU04	% Of Incidents Low impact Level 1-2	68.97%		84.21% (▼)	85.23% (▼)	79.62% (▲)	78.79% (▲)	80% (▼)	72.97% (▲)	82.09% (▼)	76.65% (▲)	78.01% (▼)	80.99% (▼)	77.65% (▲)	86.05% (▼)	89.36% (▼)
QU05	Number of Serious Incidents Reported	9		4 (▼)	1 (▲)	1 (►)	2 (▼)	3 (▼)	3 (►)	3 (►)	5 (▼)	0 (▲)	4 (▼)	2 (▲)	4 (▼)	4 (►)
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%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	75% (▼)	100% (▲)	100% (►)	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		12 (▲)	14 (▼)	8 (▲)	13 (▼)	11 (▲)	9 (▲)	21 (▼)	20 (▲)	25 (▼)	10 (▲)	21 (▼)	16 (▲)	16 (►)
QU11	Medication Errors That Caused Harm	6		0 (►)	1 (▼)	0 (▲)	0 (►)	2 (▼)	0 (▲)	0 (►)	3 (▼)	0 (▲)	1 (▼)	2 (▼)	0 (▲)	0 (►)
QU12	Medical Device Incidents	14		20 (▼)	10 (▲)	13 (▼)	17 (▼)	9 (▲)	1 (▲)	4 (▼)	15 (▼)	7 (▲)	10 (▼)	10 (►)	6 (▲)	3 (▲)
Training Compliance																
QU13	Information Governance	95.00%		79.6% (▼)	82.72% (▲)	78.66% (▼)	83.15% (▲)	81.56% (▼)	83.59% (▲)	82.74% (▼)	81.22% (▼)	80.1% (▼)	79.84% (▼)	79.51% (▼)	83.91% (▲)	85.15% (▲)
QU14	Safeguarding Childrens Level 1	85.00%		90.05% (▲)	90.41% (▲)	88.24% (▼)	82.54% (▼)	85.6% (▲)	84.3% (▼)	85.42% (▲)	83.62% (▼)	80.11% (▼)	85.91% (▲)	86.11% (▲)	86.97% (▲)	86.78% (▼)
QU15	Safeguarding Childrens Level 2	85.00%		86.78% (▲)	87.69% (▲)	86.46% (▼)	86.89% (▲)	84.51% (▼)	84.2% (▼)	83.93% (▼)	81.6% (▼)	73.37% (▼)	74.21% (▲)	73.67% (▼)	72.82% (▼)	73.09% (▲)
QU16	Safeguarding Childrens Level 3	85.00%		80.69% (▲)	81.01% (▲)	80.29% (▼)	81.12% (▲)	65.38% (▼)	65.63% (▲)	76.42% (▲)	74.11% (▼)	84.3% (▲)	85.3% (▲)	85.33% (▲)	84.47% (▼)	84.2% (▼)
QU17	Safeguarding Adults Level 1	85.00%		93.35% (▲)	93.69% (▲)	91.58% (▼)	90.96% (▼)	89.58% (▼)	88.98% (▼)	88.04% (▼)	87.35% (▼)	86.24% (▼)	86.13% (▼)	86.98% (▲)	87.9% (▲)	87.91% (▲)
QU18	Safeguarding Adults Level 2	85.00%		88.46% (▲)	88.77% (▲)	86.97% (▼)	87.74% (▲)	85.38% (▼)	85.09% (▼)	82.76% (▼)	80.14% (▼)	80.2% (▲)	79.09% (▼)	77.84% (▼)	75.62% (▼)	74.6% (▼)
QU19	Safeguarding Adults Level 3	85.00%		40.73% (▼)	42.4% (▲)	44.59% (▲)	45.06% (▲)	33.58% (▼)	33.98% (▲)	35.19% (▲)	33.02% (▼)	44.93% (▲)	44.98% (▲)	46.97% (▲)	47.01% (▲)	47.24% (▲)
Risks																
QU20	Total Number of risks	258		227 (▲)	236 (▼)	234 (▲)	237 (▼)	230 (▲)	227 (▲)	222 (▲)	209 (▲)	211 (▼)	213 (▼)	204 (▲)	204 (►)	204 (►)
QU21	Total Number of risks identified as High	111		100 (▲)	104 (▼)	103 (▲)	102 (▲)	98 (▲)	98 (►)	103 (▼)	100 (▲)	101 (▼)	99 (▲)	104 (▼)	104 (►)	104 (►)
QU22	Percentage of risks identified as High	44.02%		44.05% (▼)	44.07% (▼)	44.02% (▲)	43.04% (▲)	42.61% (▲)	43.17% (▼)	46.4% (▼)	47.85% (▼)	47.87% (▼)	46.48% (▲)	50.98% (▼)	50.98% (►)	50.98% (►)
QU23	Total Number of risks identified as High 12	57		32 (▲)	32 (►)	31 (▲)	33 (▼)	31 (▲)	32 (▼)	29 (▲)	26 (▲)	25 (▲)	27 (▼)	22 (▲)	22 (►)	22 (►)
QU24	Percentage of risks identified as High 12	15.17%		14.1% (▼)	13.56% (▲)	13.25% (▲)	13.92% (▼)	13.48% (▲)	14.1% (▼)	13.06% (▲)	12.44% (▲)	11.85% (▲)	12.68% (▼)	10.78% (▲)	10.78% (►)	10.78% (►)
QU25	Total Number of risks identified as Extreme	21		5 (▲)	9 (▼)	5 (▲)	3 (▲)	2 (▲)	4 (▼)	3 (▲)	5 (▼)	4 (▲)	4 (►)	4 (►)	4 (►)	4 (►)
QU52	Percentage of risks identified as Extreme	4.69%		2.2% (▲)	3.81% (▼)	2.14% (▲)	1.27% (▲)	0.87% (▲)	1.76% (▼)	1.35% (▲)	2.39% (▼)	1.9% (▲)	1.88% (▲)	1.96% (▼)	1.96% (►)	1.96% (►)

Quality: Exception Reporting

Bridgewater Community Healthcare NHS Foundation Trust

Quality																
Code	KPI Name	Target	Trend Line	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Falls (Bridgewater)																
QU26	Total Number of falls	23		7 (▲)	8 (▼)	17 (▼)	14 (▲)	10 (▲)	12 (▼)	10 (▲)	17 (▼)	11 (▲)	9 (▲)	17 (▼)	10 (▲)	18 (▼)
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		3.86 (▲)	4.76 (▼)	10.93 (▼)	11.43 (▼)	5.72 (▲)	11.28 (▼)	8.92 (▲)	10.89 (▼)	6.93 (▲)	7.93 (▼)	13.88 (▼)	6.39 (▲)	13.26 (▼)
QU29	Percentage of overall falls that are bed based	88.28%		57.14% (▼)	62.5% (▼)	70.59% (▼)	85.71% (▼)	60% (▲)	100% (▼)	70% (▲)	64.71% (▲)	72.73% (▼)	88.89% (▼)	82.35% (▲)	50% (▲)	77.78% (▼)
QU30	Total Number of Community Falls	11		3 (▲)	3 (►)	5 (▼)	2 (▲)	4 (▼)	0 (▲)	3 (▼)	6 (▼)	3 (▲)	1 (▲)	3 (▼)	5 (▼)	4 (▲)
QU31	Percentage of overall falls that are community falls	55.01%		42.86% (▲)	37.5% (▲)	29.41% (▲)	14.29% (▲)	40% (▼)	0% (▲)	30% (▼)	35.29% (▼)	27.27% (▲)	11.11% (▲)	17.65% (▼)	50% (▼)	22.22% (▲)
Pressure Ulcers																
QU32	Total Number of Category 2 Pressure Ulcers acquired in Bridgewater	44		37 (▼)	30 (▲)	29 (▲)	27 (▲)	38 (▼)	20 (▲)	20 (►)	32 (▼)	24 (▲)	32 (▼)	25 (▲)	17 (▲)	22 (▼)
QU33	Total Number of Category 3 Pressure Ulcers acquired in Bridgewater	5		0 (▲)	2 (▼)	1 (▲)	0 (▲)	1 (▼)	1 (►)	0 (▲)	3 (▼)	0 (▲)	1 (▼)	0 (▲)	0 (►)	2 (▼)
QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater	2		0 (►)	1 (▼)	0 (▲)	1 (▼)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	2 (▼)	2 (►)	0 (▲)	1 (▼)
QU35	Total Number of Unstageable Pressure Ulcers acquired in Bridgewater	3		2 (▼)	1 (▲)	0 (▲)	1 (▼)	2 (▼)	1 (▲)	2 (▼)	1 (▲)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)

Quality																
Code	KPI Name	Target	Trend Line	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-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%		99.32% (▼)	98.85% (▼)	99.09% (▲)	97.8% (▼)	97.9% (▲)	97.15% (▼)	98.01% (▲)	98.45% (▲)	98.48% (▲)	98.61% (▲)	98.72% (▲)	97.22% (▼)	94.97% (▼)
QU42	Number of Complaints	9		6 (▼)	5 (▲)	5 (►)	5 (►)	3 (▲)	2 (▲)	1 (▲)	4 (▼)	3 (▲)	1 (▲)	6 (▼)	4 (▲)	3 (▲)
QU44	Patient Experience - Dignity and Respect	95.00%		100% (►)	100% (►)	100% (►)	100% (►)	99.29% (▼)	100% (▲)	99.31% (▼)	99.71% (▲)	99.8% (▲)	99.49% (▼)	100% (▲)	99.19% (▼)	99.72% (▲)
QU45	Patient Experience - Information / Communication	95.00%		100% (►)	99.35% (▼)	100% (▲)	100% (►)	98.7% (▼)	98.92% (▲)	98.8% (▼)	99.71% (▲)	99.49% (▼)	99.33% (▼)	99.03% (▼)	98.39% (▼)	98.58% (▲)
QU46	Patient Experience - Access/Waiting Time	95.00%		99.32% (▼)	98.04% (▼)	97.36% (▼)	97.76% (▲)	97.05% (▼)	97.23% (▲)	96.74% (▼)	97.37% (▲)	97.34% (▼)	97.98% (▲)	99.03% (▲)	97.9% (▼)	96.51% (▼)
Patient Experience																
QU51	CQUIN - Data Quality Maturity Index (DQMI) MHSDS quarterly score	95.00%		95.2% (▼)	95.41% (▲)	94.97% (▼)	94.9% (▼)	94.81% (▼)	94.81% (▲)	94.78% (▼)	99.53% (▲)	99.52% (▼)	99.53% (▲)	99.53% (▲)	99.52% (▼)	99.67% (▲)

Quality: Exception Reporting

Flagged Indicators

Quality			
QU04	% Of Incidents Low impact Level 1-2		Point above upper control limit
QU13	Information Governance Training		Point above upper control limit
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

Quality: Exception Reporting

QU22	Percentage of risks identified as High		Points above upper control limit
QU23	Total Number of risks identified as High 12		14 points in a row below the mean

4 People

Bridgewater Community Healthcare NHS Foundation Trust

Executive Summary

Four of the five People indicators are shown as red in March 2022.

The four indicators which were red in March are as follows:

- Staff turnover (rolling) – deterioration in month
- Percentage Overall organisation sickness rate (rolling) – deterioration in month
- Sickness absence rate (actual) – deterioration in month
- Percentage of staff with current PDR – deterioration in month

Actions:

Indicator	Action	Target date	Responsible Committee

People

Trust Scorecard

People																		
Code	KPI Name	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
PO01	% Headcount of new starters attending induction programme	95.00%		91.43% (▲)	91.35% (▼)	91.97% (▲)	93.16% (▲)	99.65% (▲)	99.59% (▼)	99.53% (▼)	99.41% (▼)	99.29% (▼)	99.71% (▲)	99.47% (▼)	99.3% (▼)	99.58% (▲)
PO02	Staff turnover (rolling)	8.00%		9.67% (▲)	9.76% (▼)	10.08% (▼)	10.65% (▼)	10.57% (▲)	11.95% (▼)	12.4% (▼)	14.71% (▼)	14.56% (▲)	14.68% (▼)	15.56% (▼)	15.36% (▲)	27.69% (▼)
PO03	% Overall Organisation Sickness rate (rolling)	4.80%		5.27% (▲)	5.27% (▲)	5.32% (▼)	5.44% (▼)	5.56% (▼)	5.68% (▼)	5.84% (▼)	5.92% (▼)	5.98% (▼)	6.25% (▼)	6.45% (▼)	6.67% (▼)	6.83% (▼)
PO04	Sickness absence rate (Actual)	4.80%		5.18% (▼)	5.55% (▼)	6.21% (▼)	6.14% (▲)	6.52% (▼)	6.13% (▲)	6.59% (▼)	6.84% (▼)	6.22% (▲)	7.69% (▼)	7.2% (▲)	6.67% (▲)	6.98% (▼)
PO05	% of staff with a current PDR	85.00%		26.63% (▲)	25.57% (▼)	25.4% (▼)	26.77% (▲)	31.59% (▲)	38.3% (▲)	43.38% (▲)	47.54% (▲)	52.45% (▲)	54.16% (▲)	53.89% (▼)	57.32% (▲)	56.94% (▼)

People

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

Finance

Month Twelve Finance Report

Introduction

The purpose of this paper is to update the Committee on the financial position of the Trust at the end of March 2022 (Month 12). 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.

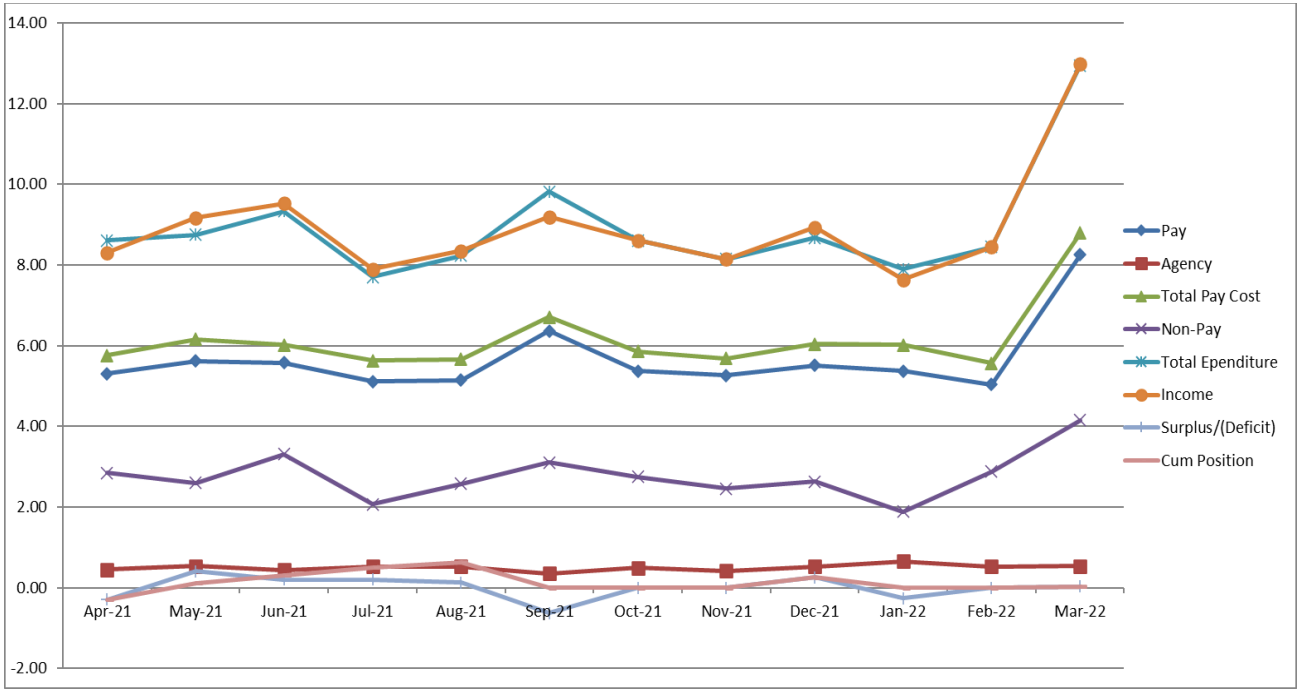
Summary Performance Month 12 2021-22	Month 12 Plan (£M)	Month 12 Actual (£M)	Month 12 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.22)	(12.98)	4.75	(101.01)	(107.18)	6.17	(101.01)	(107.18)
Expenditure - Pay	5.18	8.25	(3.07)	66.13	67.92	(1.79)	66.13	67.92
Expenditure - Agency	0.63	0.54	0.09	6.38	5.97	0.42	6.38	5.97
Expenditure - Non Pay	2.30	4.44	(2.14)	28.65	33.49	(4.84)	28.65	33.49
EBITDA	(0.12)	0.25	(0.37)	0.15	0.20	(0.05)	0.15	0.20
Financing	0.00	0.00	(0.00)	0.17	0.06	0.11	0.17	0.06
Normalised (Surplus)/Deficit	(0.12)	0.25	(0.37)	0.32	0.26	0.06	0.32	0.26
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	(0.12)	0.25	(0.37)	0.32	0.26	0.06	0.32	0.26
Other Adjustments	0.00	(0.18)	0.18	(0.32)	(0.28)	(0.03)	(0.32)	(0.28)
Adjusted Net (Surplus)/Deficit	(0.12)	0.08	(0.20)	0.00	(0.03)	0.03	0.00	(0.03)
CIP	0.21	0.21	0.00	2.16	2.16	0.00	2.16	2.16
Capital	0.23	0.81	(0.58)	1.96	1.85	0.11	1.96	1.85
Cash	4.52	26.15	21.64	4.52	26.15	21.64	19.80	26.15
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Favourable Variance Adverse Variance

Finance

Key Headlines

Run Rates to Month 12 2021/22



5 Finance

Bridgewater Community Healthcare NHS Foundation Trust

Cumulative Performance against NHSE/I Plan – Breakeven to Month 12

- The Trust is reporting a small surplus of £0.03m for the year, slightly better than the plan position of breakeven.
- H2 CIP requirement is currently 2.50%. The Trust H2 plan was for 2.76% (est £1.40m). This equates to a full year plan of £2.16m, which is reported as achieved.
- FRF suspended until further notice.
- Income is £107.18m for the year - £6.17m above the plan, this includes £2.958m of notional pension contribution income matched with notional expenditure.
- Expenditure is £107.15m for the year – £6.14m above plan.
- Pay overspent by £1.79m for the year against a plan of £66.13m, due to notional pension contribution of £2.958m (offset by notional income).
- Agency spend of £5.97m for the year against a plan of £6.38m.
- Non pay expenditure is £33.49m for the year, overspent by £4.84m against a plan of £28.65m.
- Capital charges are £0.11m 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 9 June 2022

Board Part Public

Agenda item 36/22iii

Title	Ockenden Two
Sponsoring Director	Lynne Carter – Executive Director of Nursing
Authors	Lynne Carter – Executive Director of Nursing
Presented by	Lynne Carter – Executive Director of Nursing
Exec Summary/Purpose	To brief the Board on: • The Ockenden Report March 2022 Recommendations are: • In conclusion there are no gaps in the recommendations and essential actions from the Ockenden report and the Trust can evidence this. • The Board is recommended to note the Ockenden report and be assured by the Trust's systems and processes already in place together with robust audit.
Previously considered at	
Related Trust Objective/ Intentions	Quality – to deliver high quality, safe and effective care which meets both individual and community needs
Which CQC domains are supported by this report?	Caring
Which BAF risks are addressed in this report?	BAF 2 – Safe and Effective Care
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	Ockenden Report
Author	Lynne Carter – Executive Director of Nursing
Date	9 June 2022
Purpose	To brief the Board on: • The Ockenden Report March 2022
Audience	Board

1.0 Executive Summary

1.1 The purpose of this report is to brief the Board on the implications of the Ockenden report which was published on 30th March 2022.

2.0 Purpose of the Paper

2.1 The Ockenden report 30th March 2022 gave final findings, recommendations and immediate actions to be taken following extensive investigations into failings of maternity services at the Shrewsbury and Telford Hospital NHS FT (SATH).

2.2 In addition the report recommended that all Trust boards should consider the findings of the report in relation to their own services both maternity and wider across other services where they may apply. This should be done in a "timely manner".

3.0 The Ockenden Report

3.1 The Ockenden report 30th March 2022 gave final findings, recommendations and immediate actions to be taken following extensive investigations into failings of maternity services at the Shrewsbury and Telford Hospital NHS FT (SATH).

3.2 In addition the report recommended that all Trust boards should consider the findings of the report in relation to their own services both maternity and wider across other services where they may apply. This should be done in a "timely manner".

3.3 At the time of the publication of the interim report in December 2020 Bridgewater had midwifery services and all recommendations were taken forward including the development of an overarching action plan.

3.4 The midwifery services transferred in 2021 and the Ockenden Report 2022 recommendations will be considered against the current processes within Bridgewater.

3.5 The final report stated that the SATH Trust had "failed to investigate, failed to learn and failed to improve".

3.6 1592 clinical incidents were reviewed and families and staff were interviewed. The investigation found "poor investigations" and a "lack of transparency and dialogue with families".

3.7 At the time the Royal Shrewsbury hospital had a designated local neonatal unit which was operating beyond its scope as a neonatal intensive care unit and this created additional problems.

3.8 There were a number of maternal and neonatal deaths as well as poor outcomes for several babies and their families following poor management and escalation of clinical emergencies.

4.0 Findings

4.1 The failures were as follows:

- Failure to follow national guidelines, delays in escalation and failure to work collaboratively across disciplines.
- Culture of “them and us” between midwifery and obstetric staff.
- Lack of psychological safety
- Delays with staffing and training gaps.
- Ward coordinators not supernumerary
- Locum doctors were unsupported.
- Unsafe practice was not challenged.
- Trust leadership was under constant churn and change and the board did not have full oversight.
- Under reporting of incidents
- Not declaring serious incidents
- Poor staff survey results
- Poor complaints handling
- Poor quality of incident investigation
- Local concerns with statutory supervision of midwives’ investigations
- Concerns regarding clinical guidelines and clinical audit

4.2 In addition there was a lack of senior oversight into complaints with a lack of openness and transparency, with complaints responses misspelt, using inappropriate language and not addressing concerns.

4.3 Timescales were far too lengthy and staff were not competent to assess or manage. Any action plans developed were monitored by a quality improvement midwife with no oversight by the senior leadership team.

4.4 Clinical guidelines were not produced by the multi disciplinary team, not evidence based and staff were not trained to write guidelines.

4.5 There were specific issues in relation to the staff teams and how they worked together, there were few meetings where the whole team met together, and they also did not learn together as a whole team. Lessons learned from incidents were either not identified or not shared with the team and wider organisation.

4.6 Staff were investigating incidents in which they were involved where they should only form part of evidence gathering. Staff should not investigate their own practice and there was no senior oversight.

47 Staff were not trained in how to carry out investigations and investigation training should be carried out 3 yearly.

5.0 Report Recommendations

5.1 There are several recommendations included:

- Any responses to patients and families must be in lay terms language.
- There must be a standard template for incident investigation.
- Learning from incidents should be built into multi disciplinary team training.
- Patients and families should be actively involved in both complaint and incident management
- Feedback should be open and transparent and given by senior staff within the Trust
- A robust process for all safety concerns raised by staff must be in place, together with feedback
- There should be complaint themes and trends monitoring
- All staff must be trained in complaints handling
- Any action from serious incidents which involves change of practice must be audited following implementation
- Matters arising from clinical incidents must contribute to the annual audit plan
- There must be a process for keeping all guidelines up to date

5.2 Nationally the roll out of continuity of carer in midwifery has been paused to ensure all of the Ockenden recommendations are implemented and to ensure adequate staffing.

5.3 There has also been a review of safety management with the Patient Safety Incident Response Framework developed and the introduction of this starting in 2022.

5.4 There were many concerns in relation to staffing both in numbers and the roles of staff. There should be clinical educators and practice development staff in place to support the training and development of staff. In addition, there was a need for governance facilitators and training.

5.5 In terms of clinical leadership there were no consultant nurse/therapy roles and Matrons roles were needed. The need to have clinical staff at senior levels supporting and developing both staff and practice is clearly recommended.

5.6 Team and ward coordinators should be supernumerary, however were often part of the complement of staff carrying a clinical caseload which obviously reduced supervision and support to staff.

5.7 Specifically highlighted were issues in relation to team working, culture and civility and these reflected learning from other reviews such as those at Morecambe Bay maternity services. It is important to recognise the damage that can be done if staff do not respect each other and maintain professional relationships.

6.0 Incident reviews

6.1 There were several factors in the incident reviews:

- *Individual human factors in 58% cases
- *Team communication in 53% cases
- *Lack of team leadership in 24% cases
- *Poor intra and inter professional communication in 43% cases

6.2 Staff reported being afraid to raise concerns and there was no standard escalation process.

6.3 There was no use of the Situation, Background, Assessment and Recommendation (SBAR) process which is standard in most organisations and documentation was poorly recorded or was not in place at all.

7.0 Essential actions

7.1 There are five essential actions in the report:

1. Safety which is maternity specific
2. Listening to women and families which can apply to all services.
3. Staff training and working together (staff who work together must train together) which can apply to all
4. Complex pregnancy pathways which is maternity specific, but the principle applies to all clinical pathways
5. Risk assessments in pregnancy, which is maternity specific, but risk assessment applies to all patients
6. Fetal well being which is maternity specific
7. Informed consent which is maternity specific but can apply to all patients

8.0 Bridgewater Assessment Against the actions and recommendations

8.1 An initial assessment against the report has shown that the Trust has in place comprehensive, up to date processes for risk assessment and management, guideline development and monitoring, incident reporting and management including serious incidents and escalation processes.

8.2 The Trust also has comprehensive complaint management including transparency, Duty of Candour, involving patients and families, monitoring and trend reporting to Board level. There is also a patient engagement strategy and feedback mechanisms to ensure we listen to our patients.

8.3 The implementation of the E roster system and the workforce planning will ensure the right staff are recruited and retained within the Trust and we employ clinical educators and practice development staff to ensure training and development and we have competency frameworks for all roles.

8.4 Multidisciplinary working is our model with all teams working, meeting and learning together across all services and this is also clear in our guideline and pathway development.

8.5 There is a Freedom to Speak up process together with clear methods for staff to raise concerns including face to face meetings with senior and executive staff and these are monitored and acted upon.

8.6 All learning from complaints, incidents, serious incidents, and reviews is planned, implemented and audited to ensure that it achieves the desired results and this is evidenced through our audit processes.

9.0 Recommendations

9.1 In conclusion there are no gaps in the recommendations and essential actions from the Ockenden report and the Trust can evidence this.

9.2 The Board is recommended to note the Ockenden report and be assured by the Trust's systems and processes already in place together with robust audit.

Committee Chairs Report

Name of Committee/Group:	Quality and Safety Committee	**Report to:**	Board of Directors
Date of Meeting:	21 April 2022	Date of next meeting:	23 June 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 Lynne Carter, Chief Nurse Martyn Taylor, Non-Executive Director **In attendance** Sarah Quinn, Chief Operating Officer Kristine Brayford-West, Director of Safeguarding Jan McCartney, Trust Secretary Sue Mackie, Director of Quality Governance Tania Strong, Interim Head of HR Susan Burton, Director of Nursing, Warrington Lynda Richardson, Board and Committee Administrator **Observers** Christine Stankus, Public Governor, Rest of England	Quorate (Yes/No):	Yes
		Key Members not present:	Ted Adams, Medical Director Aruna Hodgson, Medical Director Sally Yeoman, Non-Executive Director

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision

	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

Urgent Items – Infection, Prevention and Control Strategy	2,3		The Committee noted that there had been some challenges in the strategy being made available for the Committee due to current pressures.	It was agreed that a draft strategy would be presented to the Committee at its next meeting in June 2022.
Serious Incidents Compliance Report for Quarter three 2021/22	2,3,6		The Committee received a report from the Director of Quality Governance which detailed that there had been eight serious incidents reported within quarter three, and all had been reported onto the Strategic Executive Information System (StIES) within the 48 hour deadline. Of those serious incidents, seven were related to pressure ulcers and one due to a diagnostic delay. There had actually been a decrease in serious incidents of one (nine reported in quarter two and eight in quarter three). 100% of the Root Cause Analysis (RCA) investigation reports had been submitted to the commissioners within the required timescales with learning identified. The report included some examples of learning which provided the Committee with an additional level of assurance and oversight.	The Committee agreed reporting arrangements for serious incidents going forwards: it would receive the quarter four report in June 2022 along with serious incident information for May 2022 and the June and July information being received in August 2022. The Committee accepted the report as assurance of the systems and processes in place and that those were effectively managing serious incidents reported within the Trust.
Risk Register Update	2,3,6		The Director of Quality Governance highlighted the following key points: ▪ The data provided was up to 23 March 2022. ▪ There had been no Risk Management Council meetings held in December 2021 and January 2022 due to pandemic pressures, however the Deputy Chief Nurse and Head of Patient Safety had met to review risks.	It was agreed that the Chief Nurse and the Director of Quality Governance would discuss producing a report from the Risk Management Council to this Committee. This would provide a clear summary of risks in the Trust to Committee, with the appropriate depth of information and the Committee could decide on any areas that were highlighted for a deep dive exercise.

	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

			▪ There had been a reduction in the number of risks scoring 12 and above from 25 in November 2021 to 21 in March 2021. ▪ There had been two new risks reported during the last period. One in relation to dental services and one related to paediatric continence services. ▪ Two risks rated 12 plus were outstanding for review and this had been followed up with the risk owners. ▪ The circulated paper detailed themes from risks rated 12 and above. The top three themes were capacity, demand and resource, covid-19 and treatment delay and error. ▪ There had been one risk closed scoring 12 and above in relation to operational leadership in Warrington and the restructure had now been completed. ▪ Of the risks scoring 12 and above related to quality and safety there was one risk with limited assurance: Infection, Prevention and Control and assurance against the code of practice. Work was ongoing in relation to this and this was being continually reviewed and updated. Discussion took place concerning demand, capacity and resource risks across the Trust particularly concerning smaller teams with lower resilience. It was as confirmed that this was being reviewed across each borough with work being explored with partners in place and the provider collaborative to provide resilience.	This was intended to replace the Risk Register update, however the Committee agreed that the new format report mustn't lose any levels of assurance. The Committee accepted the report as assurance that the risks scoring 12 and above in relation to quality and safety related matters were being managed effectively.

	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

IQPR – month 10	2,3,6		The Committee noted continuing pressures within paediatric general anaesthesia, however there had been a small improvement observed in month around the waiting times over 104 weeks. There were increasing challenges in Cheshire and Mersey with dental waiting times on the minor oral surgery pathway and an increase in activity due to the number of patients being referred. The Committee noted that there had also been improvements within the dermatology service; there was an extensive action plan in place and a quality improvement plan. Actions were being progressed with the joint Medical Directors to gain assurance on the quality of the service being provided and a review of incidents by the Executive Management Team. It was noted that the Trust was the only organisation within the North West that did not have waiters over 104 days in relation to cancer/dermatology and the backlogs were being cleared. The Trust was concentrating considerable capacity however on delivering this service which needed to be balanced against routine work and surgery. Community Paediatrics: New staff had commenced in post along with a new consultant to manage waiting list issues and quality improvement work was ongoing to improve service function and achieve consistency between the way in which the service was operating between Halton and Warrington service. The Clinical Director was involved as part of this work.	The Committee Chair would be kept appraised of the impact of the actions and timescales for achievement of the actions/improvements described opposite. This information would be included as part of the IQPR in the future. The Committee acknowledged that the bespoke IQPR was still being developed and this must include discussions that had taken place on key matters, including the overarching discussions taking place at the Finance and Performance Committee around any areas of quality or safety concerns for this Committee to review. It was acknowledged that training compliance itself would no longer be part of the quality indicators for this Committee going forwards, but that the Committee must consider any impact on quality and safety and incidents as a result of training non-compliance. The report was continuing to develop, evolve and improve.

	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

			District Nursing: workshops were continuing between Halton and Warrington services to encourage sharing of best practice, linking into workforce planning and sharing across teams. There had been actions and improvement plans with discussion by the Executive Management Team concerning reset and resilience, supporting the service and how delivery could be ensured in the best way. This would include maximising digital options, using all available resources and supporting staff, alongside maximising workforce planning. The Chief Operating Officer advised that the areas of issue within the services were well known and efforts of staff were being concentrated around those areas where progress must be made to make improvements. Dental services: waiting times continued to be an issue, however there had been considerable background work on clinical leadership, service delivery and estates that would contribute to progressing work. An increase in pressure ulcers was noted, however there was an action plan in place which was achieving a significant improvement in pressure ulcer management. The Committee would receive a future report on this for assurance. The Committee also noted a gap around fast track discharge and appropriate care package/plans being in place which District Nurses were being tasked with, creating additional pressures. It was considered that this was reflective of the wider system pressures currently.	

	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

			Information Governance and Safeguarding training compliance still required improvement. Current level three safeguarding adults figures were reported as 37% for Halton and 44% in Warrington. Information Governance training had seen a deterioration in compliance at month 10 however a drive was continuing to achieve the required compliance level by the June 2022 deadline. Discussions were continuing on this matter at the People Committee.	
Report from the Quality Council	2,3,6		The Quality Council had recommenced meeting in March 2022 following a period of being stood down due to the pressures of the pandemic. The March meeting had acted as a 'mop up' for outstanding issues. The Quality Council was developing a business cycle and this would be presented to the Committee in June 2022. This would support alignment between the Quality Council and this Committee and both business cycles would be reviewed to this effect in advance.	The Committee received the report and agreed that it was assured concerning how quality matters were being overseen by the Quality Council across the organisation. The Committee would receive the clinical audit plan at its June meeting – it was noted that this was a current gap in the business cycle/terms of reference and this must be addressed.
Quality Account 2021/22 Update	2,3,6		The Committee received a position statement on the progress of the quality account. A first draft of the report would be available by 1 May which would then be circulated via e-governance to Committee members for comments. A completed draft would then be presented to the Committee in June prior to the final deadline. It was noted that the deadline was expected to be met.	It was noted that the quality account would potentially require Board sign off and the timescales would present a challenge around the schedule of Board meetings. It was agreed that a timeline was required for sign off of the quality account to ensure that the requirements would be met. Discussion would take

	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

				place concerning this between the Trust Secretary and Director of Quality Governance. In the meantime a further draft of the quality account would be circulated to Committee members in between meetings. The Committee received the report and acknowledged the progress being made to complete the quality account.
Review of MIAA Audits – Quality Spot Check Audit	2,3,6		The Committee received an update which confirmed that following the June 2021 spot check audit which had achieved limited assurance, action plans had been implemented to address the recommendations concerning four areas: relating to NEWS2 observations, care planning, holistic assessments, MUST and Waterlow assessments. Two follow up audits were undertaken in March and February 2022 which had achieved substantial assurance. Whilst some minor actions remained, the Committee was assured that these were not a cause for any concern and were being regularly monitored. A further audit would be undertaken by MIAA in due course to ensure that actions from the recommendations had been implemented across the Trust.	The Committee accepted the report as assurance in relation to the improvements made within the services, and that the recommendations from the report were being implemented and managed via the borough quality meetings. It welcomed the work undertaken by the teams involved and the achievement of substantial assurance in view of the pressures of the pandemic, and within a short time frame.
Impact of the Covid-19 Pandemic on Quality within the Trust	2, 3, 6		The Committee received a summary report detailing the areas with the most significant impact on quality and safety from the pandemic: staffing, incidents, harms, waiting lists and patient experience. Key issues were	The Committee accepted the report for assurance that all actions were being taken as necessary across the Trust during the ongoing pandemic.

	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

			reported in relation to each and the actions taken, evidence and assurance against each area and a summary of the current position. This work would continue to be monitored through the Trust's usual governance processes. Discussion took place concerning the position on potential harms within paediatric anaesthesia/exodontia. Whilst a statement had been previously made that there were no harms, it was acknowledged that it would be more appropriate to state that there was no evidence of harms being caused as a result of patients waiting for treatment. Harm assessment work was still being undertaken within dental services and was yet to be concluded.	
Independent Inquiry into Child Sexual Abuse (IICSA)	2,3,6		The Committee received the report and it was agreed that this would be shared with the Board in June 2022 for assurance.	
Consideration of future Deep Dives	2,3,6		The Committee discussed potential areas for a deep dive/dives to be included as part of its business cycle. The areas could be areas where the Trust had been successful or where something had gone wrong and staff members from across the Trust could be invited to attend Committee to present. It was also suggested that a written/verbal/video patient story could be provided at future meetings.	Two areas were suggested: Pressure ulcers and community paediatrics. It was agreed that any deep dives to be presented to the Committee would be scheduled at an early point in the agenda. The Chief Nurse and Chief Operating Officer would discuss the suggested subjects and the potential timescales. The agenda would also include a section at the end where the Committee would briefly discuss any

	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

				other deep dive areas that may be identified during meetings.
Board Assurance Framework	1		The Committee considered gaps in control, assurance and scoring across BAFs 2, 3 and 6.	It was agreed that the scoring for all areas would remain unchanged. It was agreed that the substantial assurance opinion for the quality spot check audit would be added to BAF2 and this would supersede any previous references. One correction was noted – the risk number in relation to the Safeguarding IHA pathway would be corrected to 2829.
Items to be shared with Board and/or other Committees	1		▪ IICSA report to be shared with the Board as per above. ▪ IG training – update would be shared with the Audit Committee concerning compliance levels. ▪ Clinical professional structure – the Committee noted that this would now be a Board level assurance report. Workforce planning had now been completed and the structure had been discussed by the Executive Management Team.	
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

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Quality + Safety Committee (Q+SC)

Title	IICSA (Independent Inquiry into Child Sexual Abuse); Child Sexual Exploitation by Organised Networks
Author	Kristine Brayford-West, Director for Safeguarding Services
Date	21st April 2022
Purpose	To inform the Committee of this National Inquiry and provide reassurance of Bridgewater's actions in response to this report
Audience	Q+SC

1.0 EXECUTIVE SUMMARY

IICSA is an ongoing Inquiry examining how the Country's Institutions have handled their duty of care to protect children from sexual abuse and was set up following the Jimmy Savile scandal.

This Inquiry considered the sexual exploitation of children by organised networks in England and Wales.
It is a crime which involves the sexual abuse of children in the most degrading and destructive ways, by multiple perpetrators.

The Inquiry chose to base this investigation on areas which had not already been the subject of independent investigation, such as Rotherham and Rochdale.
The intention was to obtain an accurate picture of current practice at a strategic level and through examination of individual cases, as well as drawing on wider knowledge about Child Sexual Exploitation (CSE) in England and Wales. Six case study areas were chosen: St Helens, Durham, Swansea, Warwickshire, Tower Hamlets and Bristol.
Findings included that 'looked after children' were sometimes placed in inappropriate or 'out of area' settings, escalating the risk of harm. Missing from home or school, formed part of the lives of children who were exploited.

Whilst there is no direct requirement for NHS Trusts to publish a response, Bridgewater's Senior Safeguarding Team have prepared plans to raise awareness and share the lessons learnt from this inquiry across our organisation.

The Trust Secretary and the Director for Safeguarding Services considered it would be helpful to prepare a report for the Q&S Committee to inform of the report and the plans in place for Bridgewater.

(There are a number of distressing cases discussed within the report- so if the full report is read-please do so with caution); https://www.iicsa.org.uk/investigations-research/investigations/child-sexual-exploitation-by-groups-and-gangs

2.0 PURPOSE OF THE PAPER

To inform Bridgewater's Q+S Committee of this significant inquiry and offer reassurance that although there are no specific recommendations for health, Bridgewater are learning lessons from this and taking the opportunity to share with our staff the learning and concerns this issue raises at a national level.

3.0 BACKGROUND AND DESCRIPTION OF THE ISSUE

The Independent Inquiry into Child Sexual Abuse (IICSA), chaired by Professor Alexis Jay OBE, was set up because of serious concerns that some organisations had failed, and were continuing to fail to protect children from sexual abuse.

The report highlights extensive failings by the local authority and police and there appeared to be a flawed assumption that CSE was decreasing, when in reality it is becoming more of a hidden issue. It can be underreported when linked with other forms of criminal behaviour, such as county lines.

Since 2015, CSE has been a designated Strategic Policing Priority which gives the same significance as terrorism and serious organised crime. The CCE (Child Criminal Exploitation) reference in the report covers all aspects of criminal exploitation such as trafficking and county lines.
The inquiry demonstrates that children are being exploited by networks in all parts of England and Wales.
The inquiry did not receive a reliable picture from the six areas and the data proved to be confusing with inconsistencies and unexplained variations in the figures.
Although data indicated a decline in CSE cases- this was thought it may be due to changes in local recording practices.

It is widely documented that alcohol, drugs and violence are tools to groom children, this report finds that the perpetrators are finding new ways, via mobile telephones, social media and dating apps. to groom too.

Harrowing detail is shared within the report and there is clear evidence of actual harm to babies, infants, and children. Children regularly go missing; with adults who pick them up in cars, take them to house parties and abuse them. Children with disabilities featured in more than a third of the cases.

Often the child is considered the offender (by being responsible for what has happened to them) and the perpetrator often not prosecuted. Although there were no recommendations for health, one of the six recommendations is to strengthen the criminal justice system by amending legislation in sentencing those convicted of offences related to CSE.

4.0 Response to the issue

On the inquiries publication, the Senior Safeguarding Team (Director of Safeguarding, Heads of Safeguarding and Named Nurses), met to discuss the report and how Bridgewater can share the lessons learnt across our Organisation.
The Senior Safeguarding Team have plans in place to ensure that our staff, particularly Specialist Safeguarding Nurses, Children in Care Nurses, Specialist Nursing Services and the 0-19 teams, have an increased awareness and are confident in identifying and reporting any concerns.

In Halton and Warrington there are two identified Specialist Safeguarding Nurses leading on CSE and the Named Nurse in Halton is a member of the Safeguarding Children Partnership for Contextual Safeguarding.

There is a task + finish group led by the Specialist Safeguarding Nurses who have a special interest and experience in this field. This group includes representative from each of the Boroughs safeguarding teams, to review and refresh the Safeguarding training Level 3 and offer bespoke training in addition.

5.0 Plans

Plans;

- Discuss the Inquiry findings and Bridgewater plans at April's STAG (Safeguarding Trust Assurance Group)
- Raise awareness at Borough Quality meetings
- Level 3 safeguarding children training has been refreshed and updated to increase knowledge and awareness of the inquiry's report/ findings
- Bespoke CSE training dates available; details on the hub and the Trust Bulletin- 3rd May, 15th June and the 21st of June 2022
- Support local authority and police colleagues where required, in addressing the findings of this inquiry

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Bridgewater Board 9 June 2022

Board Part Public

Agenda item 37/22i

Title	Finance Report – April 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 1
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 4 – Financial 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	CIP – Cost Improvement Plan
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 – April – Month 1
Author	Nick Gallagher – Executive Director of Finance
Date	9 June 2022
Purpose	To brief the Board on: • Financial position as at Month 1
Audience	Board

1.0 Executive Summary

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

- Financial position as at Month 1
- CIP plans and delivery
- Capital and Cash.

2.0 Financial Position as at Month 1

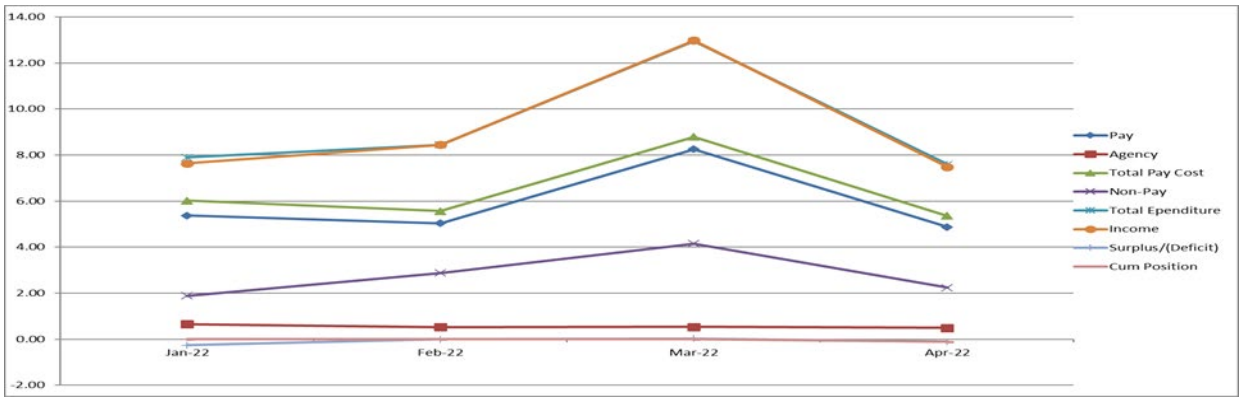
2.1 The key headlines for month one are shown in the table below:

Summary Performance Month 01 2022-23	Month 1 Plan (£M)	Month 1 Actual (£M)	Month 1 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.45)	(7.49)	0.04	(7.45)	(7.49)	0.03	(88.93)	(88.93)
Expenditure - Pay	4.80	4.87	(0.07)	4.80	4.87	(0.07)	57.60	57.60
Expenditure - Agency	0.41	0.49	(0.08)	0.41	0.49	(0.08)	4.95	4.95
Expenditure - Non Pay	2.32	2.24	0.08	2.32	2.24	0.08	27.45	27.45
EBITDA	0.08	0.12	(0.04)	0.08	0.12	(0.04)	1.07	1.07
Financing	0.03	(0.01)	0.04	0.03	(0.01)	0.04	0.37	0.37
Normalised (Surplus)/Deficit	0.11	0.11	0.01	0.11	0.11	0.01	1.45	1.45
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.11	0.11	0.01	0.11	0.11	0.01	1.45	1.45
Other Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.11	0.11	0.01	0.11	0.11	0.01	1.45	1.45
CIP	0.09	0.21	0.12	0.09	0.21	0.12	4.20	4.20
Capital	0.51	0.00	0.51	0.51	0.00	0.51	2.10	2.10
Cash	26.67	26.15	(0.52)	26.67	26.15	(0.52)	25.20	25.20
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 plan submitted to NHSE/I and agreed at Board in April 2022.

2.3 All month 1 run rates are consistent with expectations and previous year comparators.



3.0 Cost Improvement Programme (CIP)

3.1 Cost savings requirements were identified in the planning guidance and were followed up with additional requirements identified by the ICS.

3.2 This includes a 2% recurrent CIP and additional cost reductions of 2.5% (this is primarily driven by the 53% reduction in Covid funding for 2022/23).

3.3 This results in total savings for 2022/23 of £4.197m (4.5%), split between £1.865m recurrent CIP and £2.332m non recurrent savings.

3.4 The Trust plan to month 1 is £0.09m, which is reported as achieved due to additional income for the Performance / BI SLA with STHK together with a reduction in covid spend.

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, thought the system is currently planning for a deficit.

4.2 It is likely that organisations will be asked to revisit their plans in order to reduce that planned deficit.

5.0 Capital, Loans, Cash and Better Payment Practice Code

5.1 There has been no capital expenditure during April.

5.2 Capital schemes for 22/23 have been identified and approved in principle by the capital committee. All schemes are currently in the process of being reviewed and finalised with Procurement for sign off to ensure that schemes can be delivered within the financial envelope requested with a completion deadline of 30th June 2022.

5.3 In April there was a net cash outflow of £0.48m with a closing cash balance of £25.67m.

5.6 Total debt as at 30th April is £9.82m excluding bad debt and credit note provisions, of which £7.46m relates to invoiced debt. Overall debt continues to decrease and reduced by £0.36m from March.

5.8 The table shows the percentage (number and value) of invoices paid within BPPC terms.

	Target to be paid %	No of Invoices %	Value of Invoices %
Apr-22	95	99.8	99.9
Year to date performance	95	99.8	99.9

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 exceeding this.

6.0 Use of Resources Rating (UOR) - Finance

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

7.0 Recommendations

7.1 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:	28th April 2022	Date of next meeting:	19th May 2022
Chair:	Tina Wilkins	Parent Committee:	Board of Directors
Members present/attendees:	**Present:** Tina Wilkins, Non-Executive Director and Committee Chair Linda Chivers, Non-Executive Director Gail Briers, Non-Executive Director Nick Gallagher, Director of Finance Sarah Quinn, Chief Operating Officer **In attendance:** Lynne Carter, Chief Nurse Rachel Hurst, Deputy Director of Finance John Morris, Deputy Director of Transformation/Estates Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Jan McCartney, Trust Secretary Lynda Richardson, Board and Committee Administrator **Observers**: Rita Chapman, Lead Governor	Quorate (Yes/No): Key Members not present:	Yes Jan McCartney

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Finance	4		Month 12 finance report received and provided assurance. The Committee noted that: • 21/22 achieved a small surplus • Maintenance of improvement in BPPC performance	The Committee noted the achievement of all year end targets. The Committee noted the achievement in some areas of both recurrent and non recurrent CIPs. The 2022/23 CIP plans

	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

			• healthy cash position • significant recovery of aged debt • Capital slightly under plan	will clearly identify recurrent and non recurrent CIPs.
Finance	4		2022/23 Financial Plan was received. The Committee were updated on the process and work that had been undertaken to finalise the plan. The final plan was for a deficit of £1,449k. This included the revised system top up and covid allocations. The Committee were informed that a final plan will be presented to Board for formal approval at the beginning of May.	The Committee received the paper and were assured by the progress that been made to finalise the plan and the consequent financial impact. The Committee noted the financial gap still remaining at a system level. The Committee took the view that the Trust had taken all the steps it could to mitigate its financial position and it would be very difficult to accommodate any further requests for improvement to the financial position. The Committee recommended the 22/23 plan to Board for final approval.
Performance	4,8		The Dermatology funding request was taken as an urgent request at the discretion of the Chair. This paper set out a proposal to resolve the BAU delays and the routine 18 weeks waits. The cost of £1.02m has been included within the 22/23 financial plan.	The Committee noted the cost of £1.02m which would deliver the current waiting pressures and also the ongoing transformation work running alongside this which would enable the Trust to deliver an operational service which is sustainable both from a clinical and financial perspective. The Committee recognised that these costs had been reflected in the 22/23 plans and that and additional funding contribution of £500k had recently been agreed with Commissioners.

	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 Committee noted that discussions remain ongoing for additional funding to offset the cost pressure. The Committee raised concerns regarding the current model for service delivery. The Committee delegated the responsibility for monitoring the progress of the transformation programme to Quality and Safety Committee. This Committee retains the responsibility for financial and performance and will escalate any issues as needed. The Committee recommended the proposal to Board for final approval.
			Warrington Supporting Discharge Mandate This paper sets out the opportunity to support the programmes being undertaken by the Warrington Wider System Sustainability Group. The group is working together to develop an Adaptive Reserve Fund to pump prime schemes that will improve transfers of care and free up recurrent funding to be utilised in a more effective way.	The Committee recognised that the proposal had potential to support working together in a different way in the Warrington area by having a pot of money that business cases could bid against to support system working. The Committee requested that there would be regular standard reports made available for all partners. The Committee recommended the proposal to Board for final approval.

	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 paper proposed the investment of £250k into the scheme by the Trust, with contributions from all parties totalling £2,600k.	
Digital	8		No update this month	
Estates	4		Spencer House Occupancy and Options The paper detailed options around the occupancy of Spencer house or movement to alternative premises.	The Committee noted the opportunities relating to the estates strategy, the green plan together with co-location of services and stakeholders. The Committee recognised the recurrent impact of the proposal was reliant on the rationalisation of the estate. The Committee recommended the proposal to Board for final approval.
Audit	4		No update this month	
Risk	4		None this month	
BAF	4,7,8		No update this month	
Healthcare Travel Costs Policy	4		The Committee received the updated Policy.	The Committee approved the policy.

Meeting Review – The Committee Chair noted that there were a number of papers that had been received late and one paper had to be taken at the discretion of the Chair. The Committee were in agreement that this was unacceptable and placed additional pressure on Committee members to review the papers in advance of the meeting. Despite this, the Committee felt that there had been a full discussion and challenge of the proposals put forward in the papers.

The observer – The lead Governor commented that it had been a very good meeting with good challenge and debate.

	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

Risks Escalated – None **Actions delegated to other Committees** – The Committee delegated the responsibility for monitoring the progress of the Dermatology transformation programme to Quality and Safety 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

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:	19th May 2022	Date of next meeting:	21st July 2022
Chair:	Tina Wilkins	Parent Committee:	Board of Directors
Members present/attendees:	**Present:** Tina Wilkins, Non-Executive Director and 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 **In attendance:** Lynne Carter, Chief Nurse Rachel Hurst, Deputy Director of Finance John Morris, Deputy Director of Transformation/Estates Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Jan McCartney, Trust Secretary Sam Scholes, Head of Corporate Governance Lynda Richardson, Board and Committee Administrator **Observers:** Jilly Wallis, AHP Lead Sue Mackie, Director of Quality Governance Peter Hollett, Public Governor, Halton	Quorate (Yes/No):	Yes
		Key Members not present:	Jan McCartney

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision

	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

Finance	4		Month 1 finance report received and provided assurance. The Committee noted that: • Month 1 22/23 deficit on plan • CIP on plan • Maintenance of improvement in BPPC performance • healthy cash position • No capital spend to date	The Committee noted that pay and agency were overspent and this was explained that was largely due to a profiling issue with budgets, combined with still high levels of Covid sickness during April. The Committee to receive a briefing session on aged debt before the next meeting. The Committee to ask the Trust Chair to raise system pressures and impact on community services in the ICS Finance Committee.
Finance	4		Annual Accounts update	The Committee noted the paper.
Finance	4		2022/23 CIP Plan was received. This outlined the process to be followed and included the CIP Council Terms of Reference.	The Committee noted the recurrent and non recurrent targets and the proposed allocation across services. All CIP plans will be subject to a QIA. Updates to be included within the finance report including deliverability rating and phasing.
Finance	4		Procurement report update noted including the workplan for 2022/23.	The Committee noted the workplan including the CIP target for Procurement. This referenced ICS collaborative work and ensuring Community services were represented.

	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 Committee noted the 'good' status awarded to the Procurement Team under the new Government Commercial Operating Standards Assessment.
Performance	4,8		IQPR for month 12 was received by the Committee Noted that planned recovery trajectories were now included within the report. The Chair's report from Performance Council for month one was received. This was a detailed report which provided assurance to the Committee. The Committee received and noted the Cheshire and Mersey Long Stay report.	Patient cancellations were discussed by the Committee which relates to a software issue (EMIS) which inflates the figures reported. This is under constant observation by the COO. Performance had reduced around the UTC and a change in access routes had taken place from 29th April which has resulted in a demonstrable improvement in performance. Significant improvement in dental long wait times. The Committee noted that the report had now been rag rated as requested. Work to develop an assurance rating which is more sensitive to the individual directorates will be brought to the July meeting. The Committee considered the impact of long stay in acute hospitals on community services.
Digital	8		The Committee received a verbal update from DIGIT	The Committee noted that the DIGIT meeting was held via e governance and July's chair's report form DIGIT will

	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

			Cyber security update was received by the Committee and noted that this had previously been considered by Audit Committee. Digital Strategy update was received and noted. Qlik roll out paper was received and noted.	contain a record of the virtual meeting content. The Committee received the update and noted the confirmation of new timescales and that it was on track. The Committee noted the report and the workshop arranged for 7th July 2022.
Estates	4		No update this month	
Audit	4		The paper was received and noted.	
Risk	4		The paper was received and noted.	
BAF	4,7,8		BAF 4 BAF 7 BAF 8	The Committee noted that the gaps in control and rational for risk needed to be reworded (reference 22-23 finance regime). The Committee noted the risk remains the same. The Committee asked that adaptive reserve be added as a control. All references to STP and Out of Hospital Cell to be updated.

	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 Committee noted that a full review of BAF 8 by EMT would take place and come to the July meeting taking into account any consequential impact of the Digital Strategy.	
Meeting Review – The observer – The lead Governor commented that it had been a very good meeting with good challenge and debate. Director of Quality Governance commented that it had been a very interesting meeting with good challenge.					
Risks Escalated – None **Actions delegated to other Committees** – Monitoring of Ulysses transition to Datix delegated to Audit Committee. Ask Trust Chair to raise system pressures and impact on community services in the ICS Finance Committee. Ask EMT to review BAF 8 ready for July meeting.					

	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

Name of Committee/Group:	Audit Committee		**Report to:**	Board of Directors
Date of Meeting:	27 April 2022		Date of next meeting:	19 May 2022
Chair:	Linda Chivers		Parent Committee:	Trust Board
Members present/attendees:	**Committee Members Present** Linda Chivers, Committee Chair Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Tina Wilkins, Non-Executive Director Sally Yeoman, Non- Executive Director	**Officer in Attendance** Nick Gallagher, Director of Finance Lynne Carter, Chief Nurse Sarah Quinn, Chief Operating Officer Jan McCartney, Trust Secretary Rachel Hurst, Deputy Director of Finance Debbie Weir, Financial Controller Lisa Warner, MIAA Audit Engagement Manager Gary Baines, MIAA Audit Engagement Manager Paula Fagan, MIAA IT Audit Lead (for items on Cyber Security) Phillip Leong, Anti-Fraud Specialist, MIAA James Boyle, Director, Public Sector Audit, KPMG **Observers** Rita Chapman, Lead Governor Samantha Yates, Director of Nursing, Halton Jilly Wallis, Allied Health Professionals Lead	Quorate (Yes/No):	Yes
			Key Members not present: Abdul Siddique, Non-Executive Director	**Apologies received from** Abdul Siddique, Non-Executive Director Ted Adams, Medical Director (with consent of the Chair) Bill Harrison, Governor

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
e- Governance approval of a change to the Anti-Fraud work plan for 2021/22 to replace the proactive detection	1,4		Confirmation was received that a quorate decision was made by e-governance to approve the revisions to the Anti-Fraud work plan for 2021/22	Assurance received

	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

exercise on procurement to one on mandate fraud				
e-Governance to approve the Anti-Fraud Annual Plan for 2022/23	1,4		Confirmation was received that a quorate decision was made by e-governance to approve the Anti-Fraud Annual Plan for 2022/23	Assurance received
e-governance to note the approval of the External Audit Fee for the "021/22 Audit Services	1,4		Confirmation was received that a majority decision was made by e-governance to approve the External Audit Fees. The Trust Secretary will confirm whether the voting number of Governors met the quoracy requirement of the Constitution.	Partial Assurance received
Well-led – Monitoring of Action Plan	1		The Committee received the updated Well-led Action Plan and a verbal update from the Committee Chair and Trust Secretary on the implementation of actions. It was noted that although the delivery of the action plan is progressing it is behind where it should have been as regards timeframe. The evidence associated with each action will be audited as part of the external audit on Value for Money and reported as part of the year end audit findings.	Each Committee to continue monitoring delivery of actions relating to their sphere of activity
Review of Freedom to Speak Up (FTSU) Policy	1,2,5		This item was deferred from the January meeting. It was noted that recruitment for a new FTSU is in train and that the policy will also need to be revised to reflect the Trust moving to a Just and Learning Culture.	Revised Policy to come to a future meeting
Review of Audit Committee Annual Work Plan 2022/23	1		The Committee approved the work plan	Assurance received
Annual Audit Committee Report	1		The Committee received the annual report on the work of the Committee to gain assurance that the Terms of Reference had been met. The report informs the Annual Governance Statement	Assurance received
Annual Reports from Board Committees	1		The Committee received reports from each Board Committee to provide assurance that the Terms of Reference for each	Assurance received, although it was noted the Reports should all have at least gone

	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 had been met in the year. The reports inform the Annual Governance Statement.	through their relevant Committee for approval or at least been reviewed by the Committee Chair prior to submission to the Audit Committee.
Review of BAF and Corporate Risk Register systems and processes	1		In addition to a comprehensive review of BAF 1 the Committee sought and received assurance that the systems and processes of Risk Management were operating effectively across the Trust. It was agreed that given the potential for significant weakness in Governance identified in the Value for Money Risk Assessment and the delayed delivery of the Well Led Action Plan that the current Risk Score should be increased to 4x3 (12) pending the findings of the external audit which will report in June	Current Risk Score on BAF 1 to be increased to 4x3 (12)
MIAA Governance Checklist	1		The completed MIAA Governance Checklist template was received.	Assurance noted and to be added to BAF 1
Registers of Interests	1		The Committee received updates on new declarations of interest from Board Directors and staff and on the declaration of Gifts and Hospitality. The Committee approved the publication of the registers.	Assurance received
Review of Losses, Special Payments and Waivers	1,4		Proposed bad debt write offs totalling £12,473.69 were noted and assurance received that all possible recovery options had been exhausted. The committee were assured that due process had been followed for all 19 waivers, which were documented.	Assurance received
Update on Annual Accounts progress - IFRS 16 Leases	1,4		The Committee received assurance that a robust process had been followed to enable the Trust to comply with IFRS 16	Assurance received

	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

			Leases. Theis will be fully audited as part of the annual external audit.	
IR35	1,4		The Committee received a verbal report on the progress to agree the final report from the external review. Assurance was received that the draft report contained nothing of major concern	The final report is delayed and thus prevents full assurance being received that the Trust has applied IR35 appropriately.
Review of Accounting Policies for 2021/22	1,4		The Committee approved a number of changes to the accounting policies to be applied for the 2021/22 year end	Assurance received
Mersey Internal Audit Agency Progress Report	1, 2, 4		The Committee considered a paper on the Trust's activity to ensure Cyber Security across all of its activities and discussed the value that could be added through an independent Internal Audit in year. The internal Audit Plan for 2022/23 was approved with the inclusion of a Cyber Security Audit. It was further agreed that an annual report on Cyber Security measures would be provided to the Committee on an Annual basis. Whilst there have been some delays in finalising a number of ongoing reviews, assurance was provided that there would be no issue in relation to the year end Head of Internal Audit Opinion. The Committee considered the findings of the Covid Spend Audit which received Substantial Assurance. The Committee considered the Moderate Assurance level findings and recommendations on the Fit and Proper Person Test Audit. The Committee noted the High/Substantial Assurance findings on the Key Financial Controls Audit The Committee considered the Substantial Assurance findings on the Quality Spot Checks follow up Audit.	Assurance received. Assurance received Substantial Assurance level of the Covid Spend Audit to be added to the BAF 4 Moderate Assurance on the Fit and Proper Person's Test Audit to be added to BAF 1 High/Substantial Assurance on Key Financial Controls to be added to BAF 4

	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 committee considered the MIAA finding that the NHS requirements had been met on the Assurance Framework. The Committee received a verbal update on the draft Head of Internal Audit Opinion (HOIA) for 2021/22. This remains draft at this time as there remain audits to be finalised. It was noted that due to timing the DSPT and E-Prescribing Audit findings will not be included in the 2021/22 HOIA. The Internal Audit Charter was approved. It was noted that the MIAA Audit team will be changing for 2022/23. This will bring us into the fold of the Cheshire and Mersey providers Audit team and will bring both opportunities for collaborative audits and information sharing	Substantial Assurance on Quality Spot Checks follow up to be added to BAF 2 NHS requirements on the Assurance Framework to be added to BAF 1 Assurance received Assurance received
Annual Review of Effectiveness of Internal Audit	1		The Committee received the findings of the annual review into the effectiveness of the Internal Audit Function. Overall, the views were positive with a significant number of comments provided	Assurance received
Anti-Fraud report	1,4		The Committee received the regular progress report. One point of note is the notification from the CPS that they will be issuing a discontinuation for a warrant for arrest. The case goes back to March 2018 and the individual no longer resides in the UK. The Committee received the Ant-Fraud Annual Report for 2021/22	Assurance received Assurance received
External Audit progress report	1,4		The Committee considered the progress on the annual external Audit which included the Value for Money Risk Assessment. Of the three key areas considered only the Governance domain was identified to be a potential	Assurance received

	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

			significant weakness and will undergo testing to rebut the risk. It was not felt that there were likely to be significant weaknesses in either the Financial Sustainability or Improving economy, efficiency and effectiveness. This is an improvement on last year. The Committee also received the regular Sector update which includes articles of interest.	
Risks Escalated – None from the meeting				

	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

Name of Committee/Group:	Audit Committee		**Report to:**	Board of Directors
Date of Meeting:	19 May 2022		Date of next meeting:	20 June 2022
Chair:	Linda Chivers		Parent Committee:	Trust Board
Members present/attendees:	**Committee Members Present** Linda Chivers, Committee Chair Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Tina Wilkins, Non-Executive Director Sally Yeoman, Non- Executive Director	**Officer in Attendance** Colin Scales, Chief Executive Officer Nick Gallagher, Director of Finance Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer Jan McCartney, Trust Secretary Rachel Hurst, Deputy Director of Finance Debbie Weir, Financial Controller Gareth Pugh, Assistant Director of Finance Lisa Warner, MIAA Audit Engagement Manager Gary Baines, MIAA Audit Engagement Manager James Boyle, Director, Public Sector Audit, KPMG **Observers** Rita Chapman, Lead Governor Bill Harrison, Governor	Quorate (Yes/No):	Yes
			Key Members not present: Abdul Siddique, Non-Executive Director	**Apologies received from** Abdul Siddique, Non-Executive Director Ted Adams, Medical Director (with consent of the Chair)

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Review of Annual Accounts progress	1,4		The Director of Finance provided assurance that the year end audit was coming to an end and progressing smoothly. No issues had been identified to date.	Assurance received

	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

Going Concern assessment	1,4		Under International Accounting Standard 1 (IAS!) the Trust is required to make and assessment of the Going Concern Basis for preparing statutory accounts. The Committee received assurance that that the expectations relating to assessing the Trust as a Going Concern were met and despite the current NHS Financial operating regime the Trust does not view itself as an outlier. The Committee were satisfied that it was appropriate to agree the Going Concern Assessment.	Assurance received
Mersey Internal Audit Agency Draft head of Internal Audit Opinion	1,		The Committee received the draft Head of Internal Audit Opinion (HOIA) for 2021/22. The overall opinion provides Substantial Assurance for the second year and is a judgement based on: 1. The organisation's Assurance Framework 2. Core and mandated reviews, including follow up; and 3. A range of individual risk based assurance reviews The paper also provided a schedule of things for the Trust to consider when the Annual Governance Statement is being signed. The Committee was assured that most if not all of these had been considered across the Board Committees. The Committee noted MIAA's approach to quality assurance which includes ISO9001:2015 accreditation and compliance with the Public Sector Internal Audit Standards.	Assurance received. Assurance received
Review of Draft Annual Accounts and Annual Report to include the Annual Governance Statement	1,4		The Committee received and noted the draft Annual Accounts which had been submitted within the national timeframe. The Committee received and noted the draft Annual Report and Annual Governance Statement, which had already been subject to e-review and review by KPMG. It was noted there	Assurance received Assurance received

	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

			remain a few outstanding sections and the final report will be considered at the meeting on 20 June. The Chief Executive Officer gave his assurance on the content and representation of the Annual Report and AGS in respect of systems and governance.	
External Audit progress report	1,4		The Committee noted the progress on the annual external Audit which included the Value for Money Risk Assessment. It was noted the audit was more detailed than in previous years but that better progress had been made compared to this time last year. KPMG advised that at this point they have no concerns to report. In respect of the VFM audit KPMG advised that, as it stands, they intend to issue a clean VFM Opinion, but that will not be finalised until full testing is complete.	Assurance received
Risks Escalated – None from the meeting				

	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	9 June 2022
Board Part	Public
Agenda item	38/22

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

Open Board

Title	Integration & Collaboration
Author	Rob Foster, Programme Director – Integration and Collaboration Sarah Quinn, Chief Operating Officer
Date	9th June 2022
Purpose	To provide an update to the Board in relation to integration and collaboration.
Audience	Open 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 Health and Care Act received Royal Accent in April 2022.

2.2 The main purpose of the Health and Care Act is to establish a legislative framework that supports collaboration and partnership-working to integrate services for patients. Among a wide range of other measures, the Act also includes targeted changes to public health, social care and the oversight of quality and safety.

2.3 At the heart of the changes brought about by the Act is the formalisation of integrated care systems (ICSs), which are due to become statutory on 1st July 2022.

Cheshire & Merseyside

2.4 Appointments have been made to key leadership roles for NHS Cheshire and Merseyside Integrated Care Board (ICB) and all Place-Based Directors have been appointed.

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 The Good Governance Institute (GGI) continue to support the development of a strategy and associated governance arrangements for the Provider Collaborative.

3.3 Discussions are taking place with various stakeholders across the system about the development work, helping to form and shape the emerging strategy and governance.

4.0 Place Update

4.1 Both Warrington Together and One Halton continue to progress and develop.

4.2 In both places, the governance arrangements continue to be developed and embedded by the respective PMO leads.

4.3 The place strategies and priorities also continue to be developed, in conjunction with place partners.

4.4 Both places are also working closely with the Cheshire & Merseyside digital team, on the development of place-based strategies. Whilst each place is developing its own digital strategy, discussions between the place-based leads are on-going, with a view to identify any ideas where collaboration will enhance and/or support delivery.

4.5 Finally, both place-based teams continue to work together to design and develop initiatives to meet the needs and demands on all our services. This includes (not exhaustive) the Community Rapid Response service, Virtual Wards, Intermediate Care, Acute Discharge, integrated team working and Single Point of Access.

5.0 Recommendations

5.1 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:	11 May 2022	Date of next meeting:	13th July 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 Dr Ted Adams, Medical Director In attendance Jo Waldron, Deputy Director of People Tania Strong, Interim Head of Human Resources Kathryn Sharkey, Head of Workforce Adie Richards, Education and Professional Development Lead Razia Nazir, Knowledge and Library Service Manager Mike Baker, Assistant Director of Communications Susan Mackie, Director of Quality Governance Denise Bradley, Unison Bridgewater Branch Secretary & Staff Side Chair **Observers** Rita Chapman, Lead Governor Sam Yates, Director of Nursing, Halton Susan Burton, Director of Nursing, Warrington	Quorate (Yes/No):	Yes
		Key Members not present:	Lynne Carter, Deputy CEO/Chief Nurse (Deputy in attendance)

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
COMMITTEE TERMS OF REFERENCE REVIEW -*deferred to July*			Item deferred to the next meeting, as the People Committee ToR is currently being reviewed, along with all other Committee ToRs, as a whole suite for unified approach. The Director of People and OD confirmed that she had provided her comments regarding the TOR update as a part of an overall review.	The committee noted the deferment until July 2022.
COMMITTEE BUSINESS CYCLE REVIEW			The Committee received the amended Business Cycle as reviewed by the Director of People and OD, Paula Woods. The amendments were predominantly in relation to aligning the new Leads, following portfolio changes, after the retirement of Chris Whittaker, Associate Director of OD. The Director of People and OD advised that due to the recent portfolio changes, she would have two deputies: Deputy Director of People and Deputy (currently with the title of Assistant) Director of Communications. Also, the following officers have been added to the Leads column within the Business Cycle: Adie Richards, Education and Professional Development Lead Helen Hollett, Head of Leadership and Organisational Development Razia Nazir, Knowledge and Library Service Manager Non-Executive Director, Linda Chivers suggested that it would be helpful to see the Business Cycle for the full calendar year and for the item to be tabled once a year consistently. It was also requested that an annual review should apply to Terms	The Director of People and OD, Paula Woods would feed the comments regarding the suggestion for annual review of Business Cycle and Terms of Reference, as well as nomination of a Deputy Committee Chair, back to 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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			of Reference as well (rather than twice a year) as the agendas were very full; there was no need to re-visit TOR in year. It was agreed this would be fed back to the Trust Secretary.	
RISK REPORT UPDATES • **HR** • **OD/EPD** • **COMMUNICATION**	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. A discussion took place in relation Statutory and Mandatory training with regards to taking best practice from Trusts who may be doing well. This will be addressed and presented in the standing PDR and Statutory and Mandatory Training report at the next Committee.	The Committee were assured on the progress and governance around the management of risks through Risk Council. Updates will be provided at future meetings. The next PDR and Statutory and Mandatory Training report will include best practice from Trusts who are doing well in terms of compliance rates.
IQPR – PEOPLE INDICATORS	5, 6 and WLR 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 10 IQPR presented to the Finance & Performance Committee. That said, as per the approved changes to the target to 95% as of February 2022, Induction is reporting green as of month 11. 1 of the 5 indicators slightly improved between months 9 & 10, however as per the 'as is' position narrated for month 12, Induction has remained static at 99% and turnover has increased at 14.98% from 16.56% in month 11.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings. 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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			As per the request at the last Committee a deep-dive into turnover rates and reasons over the previous 12 month was included. Key workstreams that are underway to tackle this were presented as per the Recruitment and Retention People Operational Delivery (POD) Group. This group will focus on the assessment, gap analysis and action planning in relation to the NHSE/I Retention Toolkit. There is a task and finish group, reporting to the Recruitment and Retention, that is specifically aimed at gathering additional supporting qualitative information in relation to reasons for leaving, to ensure appropriate actions to enable improvement. Work continues in the HR and OD Team to support progress against all of 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. Mandatory and Statutory Training continues to be a challenge – a paper presented and discussions had are noted later in the agenda.	
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, paying attention to any developments since the writing of the report by way of verbal updates.	The Committee noted the report and its contents. Further updates on the workstreams will be provided in future meetings as they 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

Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Skills for Health – publication of Bridgewater's Apprenticeship Scheme Case Study - Health Education England sent a request and Case Study proformas to organisations to invite them to share their experiences of employing Apprenticeships. This was some months ago and we have recently been advised that our submission was published in April. We have shared this on social media as per the attached link. https://haso.skillsforhealth.org.uk/wp-content/uploads/2022/04/2022.02.23-Bridgewater-Community-Healthcare-Employer-Case-Study-LB-checked.pdf An update on Apprenticeships was tabled on the Committee agenda – outlined below. **NHSE/I E-Roster Programme Feedback – Request to speak at events in July -** Our Head of Workforce Transformation, Kathryn Sharkey met with NHSE/I at the end of April with regards to the funding we received as per the national requirement for Trusts to implement an E-Roster System as per their roll out programme. They have asked Kathryn to represent the Trust and speak the North West and North East Regional Attainment Levels Conference about our success. This is due to our recognised success of implementing the system within a Community Trust. They are more than satisfied that we have successfully rolled out the system with the allocated funds and timeframes. **Workforce Race Equality Scheme (WRES) – One of the top 10 Trusts for the 2021 WRES Report findings -** The Workforce Race Equality Scheme report was published nationally on the 7th of April 2022. NHS Provider organisations are expected to show progress against a number of indicators of workforce	There will be a focus on external communications and sharing good news stories.

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			equality. There are 9 indicators of workplace experience and opportunity for different ethnic groups in the NHS workforce. The WRES report provides more granular data than previous years, increasing the scope to understand the intersectionality of race and other characteristics on the NHS staff experience (namely gender and occupational group). We are in the top 10 Best Performing Trusts for 3 of the 9 indicators: - Indicator 2 - White applicants being appointed from shortlisting compared to BME applicants: 2016-2021 - Indicator 6 - Percentage of BME staff experiencing harassment, bullying or abuse from staff in the last 12 months: 2015 -2020 - Indicator 7 - Percentage of staff believing that their trust provides equal opportunities for career progression or promotion: 2015 – 2020 We appreciate that Indicator 2 could be open to interpretation as per how it is stated in the WRES. This is, the number of BME applicants being appointed from shortlisting compared to white applicants. NHS England » Workforce Race Equality Standard 2021 **NHS Employers: Health & Wellbeing Framework Implementation Workshops -** Feedback following the launch of NHS Employer's Health and Wellbeing Framework has highlighted challenges around the embedding approach	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			of it, as nationally there is a diverse mix of organisation size, resource availability, senior management support and varying skill sets amongst HWB Teams across health and care organisations in our region and beyond. Whilst they cannot address all the challenges, NHSE/I are able practically support regions with a set of workshops starting in May 2022. This is a collaborative approach between all the Regional HWB Teams, but they also have the support of the National HWB Team who they are working with to ensure ongoing support is effective. Workshops kick off with a dedicated session on using the diagnostic tool with presenters from the National HWB Team (sharing how it should work) and a Trailblazer site (sharing how it works in practice). There will also be an opportunity for Q&As. Subsequent workshops will be focused on a specific element of the Framework and they will share a suite of editable tools to help colleagues get started on the journey. We have members of our Team aligned to these sessions and will update on our progress at future meetings. The NHS Workforce Health and Wellbeing Framework is a diagnostic tool to be used in a flexible way to meet the needs of organisations. Resources can be used in total or in part. It's divided into two sections: organisational enablers and health interventions. There is an easy-to-use diagnostic tool to help develop and evaluate health and wellbeing. As the Committee are aware, the Chair of the Committee is our nominated Health & Wellbeing Guardian in line with 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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			requirements of the NHS People Plan. Abdul Siddique is on the appropriate circulation lists. **The North West Anti-Racism Framework – Board endorsement 7th April 2022 -** The Regional People Board met on the 31st of March where the Anti-Racism Framework was tabled and presented by Raj Jain of the North West BAME Assembly. Our CEO was in attendance as the SRO for the People Board. There is a North West Commitment to becoming anti-racist organisations. The 'framework' provides advice and practical steps as to how we can put actions in place and support changes that work for us as an organisation as well as the North West as a whole. We did receive this when it was published back in October and reached out to Raj to see what he and the NW BAME Assembly could do to support us. Unfortunately, a suitable meeting date proved difficult. The Framework looks at 'Anti-Racist Zones', with approaches to help you to move through them. There are also 5 'Anti-Racist Principles'. 'Key drivers', 'direct deliverables' and associated resources are all outlined in the framework to help make anti-racism happen. We are currently assessing ourselves against the framework as endorsed by our Board. A fifth principle relates to a review of progress and how we are performing against each of the key drivers and direct deliverables by way on an annual review of our approach. There is also an accreditation process outlined in the framework by way of a submission to the BAME Assembly, along with additional anti-racism resources.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Accreditation comprises of a 'self-assessment', an 'application' to evidence each of the direct deliverables, an 'assessment panel' to review applications, and if successful with accreditation, there will be a recognition of the same on the BAME Assembly's intranet. **Our Just Culture Journey: Update on progress - Our proposed 'Stepped Approach' is out for consultation -** Amanda Oates, Director of People at Mersey Care briefed our Board on Mersey Care's approach to the programme on the 25th of April. Our Staff-side colleagues have worked, in partnership with us to set up a small Task & Finish Group to agree our 'stepped approaches' to the managing and handling of incidents through a just culture lens. There will be some short training sessions and support in its utilisation once agreed. The Steering Group members are: • Ros Connolly – Project Lead • Alan Lee - Patient Safety • Denise Bradley - Unison • Heather Roughley - Unison • Tania Strong - Head of HR The stepped stages/approaches are out to consultation until the 10th of May. Our Project Lead is continuing to link with Managers to attend operational meetings.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			We are about to finalise an in-house training package for our Trust Board which will include links to Mersey Care's e-learning packages. Two Executives have taken part in the full 4 day programme. **Leadership Development Programme – Operational Managers -** Following the restructure of Operational Services, the Trust's Organisational Development Team were approached to develop and support the delivery of a bespoke Leadership Development Programme for our Operational Managers. Consultation with the Chief Operating Officer, the Borough/Service Directors and some Corporate leads has facilitated the development of a programme that will be delivered by AJM Consulting. Following an open market tender process, early in 2021, AJM Robertson Consulting Ltd was awarded an Engagement Contract for the design, development and delivery of a Leadership Programme for a broad range of senior and middle leaders from Warrington Borough Council's Social Care Directorate, together with a number of colleagues from Bridgewater. The programme will consist of 3 components: 1. An initial 360-degree appraisal with supportive career conversations 2. A Bridgewater-specific transactional skills and knowledge development programme 3. A Transformational Leadership Development 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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Further updates will be provided to the Committee as per the Programme launch in the coming months, its delivery and evaluation. **Workforce Planning at Trust and 'Place' levels -** Workforce plans have been developed for our services and are to be aggregated up into an overall Trust Workforce Plan. This will support the Trust's Quality & Place Strategy and its enabling People Strategy, Plans and Frameworks. Workforce planning at 'place' level was table at the Trust's Executive Management Team Meeting on 19th April. This will remain on the EMT agenda as links are established with the Place Based Leads. Workforce planning at a regional/system level was tabled for discussion at the North West Social Partnership meeting on the 29th April. The SPF is a meeting of HR Directors and Trade Union Officials. There will be a further session on joint working, facilitated by the ICS' Chief People Officer in July. The People Board have secured funds for workforce planning support over the next few years. There's a recognition that we need to get better at this and have an integrated whole system plan. More detail is to be provided to HR Directors over the coming weeks and months **Bridgewater's Menopause Support Policy -** Our new Menopause Support Policy is available on the policy page of the Trust's Hub. This is a new policy for Bridgewater and we	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			are one of the first Trust's in England to agree a policy solely for menopause support. Nationally, the ESR System is being developed to enable the recording of absence related to menopause. Menopause is a focus of the North West Retention Programme. We are proud to display our Menopause Friendly badge. We have a Trust Menopause Support Network, supported by Ted Adams, the Trust's Medical Director. PROUD to display the BADGE **Well-led Action Plan: Agenda items linked to Recommendations 7 and 8 -** The areas of the Well-led Action Plan that are linked to the People Committee are an integral part of the Committee's business cycle. Areas are also covered in the Integrated Quality & Performance Report (IQPR) that is overseen by the Finance & Performance Committee. The detail with regards to the five People Indicators is tabled as a standing item for this Committee to consider and discuss in more depth.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			The Committee agenda items that link to the Well-led Action Plan, as tabled, are: • This report: Just Culture, leadership development, and health and wellbeing updates • 51/22 (ii) IQPR (Recommendations 7 and 8) • 55/22 Review of Staff Sickness (Recommendation 8) • 60/22 (i) PDR and Statutory & Mandatory Training (Recommendation 7 (safeguarding) and Recommendation 8) • 62/22 (i) Delivery of Occupational Health Services (Recommendation 8) There was a recognition from the Committee as to the extensive work being done to drive the People Agenda. It was noted by the Committee that we need to focus on external communication and getting good new stories out there in the public domain.	
NATIONAL STAFF OPINION SURVEY – RESULTS REPORT AND ACTION PLAN – ***as deferred from March***	5 and 6		The National Staff Opinion Survey – Results Report and Action Plan was presented to the Committee for information and assurance purposes. The following areas were highlighted to the Committee by Mike Baker, Assistant Director of Communications and Engagement. This Committee Paper follows an update on the Initial Benchmark Report presented to April 2022 Trust Board. The benchmarking results provide information for the Trust as a whole and by Directorate. Trust Board, Senior Managers	The Committee noted the report and its contents. Further updates on progress of action plans will be provided at future meetings. Request for detailed information in relation to our Learning, Organisational Development and Education offer. To be presented with the standing PPDR and Statutory and Mandatory Training paper at the next 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

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			and Directorate Leads have now had sight of the benchmark report, staff survey results and actions plans. Overall, the survey results are pleasing. Our areas for improvement and further development relate to the following People Promise themes; 'we are always learning' and 'we work flexibly'. We have maintained our 'staff engagement' score of 7.2 which is the national average. This is pleasing taking into consideration the survey was completed during the second year of the pandemic and whilst staff were continuing to work under ongoing significant pressures. We are at the national average for being 'compassionate and inclusive', 'safe and healthy' and 'teamworking'. With the exception of 'we are always learning' our scores are not statistically significant in terms of being below the national averages for being 'recognised and rewarded', 'having a voice that counts' and 'working flexibly'. Also pleasing was the sustaining of our staff survey response rate of 50% for a second year running. The 2021 Survey changed significantly in terms of its questions and we will therefore be changing our approach to action planning accordingly. Areas of improvement and further development will be worked on via the Trust's People Hub and PODs whose primary focus is the delivery of the NHS People Plan and the 7 People Promises.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			We will also focus on the Staff Friends and Family Test (SFFT). The two questions with regards to recommending the Trust as a place to work and receive treatment to family and friends will be considered as above. There will be focused actions by directorates for Dental, Halton Children's Services and Warrington Adult Services. The NHS People Pulse Survey will also provide us with a temperature check as to how we are progressing. Updates are formally provided to: - Trust Board - The People Committee - Performance Council - Staff Engagement Steering Group - Joint Negotiation & Consultation Committee (JNCC) - Local Negotiation Committee (LNC) A discussion took place around the challenges in terms of 'we are always learning' and the Committee requested some more detailed information in relation to what our learning offer is across the Trust. There was an agreement that this would be provided as an appendix to the current PPDR and Statutory and Mandatory Training paper at the next Committee. Jo Waldron, Deputy Director of People and Organisational Development and Mike Baker, Assistant Director of Communications and Engagement assured the Committee that there is a commitment to support managers to get	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			underneath the data. It was noted the importance of not making assumptions but to present results to staff with a view to asking what they would want to maintain, stop, or see different in the future. These discussions should help to inform the action plans.	
REVIEW OF PEOPLE STRATEGY	5 and 6		The Review of the People Strategy was presented to the Committee for information, assurance and approval for onward *overall* endorsement/approval to Trust Board. The following areas were highlighted to the Committee by Paula Woods, Director of People and Organisational Development. A Workforce Strategy was developed and approved by the People Committee and Trust Board back in 2019. This was a 3-year strategy to 2022. Since the development of the Strategy there have been some significant changes at national and regional levels. We have seen the introduction of the NHS People Plan (July 2020) and Our NHS People Promises (July 2021), along with a White Paper on integration and collaboration, including the formation of Integrated Care Systems and Integrated Care Boards. The Strategy was produced following the issue of the NHS Long Term Plan in 2019. It was recognised at that time that we could expect some significant workforce developments being announced nationally to deliver the plan, including the strives to have 'one workforce' irrespective of employer as	The Committee endorsed the People Strategy for progression to Trust Board for overall endorsement/approval. The Committee will continue to receive assurances on the operational delivery of the Strategy via the Trust's People Hub and PODs. There will be an annual report illustrating how the measures for success and KPI have been delivered on.

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			per the creating of integrated care models and cross organisational boundary working. Following a refresh of the Trust's Quality & Place Strategy last year, it was agreed that there would be a refresh of enabling strategies. It was also agreed that the Workforce Strategy would be referred to as the 'People' Strategy as this accorded with national strategic and operational people agendas as per the NHS People Plan and Promises that were issued as national drivers to support the Long Term Plan. Notwithstanding that, there were also other national drivers for change as per "The White Paper – Integration and Innovation: Working together to improve health and social care for all". This sets out legislative proposals for health and social care. At the time of writing, this has just received Royal Assent. Integrated Care Systems are geographically based partnerships that work together to integrate services and improve population health. ICSs will be put on a statutory footing from July 2022, after being delayed from April 2022. From July 2022, all NHS Trusts providing acute and mental health services will need to join a Provider Collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England. The rationale for providers working together this way comes down to improving efficiency, sustainability, and the quality of care.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			• The People Strategy will involve engagement at senior levels with communication and engagement plans throughout the organisation • The People Strategy will be delivered by way of the Trust's People Hub and People PODs • People Operational Delivery Plans will be tabled at future meetings in line with the Committee's reporting cycle • Partnership working with our Staff-side colleagues remains a priority and representatives are linked to the Trust's People agendas	
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET OF 4.8% - *including trends information requested in relation to Stress and Infection Diseases related absence.*	5, 6 and WLR 8		The Review of Sickness Absence against Trust Target report was provided for information and assurance purposes. Trust sickness absence for the period 01 April 2021 to 31 March 2022 was 6.83% compared to 01 April 2020 to 31 March 2021 (5.27%). The trust sickness absence target is 4.8%. Over the rolling 12-month period, rolling sickness absence rates has increased month on month from 5.27% to 6.83%. Actual sickness absence % rate has fluctuated month on month. From September 2021 it has shown a month on month increase to January 2022 where sickness absence was at the highest rate. It has reduced in February 2022 and further increased in March 2022 to 6.98%. Long Term absence is showing a decreasing trend from January 2022 and short-term absence is fluctuating over the 12-month period.	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Over the 12-month period, stress, anxiety and depression has decreased. Covid absence has increased month on month due to highly infectious rates. 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 Trust's Health & Wellbeing offer. As per a request in March 2022 Committee, a two year picture of absence for both Stress/Anxiety and Depression and Infectious Diseases was provided in this report. Over the 12-month period, stress, anxiety, and depression has decreased – although it continues to be our highest reason for absence. Covid absence has increased month on month due to highly infectious rates.	
EMPLOYEE RELATIONS REPORT INCLUDING FREEDOM TO SPEAK UP REPORT	5 and 6		The Employee Relations Report was presented by Tania Strong, Interim Head of HR for information and assurance on the management of employee relations cases. The Committee were asked to note the progress with the management of various employee relations cases. The Trust's Just & Learning journey will continue to support improvement and promotion of restorative interventions wherever appropriate. There was a discussion around a small number of cases which had been in progress for some time. Tania Strong, Interim Head of HR advised that a number of these cases were coming to a conclusion, others were delayed due to an	The report was noted 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

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			inability for those involved to engage due to illness. All current cases, including those subject to suspension, remain under review regularly with consideration of the Just and Learning Principles. The FTSU annual report was also presented for information and assurance to provide a summary of the FTSU activity during 2021/22. This report provides an overview of developments including current mechanisms for speaking up, data returns to the NGO, national staff survey results and activity undertaken during 2021/2022. A summary of the data relating to concerns raised to FTSU Guardians during 2021-22 as reported to the National Guardian's Office was presented. Arrangements for FTSU during 2021 included two FTSU Guardians (Lead Guardian - Deputy Chief Nurse/Deputy Director of Infection and Prevention Control and Guardian - Interim Head of HR) who worked jointly to deliver the FTSU offer. They are supported by a network of FTSU champions. The Lead FTSU Guardian retired in Autumn 2021 - following this a review was undertaken which identified that it would be optimal to have a dedicated FTSU Guardian to take forward and continue to embed the role of FTSU and support and increase the network of Champions, with the aim of raising visibility and promotion of ways of speaking up.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			A job description based on the recommended FTSU national job profile has been developed and recruitment to the Lead FTSU Guardian post is underway. Following a Mersey Internal Audit report for 2020/21 in which the Trust received 'Substantial Assurance', to further understand staff's perception of the FTSU role and undertake a baseline survey to determine whether a lack of awareness of the FTSU Guardian's role was contributing to the low numbers of concerns raised, a short survey was conducted in June 2021. There were 291 respondents equating to a 17% response rate, and the results indicated the following: 63% of staff had heard about Freedom to Speak Up, however only 43% of staff said knew how to raise a concern. The understanding around the types of concerns that could be raised were varied, ranging from a 53% awareness that issues raised via Ulysses (the Trust's incident reporting system) may be appropriate, through to awareness of Patient Safety/Quality and Staff Safety, at 80% and 81% respectively. In September 2021 the Lead Freedom to Speak Up Guardian presented an awareness raising session at 'Time to Shine' which led on to various promotions as part of October being 'Speaking Up' month. FTSU activity has reduced during the COVID period but to keep the raising concern messages live, there have been reminders placed in the weekly COVID Bulletin that if 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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			have concerns then they still have the opportunity to raise any concerns. The baseline survey or similar mechanism for testing staff awareness of FTSU will form part of continual improvement plans to raise the profile of FTSU going forward, in conjunction with the staff survey results. The Committee asked whether there was an intention to re-survey staff and/or an intention to explore the data in more detail. Tania Strong, Interim Head of HR advised that this would be considered in line with the recruitment of the Lead FTSU Guardian post going forward. The Committee also noted the non-renewal of the Questback system and asked what plans are in place to consider how staff may raise concerns in the future. Tania Strong advised that the Questback system had historically been under utilised and assured that plans are underway to ensure that a more robust system is provided and communicated to staff with support from our Communications Team. Staff have an ability to raise concerns directly with FTSU guardians.	
SYSTEM STAFFING IMPLEMENTATION UPDATE	5 and 6		The System Staffing Implementation Update report was provided for information and assurance purposes. All services with exception of Dental are now live on the system and rostering in advance on 6 weeks. Dental Services training has taken place. There is ongoing work to support the Dental services to go live onto the system with configuration	The report was noted and the Committee were assured on the 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

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			to the system on hours and annual leave calculations for those who are not on agenda for change terms. The work undertaken as part of the SafeCare workstream of the project to align priorities, dependency and timings of clinical interventions based on local Trust data will support accurate qualitative and quantitative information regarding clinical caseloads that can then be triangulated against staffing. As there are different electronic record systems in Halton and Warrington, the implementation of scheduling systems has differed; Scheduling of rosters on SystmOne (Autoplanner) is now live in Warrington District Nurses. In Halton Allocate and EMIS are working together for a solution on interface of systems with Bridgewater as a test pilot for the interface. As per the request at the March 2022 Committee in terms of indicative timeframes, as at the 3rd of May, Allocate supported a kick off meeting to commence the process and roll out plan to implement the system. The Trust has met with NHSI on a monthly basis to update on the progress implementation of the system within a community organisation. Due to our successful roll out, NHSI have asked us to speak at the North West and North East Regional Attainment Levels Conference about our success. Linda Chivers updated the Committee that an initial audit report had been received with a full report anticipated in 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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			near future – initial results were very positive and MIAA were impressed with how the implementation of the system had been managed.	
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 one policy had been reviewed with highlights of the key legislative and organisational changes provided to the Committee for ease of reference: • Leavers Policy The Local Clinical Excellence Award process for consultant staff is currently under review and the Trust is still awaiting updated guidance from NHS Employers. The refreshed guidance will become effective immediately upon release. The old policy was effective up to 31st March 2022 and therefore has been removed from the intranet on 1st April 2022. Once we receive the new guidance from NHS Employers, the policy will be reviewed and updated in line with this new guidance prior to the processing of the 2022 awards. Paula Woods, Director of People and Organisational Development updated to advise that given the delays in relation to the dissemination of the guidance from NHS Employers, the Regional approach may be to split the funds equally between all Consultants as per the approach last year.	The Committee noted the content of the 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

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
MEDICAL AND DENTAL GOVERNANCE MEETING TERMS OF REFERENCE			The Medical and Dental Governance Meeting Terms of Reference were presented for approval. The Medical and Dental Professional Governance Meeting runs monthly to ensure that relevant information relating to the performance of the Medical and Dental workforce is shared between key stakeholders such that any concerns are appropriately addressed and monitored. It reports to the People committee twice a year and considers appraisal, conduct, capability, professional registration, incidents and complaints.	The Committee noted and approved the contents of the Terms of Reference.
ORGANISATIONAL DEVELOPMENT UPDATES:	5 and 6		Three reports were presented for information and assurance purposes – PPDR & Mandatory and Statutory Training Compliance, Knowledge and Library Services Annual Report, Apprenticeship Scheme Levy and Update.	
PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE	5 and 6 and WLR 7 and 8		The Committee noted the contents of the report and the associated agreed actions. 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.	The Committee noted the reports. Future reports will outline progress in relation to agreed trajectories. The following will be provided at the next Committee in July 2022. • A review of what other high achieving Trust's are doing to attain higher PDR/MT compliance

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Compliance rates are presented to Trust Board with the People Indicators within the IQPR being discussed in detail at the People Committee. M12 (latest available data when this paper was written) compliance with Mandatory Training shows 11 requirements at green, 9 at amber and 2 at red. There is an overall slight increase in compliance from the month 11 position in 16 modules. There were small decreases identified in 6 modules, however these were not statistically significant. PPDR compliance has remined static at around 57% last month and is still significantly adrift of the 85% target. In line with guidance provided by Gold Command, work continues to identify when meaningful well-being conversations have taken place. Communication has focussed on reminding staff to inform the EPD Team when conversations have taken place, retrospectively if necessary. However, sickness levels in clinical and non-clinical staff and increased demands on staff still presents a challenge. The EPD Team continue to offer targeted support to those areas with the lowest compliance rates. There is a commitment to focus on specific trajectories on the completion of specific modules, based on the associated risk of non-compliance as follows: • **Safeguarding Children Level 2 and Safeguarding Adults Level 3 compliance to be 85% in all teams by 1st May 2022.** This is the biggest discrepancy and considered to be a	• A report detailing our Trust's learning offer available to staff so that the Committee has a better understanding of all types of learning ongoing and available within 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

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			significant risk, so this should be of the highest priority, noting that the timescale allows for recovery and planning to achieve the compliance. • **Data Security Awareness compliance to be 95% in all teams by 1st June 2022.** This is a challenging target to reach as we don't have 95% of staff in work as per absence rates being over 5%. That said, periods of staff absence aren't all year round, particularly short-term absence. Communications to significantly improve take up have been highlighted in Team Brief. • **Resus Level 2 compliance to be 85% by 1st July 2022.** This is also a challenge because staff need to be released to attend resus training face-to-face. That said, this should be realistic as our EPD Lead, will be arranging bespoke sessions where possible. Managers have been requested to allocate time in the E-Roster system for the completion of mandatory training, based on the agreed trajectories. Communications have gone out via Team Brief and the Bulletin, highlighting priority areas to focus on – safeguarding, resus and information governance under the banner of **'Make May Mandatory.'** A detailed discussions took place in relation compliance alongside our Staff Survey results in relation to 'We are always learning.' On that basis the following were asked from 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

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			• A review of what other high achieving Trusts are doing to attain higher PDR/MT compliance • A report detailing our Trust's learning offer available to staff so that the Committee has a better understanding of all types of learning ongoing and available within the organisation. This will be provided at the next Committee in July 2022.	
KNOWLEDGE AND LIBRARY SERVICES ANNUAL REPORT	5		The Committee noted the contents of the Library & Knowledge Service Annual Report 2021-2022 report and the actions associated. The report was presented by Razia Nazir, Knowledge and Library Services Manager and the following was noted in terms of achievement and priorities for the service. • Continue to develop digital ways to deliver support and increased access to library services and resources. Last year's developments include: • Setting up the NHS Knowledge and Library Hub which connects Bridgewater staff and learners to high quality knowledge and evidence resources in one place. • Increasing access to eBooks – over 850 eBooks added to the library catalogue • Set up a book club as part of the wellbeing initiative • Sending out welcome emails to all new starters	The Committee noted the reports and were assured on the progress and plans

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Service activity continues to be impacted by Covid-19 and recovery although activity slowly picking up. The most significant increase was seen in accessing e-Resources up from 672 in 2020 to 1081 last year. HEE replaced the Library Quality Assessment Framework (LQAF) with the Quality and Improvement Outcomes Framework (QIOF) in 2019. Due to the pandemic Bridgewater LKS, in line with Health Education England requirements submitted an initial base-line self-assessment in September 2021. The QIOF for NHS funded library and knowledge services operates a different scoring scheme. There is no overall score awarded for QIOF. The emphasis is more on service improvement than on compliance. Upon formal receipt of feedback on the baseline self-assessment, action plans will be put into place to address any areas of development.	
APPRENTICESHIP SCHEME AND LEVY UPDATE	5 and 6		The Committee noted the contents of the Apprenticeship Scheme and Levy Update report and the actions associated. The report was presented by Kathryn Sharkey, Head of Workforce: • To provide an overview of the current apprenticeship activity and details of the Trust's performance against the 2021-22 Government set Public Sector Apprenticeship Target.	The Committee noted the reports and were assured on the progress and plans.

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			• To inform of changes to the Apprenticeship Team, their involvement in recent workforce planning activity and to provide an update of the utilisation and management of the apprenticeship levy funds moving forward. 2021-22 saw the Trust's highest number of starts on apprenticeship programmes since the 2017 apprenticeship education reforms. 53% of the apprenticeship starts in 2021/22 were externally recruited either as new posts or as an alternative to like for like recruitment to vacancies The public sector apprenticeships target came to an end on 31 March 2022. From this date there will no longer be a target set in legislation for public sector employers. However, we have been advised that it is important that public sector bodies continue to gather and report relevant apprenticeships data. Based on initial internal assessment of the data the Trust's performance against the 2.3% target for 2021/22 looks set to be reported at 2.1%. Despite improvements, it is expected that the Trust's Levy funds will remain considerably underspent. Following the workforce planning sessions, the progress with the growth of apprenticeship starts is expected to continue into 2022/23 with 38 projected starts in Q1 and Q2. Work continues to focus on making best use of funds and assure the funds spent offer best value for money and a return on investment.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			The Committee noted the extensive work undertaken in relation to the Apprenticeship agenda and welcomed the efforts of the Team.	
COMMUNICATION UPDATE	5		The Communication Update report was presented by Mike Baker, Assistant Director of Communications and Engagement for information and assurance purposes. This paper updated the People Committee of progress in communications, marketing, media relations, employee communications, awareness campaigns and stakeholder engagement. **Internal Communication and Engagement** - Trust brand and style guide. Work progresses to refresh the Trust brand and style to create a new and uniformed approach. - NHS Staff Survey. In addition to the separate Staff Survey report (agenda item 53/22), the report highlights work taking place behind the scenes during this next stage process around action planning. - Staff Awards and AMM. A date has been set for the 2022 staff awards and Annual Members' Meeting as 21 September 2022. A hybrid approach is once again being scoped. - Trust Strategy and future direction. Further work is	The Committee noted the reports and were assured on the progress and plans.

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			taking place to communicate the future direction of the Trust including a regular staff newsletter. - Staff birthday email. A new and interactive email has been created and issued to staff celebrating their birthday each month. This is part of our reward and recognition staff engagement programme. - Staff bulletins and communication. The team is looking at reducing the amount of email communication bulletins sent each week from three to one. It is proposed to use an external provider to construct a weekly Monday bulletin which will give the Trust data around open rates of the communication etc. - 'Leader in me' event. As this paper was being written a 'save the date' has been issued to staff around this year's Leader in me event. The date scheduled is Friday 1 July. **External Communication** - Media Awareness. The Trust received some high-profile media awareness during this reporting period. BBC North West Tonight ran a special news item promoting the Rapid Community Response Service. - Trust website. In line with the Gov.uk website and the NHS England/NHS website, we are working hard to give the public Bridgewater website a much needed facelift and refresh.	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Partnership Update - System engagement. System engagement has been sporadic since the last people Committee update. This is concerning on a regional North West and Cheshire and Merseyside level. **Horizon Planning** - Widnes Urgent Treatment Centre. Following a change in how patients access Widnes Urgent Treatment Centre, a key campaign is needed to help publicise this change in message. - Trust strategy and future direction. Additional work is needed to support this agenda and the creation of Quality & Place annual 'plans on a page'.	
DELIVERY OF OCCUAPTIONAL HEALTH SERVICES UPDATE	5 and 6 and WLR 8		The Delivery of Occupational Health Services Update report was presented by Tania Strong, Interim Head of HR for information and assurance purposes. The Trust's Occupational Health Services are provided externally by People Asset Management (PAM) - they were awarded the contract and commenced provision of the Trust's Occupational Health offer on 1st April 2021. PAM offer a fully consolidated OH Service including: • Occupational health appointments via management referral • Support and advice for musculoskeletal issues	The Committee noted the reports and were assured on the progress to date.

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			• Physiotherapy • Pre-employment screening • Vaccinations and health surveillance for staff • Needlestick injury support • Stress management support • Ergonomics advice • PAM Assist (Employee Assistance Programme) – a 24 hour / 7 days per week confidential helpline providing advice and support on a range of issues including bereavement, divorce, addiction and stress. • Counselling and cognitive behavioural therapy This report provided an overview of current provision, associated activity data for the period April 2021 to March 2022. Provision is monitored via monthly contract review meetings which includes attendance from the Procurement Team, with the aim of continuing to embed the service and to continually grow and developing the best offer for the Trust and its employees. Following a formal 6 month contract review meeting October 2021 and continuation of poor access performance, the decision was taken to issue a performance notice to PAM in December 2021. KPI access targets were consistently much lower than the required 90% compliance (Management Referrals were at 54%, Pre-employment screening at 33%,	

	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 (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Counselling at 52.5%). A target of all service levels to be compliant by end of Q2 Financial Year 2022/23 was set. PAM has achieved the required service standards and the report detailed the activity over the past 12 months. Given the challenges raised by the pandemic this improvement has been incredibly positive.	
MIAA INTERNAL AUDIT UPDATE – WITHIN REMIT OF THE PEOPLE COMMITTEE	5 and 6		No audits to update on at this Committee.	
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	5 and 6		A review of BAF5 was undertaken. It was noted that the results from Staff Survey should be added to BAF 5 assurances – one of very few Trusts to sustain our score for staff engagement.	The Committee were assured on the progress and governance around the monitoring of the BAF. The agreed changes to BAF5 will be reflected by Trust Secretary, Jan McCartney.
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	5 and 6		Agreed items for escalation were as follows: - People Strategy Refresh.	Items for escalation noted by Committee Chair – The People Strategy Refresh Report and People Strategy
REVIEW OF MEETNG ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			The meeting was deemed as good, with adequate level of debate and very comprehensive reports. Well-led – as per Director's Update links.	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

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	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

People Committee
Date: 11th May 2022
Agenda item: 54/22

Title	Refresh of the Trust's People Strategy (as per the NHS People Plan and People Promises)
Sponsoring Director	Chief Executive – Colin Scales
Authors	Director of People & Organisational Development – Paula Woods
Presented by	Director of People & Organisational Development – Paula Woods
Exec Summary/Purpose	A Workforce Strategy was developed and approved by the People Committee and Trust Board back in 2019. This was a 3-year strategy to 2022. Since the development of the Strategy there have been some significant changes at national and regional levels. We have seen the introduction of the NHS People Plan (July 2020) and Our NHS People Promises (July 2021), along with a White Paper on integration and collaboration, including the formation of Integrated Care Systems and Integrated Care Boards. The Strategy was produced following the issue of the NHS Long Term Plan in 2019. It was recognised at that time that we could expect some significant workforce developments being announced nationally to deliver the plan, including the strives to have 'one workforce' irrespective of employer as per the creating of integrated care models and cross organisational boundary working. Following a refresh of the Trust's Quality & Place Strategy last year, it was agreed that there would be a refresh of enabling strategies. It was also agreed that the Workforce Strategy would be referred to as the 'People' Strategy as this accorded with national strategic and operational people agendas as per the NHS People Plan and Promises that were issued as national drivers to support the Long Term Plan. Notwithstanding that, there were also other national drivers for change as per "The White Paper – Integration and Innovation: Working together to improve health and social care for all". This sets out legislative proposals for health and social care. At the time of writing, this has just received Royal Assent. Integrated Care Systems are geographically based partnerships that work together to integrate services and improve population health. ICSs will be put on a statutory footing from July 2022, after

	being delayed from April 2022. From July 2022, all NHS Trusts providing acute and mental health services will need to join a Provider Collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England. The rationale for providers working together this way comes down to improving efficiency, sustainability, and the quality of care.
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 **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?	*Safe* *Responsive* *Well-led*
Which BAF risks are addressed in this report?	BAF 5 – Staff engagement and morale BAF 6 - Staffing levels BAF 9 – Risk of Trust Objectives due to Covid-19 pandemic
Other risks highlighted/addressed in this paper? (e.g. financial, quality, regulatory, other)	
Equality Impact assessment	Trust policies and procedures are impact assessed. Various people agendas are linked to legislative frameworks that have due regard for equality, diversity and inclusion
Explanation of any acronyms in the report	The acronyms are listed in the People Strategy
Next steps	The Committee is asked to note that: • The People Strategy will involve engagement at senior levels with communication and engagement plans throughout the organisation • The People Strategy will be delivered by way of the Trust's People Hub and People PODs

	• People Operational Delivery Plans will be tabled at future meetings in line with the Committee's reporting cycle • Partnership working with our Staff-side colleagues remains a priority and representatives are linked to the Trust's People agendas
Recommendations	The Committee is asked to: • Endorse/approve the People Strategy for progression to Trust Board for overall approval • Continue to receive assurances on the operational delivery of the Strategy via the Trust's People Hub and PODs

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

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

Bridgewater Community Healthcare NHS Foundation Trust

People Committee

Title	Refresh of the Trust's People Strategy (aligning to the NHS People Plan and Our NHS People Promises)
Author	Paula Woods – Director of People & Organisational Development
Date	3rd May 2022
Purpose	To provide the Committee with a refreshed People Strategy that considers the NHS People Plan, Our NHS People Promises and the changing landscape as per integration and collaboration (Integrated Care Systems)
Audience	People Committee

1.0 EXECUTIVE SUMMARY

1.1 A Workforce Strategy was developed and approved by the People Committee and Trust Board back in 2019. This was a 3-year strategy to 2022. Since the development of the Strategy there have been some significant changes at national and regional levels.

1.2 We have seen the introduction of the NHS People Plan (July 2020) and Our NHS People Promises (July 2021), along with a White Paper on integration and collaboration, including the formation of Integrated Care Systems and Integrated Care Boards. At the time of writing, this has just received Royal Assent.

1.3 The Strategy was produced following the issue of the NHS Long Term Plan in 2019. It was recognised at that time that we could expect some significant workforce developments being announced nationally to deliver the plan, including the strives to have 'one workforce' irrespective of employer as per the creating of integrated care models and cross organisational boundary working.

1.4 Following a refresh of the Trust's Quality & Place Strategy last year, it was agreed that there would be a refresh of enabling strategies. It was also agreed that the Workforce Strategy would be referred to as the 'People' Strategy as this accorded with national strategic and operational people agendas as per the NHS People Plan and Promises that were issued as national drivers to support the Long Term Plan. Notwithstanding that, there were also other national drivers for change as per "The White Paper – Integration and Innovation: Working together to improve health and social care for all". This sets out legislative proposals for health and social care.

1.5 Integrated Care Systems are geographically based partnerships that work together to integrate services and improve population health. ICSs will be put on a statutory footing from July 2022, after being delayed from April 2022.

1.6 From July 2022, all NHS Trusts providing acute and mental health services will need to join a provider collaborative. This is different from previous initiatives because collaboration is now mandated, rather than encouraged, and provider collaboratives will become a universal part of the health and care landscape across England. The rationale for providers working together this way comes down to improving efficiency, sustainability, and the quality of care.

2.0 INTRODUCTION

2.1 The publication of the NHS People Plan and Our NHS People Promises required a refresh of the People and its strategic priorities. The previous Workforce Strategy referred to what the future 'could' look like. The landscape, as envisaged, changed significantly as did the future direction of the Trust.

2.2 Our People Strategy sits alongside the Trust's Equality & Diversity Strategy as enabling Strategies to our overall Quality & Place Strategy. Underpinning those Strategies, as referred to earlier are Plans and Frameworks which include, but are not limited to Staff Communication, Engagement, Health & Wellbeing, Education, Talent Management and Succession Planning.

2.3 In addition to the Trust's People Strategy there are other enabling strategies aligned to the Trust's overall objectives:

- EDI Strategy
- Dental Strategy
- Children's Strategy
- Clinical Strategy
- Engagement Strategy
- Digital Strategy
- Finance Strategy
- Estates & Environment Strategy

3.0 CURRENT STATE OF PLAY

3.1 The required refresh of our People Strategy has been presented to the People Committee previously, noting that nationally, there was a 10-year Strategy further awaited for 'The future of NHS Human Resources and Organisational Development' as issued by the Chief People Officer on the 22nd of November 2021. This had 8 themes which supported the NHS People Plan Pillars and Promises. The Committee are sighted on these developments as per previous Director Update Reports.

3.2 Whilst the future of NHS HR and OD has a 10-year vision to 2023, it is in support of the delivery of the delivery of the 4 Pillars of the People Plan and the 7 People Promises, as per the overall NHS Long Term Plan. There are no significant changes as such.

3.3 There is both national and regional support in place for Trust's to deliver on all of these People agendas, including how we work collaboratively at place and as a system.

3.4 The world of work is changing at a pace we could never have imagined because of the pandemic. Existing ways of working, models of care and organisational boundaries are being transformed which include evolving technologies, automating tasks and remote working.

3.5 Attracting, developing and retaining our workforce is now a significant challenge as we face national staff shortages, our highest levels of turnover as an institution and at least two years of recovery and restoration to pre-pandemic service delivery.

3.6 As we embrace national drivers and our future direction, we must remain focused on prioritising the health and wellbeing of all our people. A healthy, resilient, and engaged workforce will creative a positive impact on our communities, ensuring that we meet the needs of our patients now and in the future.

4.0 THE OPERATIONAL DELIVERY OF OUR PEOPLE STRATEGY

4.1 As the Committee are aware, we have been prioritising the delivery of the 4 Pillars of the People Plan and 7 Promises via our People Operational Delivery Groups that are more commonly referred to as PODs. The PODs have oversight and direction from the Trust's People Hub. Progress is reported to various Trust meetings and groups with overall assurance via this Committee and ultimately the Trust Board.

4.2 At the end of each financial year, the People Strategy will be reviewed against its key performance indicators (KPIs). An annual summary of delivery and achievements against the Strategy will be published alongside it.

5.0 NEXT STEPS

5.1 Our refreshed People Strategy will be subject to a final proofread and put into the Trust's new branding. It should be noted that the ICS illustration refers to April 2022 which was subsequently superseded by July 2022.

5.2 The Strategy will be shared and discussed with the following:

- The Executive Management Team (EMT)
- Senior Leadership Team (SLT)
- Our Staff-side Colleagues

5.2 Crucial to the delivery of our people agendas is staff communication and engagement. Staff are aware of the work of our PODs which has been presented to the Committee as per the POD Group action plans. At present, there are 3 weekly Bulletins that inform staff of key people agendas in addition to our monthly Team Brief. Our People Values are communicated at every opportunity and these will be tested out and evaluated through various engagement activities and programmes of work.

5.3 Our 2021 NHS Staff Survey results have been analysed and action plans are in place that align with the NHS People Plan and Promises. Directorate action plans will be tabled at the Trust's Finance, Performance & Workforce Meetings (FWP) with assurances to the Trust's Performance Council. Overall assurance will be to this Committee.

5.4 As the Committee are aware, we have the following in place which supports communication and engagement at all levels:

- Health & Wellbeing POD
- Culture & Leadership POD
- Recruitment & Retention POD
- Education, Learning & Development POD
- Staff Engagement Steering Group
- Joint Negotiation & Consultation Committee (JNCC)
- Local Negotiation & Consultation Committee (LNC)

5.5 The Staff Survey is a great indicator of staff satisfaction, engagement and morale. Quarterly Pulse Surveys enable a temperature check as we focus on continuous improvement and those areas that we have identified for further development as outlined in our programmes of work and action plans. The Surveys reconcile to the 7 People Promises.

5.6 Our partnership working arrangements are to be commended. Our Staff-side Colleagues remain as committed as ever to ensuring the best possible employee relations climate and staff experience. With their active input, we have ensured that staff have been fully supported throughout the pandemic.

5.7 Our Just Culture Journey will further embed our commitment to an environment where we can share our concerns, reflect and learn and most importantly have the psychologic safety to do so. As above, our Staff-side Colleagues have played a significant role in this significant transformation programme and will continue to do so.

6.0 RECOMMENDATIONS

6.1 The Committee is asked:

- to endorse the refreshed People Strategy for overall Board approval
- to continue to receive assurances on the operational delivery of the Strategy via the Trust's People Hub and PODs

7.0 APPENDICES

Appendix 1 The Trust's People Strategy

Bridgewater Community Healthcare NHS Foundation Trust

Bridgewater Board June 2022

Board Part Public

Agenda item 40/22i

Title	NHS Provider Licence self- certification
Sponsoring Director	Colin Scales, Chief Executive
Authors	Jan McCartney, Trust Secretary
Presented by	Jan McCartney, Trust Secretary
Exec Summary/Purpose	NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements. Providers need to self-certify the following after the financial year end • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • The provider has complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) In order to do this, the Trust has elected to use the self certification templates (attached) as provided by NHS Improvement. Condition CoS7 does not apply as this Trust does not provide any designated Commissioner Requested Services. Boards must sign off on self-certification.

Previously considered at	N/A
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?	***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 approve the certificates as attached.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Bridgewater Community Healthcare NHS Foundation Trust

Insert name of organisation

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration" | **Financial Year to which self-certification relates** | 2021/22 | Please Respond

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risks identified. Assurance include the Annual Report (declaration of compliance with the Code of Governance) and systems and controls assurances are obtained via the Audit Committee as described in the Annual Governance Statement (AGS) 2021/22. The Head of Internal Audit Opinion for 2021/22 stated an overall opinion of 'Substantial Assurance, can be given that there is an adequate system of internal control...' Effectiveness review of Board Committees are also undertaken.	#REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No material risks identified Key documents are highlighted/circulated to the Board through the Trust Secretary. Legislative and regulatory changes are diseeminated through membership of the NW FT Company Secretary Network and NHS Providers Complany Secretary Network. The Board reviews/discusses key guidance at Board meetings and/or Board Development sessions.	#REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified Committees are established with clear lines of reporting. Board approved Terms of Reference are in place clearly describing the Committee responsibilities, memberships and reporting arrangements. Along with the Committee Cycles of Business, the Terms of reference are updated annually to reflect the changing needs of the organisation. There are a wide rannge of additional controls in place including an approved Scheme of Delegation, Standing Financial Instructions, Board member appraisal process and agreed Executive portfolios.	#REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	No material risks identified There are a range of systems/and or processes in place which evidence the Trust's ongpoing compliance with the requirement. These include: Trust Board Meetings, presentation of the Integrated Quality Performance Report to each Board meeting which covers Quality, Finance,Performance and People presented to the Board. The Trust's Board Assurance Framework is reviewed at each Board and Committee of the Board. The External and Internal Audit Annnual opinion and Audit Annual Plan are approved by the Audit Committee.	#REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	No material risks identified Non-Executive and Executive Directors during 2020 - 21all received a robust performance and appraisal review. This included the Board members who have clinical, medical, financial, operational, and HR expertise. The Board includes clinical non-executive directors, a Medical Director and Chief Nurse who are accountable for assurance of and delivery of the quality agenda. Quality metrics are scrutinised at the Health and Safety Committee and assurance provided to the Board via the Chair's report. The Quality dashboard is reviewed at a number of levels before being presented for assurance to the sub-committee of the Board. Robust arrangements are in place for staff, patients and members of the public to raise concerns in relation to the quality of care including Freedom to Speak up Guardian, PALS and Complaints. There are Friends and Family Test systems in place and the Trust has an active Council of Governors with a keen focus on quality of care. There is clear accountability for quality of care throughout the Trust allowing for appropriate escalation to the Board. Indpendant external Well led review conducted. Ongoing Board development facilitated by GGI and NHS Providers.	#REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is satisfied. During 2021/22 the Board of Non-Executive and Executive Directors were sufficient in number and appropritely qualified. The Executive Directors are all substantive appointments and have a range of skills, knowledge and experience. Non-Executive Directors and the Chair also have a variety of skills, knowledge and experience and are from a range of backgrounds, including operational, financial and clinical	#REF!

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Karen Bliss - Chair **Name** Colin Scales - CEO

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A

Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates 2021/22 Please Respond

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Karen Bliss	**Name**	Colin Scales
Capacity	Chair	**Capacity**	Chief Executive Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Bridgewater Community Healthcare NHS Foundation Trust *Insert name of organisation*

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2021-22 Please complete the explanatory information in cell

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

Internal Audit - Substantial Assurance
Board committees
Trust continuous improvement plan in place
Internal audit plan agreed for 22/23
Leader in Me
Governance Structure
Declarations of Interests

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Karen Bliss	**Name**	Colin Scales
Capacity	Chair	**Capacity**	Chief Executive Officer
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

Bridgewater Community Healthcare
NHS Foundation Trust

Bridgewater Board Date 9 June 2022

Board Part Public

Agenda item 40/22ii

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	**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?	***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	9 June 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 Board ToR were previously in 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	
All sections	Updated format
Basis of Authority	Update to basis of authority to include the legal basis of the Board
Membership	Membership now specified in detail Medical Director (vote shared by two part-time Medical Directors) Corporate governance support will take minutes and provide appropriate support to the Chair and Board members
Frequency of Meetings and Location	Meetings will normally be bi-monthly however the Board may agree to vary the frequency Frequency of members attendance specified including reference to 75% of diarised meetings. If required, the Board may meet via digital technology. In this event, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	'Chairman' replaced with 'Chair' Number of Non-Executive Directors increased to 4 from 3
Duties and Responsibilities	Reference to the Integrated Care System in partnership working
Inputs	Agenda, supporting papers and minutes added Chair's *Assurance* Reports from Committees

	Escalation from Board level Committees Request for further information or assurance from Council of Governors
Outputs	Board Assurance Report to Council of Governors Board summary published on Trust website
Other matters	Attendees Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the Board. Deputies have no voting rights. Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation.)
Process for monitoring compliance with Terms of Reference	Inclusion of Appendix A, Monitoring Compliance with Terms of Reference

3.0 RECOMMENDATIONS

3.1 The Board is asked to approve the proposed changes.

Appendix 1 – Draft Board Terms of Reference

Appendix 1

Bridgewater Community Healthcare NHS Foundation Trust

Board of Directors
Terms of Reference

Name	Board of Directors
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.
Basis of Authority ~~Membership~~	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 Health and Social Care (Community Health and Standards) ~~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.
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 Director)

	Up to six Executive Directors, currently comprising: • Chief Executive Officer (also the Accountable Officer) • Deputy Chief Executive Officer / Chief Nurse • Director of Finance • Chief Operating Officer • Medical Director (vote shared by two part-time Medical Directors) • 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. Corporate governance support will take minutes and provide appropriate support to the Chair and Board members.
Connectivity	Committees reporting to the Board: • Audit Committee • Finance and Performance Committee • Nominations and Remuneration Committee • People Committee • Quality and Safety Committee

Formatted: Font color: Red

	• Any other ad-hoc Committee established by the Board
Frequency of Meetings and Location	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. Each member is to attend at least 75% of the diarised meetings within a calendar year. 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. If required, the Board may meet via digital technology. In this event, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	The Board of Directors will be quorate when seven 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 four Non-Executive Directors (one of whom must be the Chair or Vice-Chair of the Board). If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	**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 as part of the Integrated Care System 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. **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. **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. **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. • The Board is responsible for ensuring a Fair and Just Culture and taking a positive stance on Anti-Racism. **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. **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. **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 publicly, primarily via the Trust's website. • Publishes an annual report and annual accounts. **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.
Inputs	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 working 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. • Reports and plans as per agreed Board of Directors work plan, • Chair's ~~Reports~~Assurance Reports from Committees • Reports / formal correspondence from Regulators & key stakeholders • ~~Delegated / transferred issues~~Escalation from ~~Board and/or~~ Board level Committees~~.~~ • Request for further information or assurance from Council of Governors
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 working 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.~~ • Board Assurance Report to Council of Governors • Board summary published on Trust website.
Closed Session	On specific occasions it may be necessary for the Board to meet in closed sessions. Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.
Other Matters	**Attendees** • Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the Board. Deputies have no voting rights.

Formatted: Font: (Default) Arial

Formatted: Normal, No bullets or numbering

Formatted: Font: (Default) Arial

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.63 cm + Indent at: 1.27 cm

Formatted: Font: Not Bold

Formatted: Font: Not Bold

Formatted: Indent: Left: 1.27 cm, No bullets or numbering

	• Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation.) **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. (See Appendix A) These Terms of Reference will be reviewed by the Board at least annually.
Issue Date	Month YEAR
Review Date	Month YEAR

Formatted: List Paragraph, Bulleted + Level: 1 + Aligned at: 0.63 cm + Indent at: 1.27 cm

Formatted: Font: Not Bold

Formatted: Font: (Default) Arial

Formatted: Normal, Indent: Left: 0.63 cm, No bullets or numbering

Appendix A

Monitoring Compliance with the Terms of Reference for Board of Directors

Aspect of compliance or effectiveness being monitored	Monitoring method	Individual responsible for the monitoring	Frequency of the monitoring activity	Group / Committee which will receive the findings / monitoring report	Group / Committee / individual responsible for ensuring that the actions are completed
Duties of the Board	Review of agenda items	Trust Secretary	Annually	Board of Directors	Board of Directors
Reporting arrangements to the Trust Board	Review of Board agenda	Trust Secretary	Annually	Board of Directors	Board of Directors
Membership, including nominated Deputy	Annual report	Trust Secretary	Annually	Board of Directors	Board of Directors
Frequency of attendance by Members	Annual report	Trust Secretary	Annually	Board of Directors	Board of Directors
Reporting arrangements	Review of minutes	Trust Secretary	Annually	Board of Directors	Board of Directors
Requirements for a quorum	Review of minutes	Trust Secretary	Annually	Board of Directors	Board of Directors
Frequency of meetings	Review of minutes	Trust Secretary	Annually	Board of Directors	Board of Directors

The monitoring of compliance for the Board will be undertaken on behalf of the Trust by the Trust Secretary.

ISSUE DATE	Month YEAR
REVIEW DATE	Month YEAR