NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST
PUBLIC BOARD MEETING

Thursday 4 August 2022, 10am
Halliwell Jones Stadium, Warrington

A G E N D A

Item	Time	Item Title	BAF Reference	Action
50/22	**10.00**	**APOLOGIES FOR ABSENCE – Nick Gallagher** **DECLARATION OF INTEREST IN ITEMS ON THE AGENDA**		**Information** **Assurance**
51/11	**10.00**	**MINUTES OF THE LAST MEETING:** (i) **BOARD MEETING HELD ON 9 JUNE 2022** (ii) **EXTRAORDINARY BOARD MEETING HELD ON 20 JUNE 2022**		**Assurance/ Approval**
52/22	**10.05**	**MATTERS ARISING FROM THE ACTION LOG**		**Action/ Assurance**
53/22	**10.10**	**ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE CHAIR**		
54/22	**10.10**	**SPOTLIGHT ON SERVICES**		**Information**
55/22	**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	**ALL**	**Assurance/ Approval**

		BAF 6 Staffing levels BAF 7 Strategy and Organisational sustainability BAF 8 Digital Services which do not meet the demands of the organisation		
56/22	**10.45**	**KEY CORPORATE MESSAGES**	**BAF1**	**Information**
57/22	**11.00**	**QUALITY - To deliver high quality, safe and effective care which meets both individual and community needs** (i) IQPR – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 23 June 2022 – presented by the Committee Chair	**ALL** **BAF2,3,6**	**Assurance** **Assurance**
10 minute break				
58/22	**11.40**	**SUSTAINABILITY – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability.** (i) Finance report - presented by the Deputy Director of Finance (ii) Reports from the Finance and Performance Committee held on 21 July 2022 – presented by the Committee Chair (iii) Report from the Audit Committee held on 7 July 2022 - presented by the Committee Chair (iv) Financial impact on pay award announcements – presented by the Deputy Director of Finance	**BAF4** **BAF4, 7, 8** **BAF1** **BAF4**	**Assurance** **Assurance** **Assurance** **Assurance**
59/22	**12.20**	**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**

60/22	**12.30**	**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 13 July 2022 (including the Workforce Disability Equality Standard, Workforce Race Equality Standard and Allied Health Professionals Strategy and Workforce Plan for endorsement) - presented by the Committee Chair	**BAF5, 6**	**Assurance and approval**
61/22	**12.45**	**OVERARCHING CORPORATE GOVERNANCE ITEMS** (i) Amendment to Constitution (ii) Application of Trust Seal (iii) Board Business Cycle (iv) Review of Board Committee Terms of Reference	**BAF1**	**Information** **Information** **Approval** **Approval**
62/22	**1.05**	**REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK**	**ALL**	**Information**
63/22	**1.10**	**OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE CHAIR**		**Information**
64/22	**1.15**	**DATE AND TIME OF NEXT MEETING** **Thursday 6 October 2022, 10am, in person meeting – venue details to be provided.**		**Information**
65/22	**1.15**	**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 9 June 2022, 10am
Meeting held virtually via Microsoft Teams

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

In Attendance
Rob Foster, Programme Director of Integration and Collaboration
Eugene Lavan, Deputy Chief Operating Officer
Jo Waldron, Deputy Director of People
Kathryn Sharkey, Head of Workforce (for item 33/22)
Sarah Power, Careers and Apprenticeship Lead (for item 33/22)
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

Observers/members of the Public
Sarah Howarth, Borough Director, Warrington
Rita Chapman, Lead Governor
Diane McCormick, Public Governor, Halton
Peter Hollett, Public Governor, Halton

29/22 (i) APOLOGIES FOR ABSENCE
Aruna Hodgson, Medical Director
Sarah Brennan, Chief Operating Officer

The Chair welcomed all to the meeting. The Board congratulated Non-Executive Director, Sally Yeoman who had been awarded an MBE for services to the community with her role with Voluntary and Community Action in Halton and St Helens.

ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

There were no declarations of interest made.

30/22 MINUTES OF THE LAST MEETING:

7 APRIL 2022

The following amendments were agreed:

Page five, first paragraph, second sentence to read: 'It *fully* 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'

Page seven, second to last paragraph, second sentence to read: 'The Trust Secretary confirmed that the report covered the use of the seal for a full financial year, as the seal had not been applied between 31 March 2021 and 29 April 2021.'

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

31/22 MATTERS ARISING FROM THE ACTION LOG

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

25/22iii Board Effectiveness Review

The Trust Secretary advised that work was ongoing to refresh Terms of Reference in line with the areas highlighted by the review. A revised workplan for the Board would be presented to the Board in August 2022, along with the suite of Committee Terms of Reference for Board endorsement, once those documents had been reviewed and approved by each Committee as part of the June/July 2022 cycle. The Board agreed that this action would remain on the action log and this would be updated with a due date of August and an appropriate RAG rating.

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

64/21i Finance Report
19/22 Board Assurance Framework
24/22iii NHS North West Anti-Racism Framework
25/22ii Board Terms of Reference

32/22 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.

33/22 SPOTLIGHT ON SERVICES – TALENT FOR CARE TEAM

Kathryn Sharkey, Head of Workforce and Sarah Power, Careers and Apprenticeship Lead were in attendance to give a presentation to the Board regarding talent for care and apprenticeships focussed on careers and widening participation and access. The key highlights included:

- A description of the Health Care Support Worker (HCSW) recruitment campaign and the increase in applications. This included a new centralised approach, new marketing campaign, increased contact and engagement with applicants.
- Eligibility screening against a set of criteria to ensure that individuals were ready to apply for an apprenticeship.

- Values based interviews took place which helped to ensure that there were appointable candidates and a talent pool was established.
- NHS Improvement/England requested that consideration was given to onboarding and retention to ensure that individuals would want to remain as part of the organisation. An enhanced induction programme was in place with programme support.
- The programme had won a Nursing Times award which had resulted in positive outcomes including an increase in interest and awareness of the programme.
- The programme model had been replicated on smaller scale and had helped to fill vacancies with local interviewees and keeping others not appointed at that time in a talent pool. This had helped to improve cross functional working.
- It was noted that the programme agenda was substantial, but it was being ensured that the task and finish recruitment workstreams and PODs in place were linked into the People Plan. Work would also feed through into the People Committee.
- In addition, there was collaboration and partnership working in Cheshire and Merseyside with local colleges and networks with other organisations.
- A Trust careers portal was to be launched.
- Offers were in place for existing staff including skills for life (Maths and English) Apprenticeships both developmental and progressive/Care certificate/AHP support workforce project/Career ambassador volunteering opportunities and career conversations.
- There were 44 live apprenticeships with planned starts – with 25 to 30 in quarter two of the current year, however those numbers were currently provisional.
- The team had engaged with operational teams who were considering future options with apprenticeships such as healthcare/nursing associates.
- It was also noted that services were still under pressure and doing work on phased approach. Apprenticeships were planned in quarter one and two in this year with September commencements for higher level clinical apprenticeships.

The Trust Chair observed that there was not only a benefit for the organisation but also for the communities that the Trust served, providing opportunities for young people in local communities with stable employment as well as good health outcomes.

Non-Executive Director, Linda Chivers asked whether there was an improving view of apprenticeships within higher education, noting that apprenticeships were not always viewed positively in the past. The Careers and Apprenticeship Lead advised that progress was being made on this and that part of work had been around ‘myth busting’ providing advice and information on apprenticeships and correcting misconceptions. She advised that there had been work with Manchester University which were now offering apprenticeships.

Non-Executive Director, Abdul Siddique asked about the ethnic breakdown of apprentices and if there were any challenges around this. The Careers and Apprenticeship Lead advised that currently the breakdown was not diverse and this was still growing in terms of the numbers of direct entry. She advised that the Trust would need to explore whether it needed to make apprenticeships more attractive or whether it needed to review the populations that it was recruiting from to ensure an increase in diversity. She added that it would also be possible to tap into the Trust staff networks to explore if there was further work that could be done. The Head of Workforce advised that the Trust could also work with the Princes Trust and consider options such as a change in branding for apprenticeships. Non-Executive Director, Tina Wilkins referred to inclusion of male apprentices, noting that there was only one male apprentice referred to within the presentation. She also referred to inclusion for those with disabilities and including individuals from different cultures and communities. The Careers and Apprenticeships Lead advised that engagement would be an important factor across communities, including breaking down barriers including around perceptions of working in the NHS, providing information and dispelling myths such as that a certain level of previous experience was required for some roles. which may prevent some individuals from having an interest.

The Chief Executive asked how the programme could be taken forward on a wider platform, tuning into where the greatest workforce and retention challenges were. The Head of Workforce advised that there was lessons learned information from the programme that was being taken through a task and finish workforce group. She advised that the Trust was taking part in recruitment fairs, with two imminent events including a fair in Warrington. Part of work would be looking at how this information was communicated into the population and community, including that the Trust was offering a different approach and different roles compared to other employers. In addition, work was being undertaken to apply the approach and engagement from the apprenticeship posts to other recruitment drives such as higher level posts. The Careers and Apprenticeships Lead added that there was also work to be undertaken on the internal progressions routes in the Trust, illustrating career pathways for existing staff and demonstrating for new staff that there were development and progressions routes open for them in the future.

The Board thanked the Head of Workforce and Careers and Apprenticeship Lead for their presentation and recognised that work was ongoing to continue to build on the apprenticeship programme and the learning from this to support future workforce and retention.

34/22 BOARD ASSURANCE FRAMEWORK

The Trust Secretary presented the Board Assurance Framework. She highlighted that the April meeting of the Audit Committee had considered a number of changes to BAF1, including a minor change to the narrative around the principle risk, the rationale for the current score to be updated reflecting the delay in well led actions, update to the wording of the prevent controls to reflect the management structure in place and including the risk register as a prevent control, detect controls to include the online staff survey, an update to assurances which would include adding MIAA governance checklists and gaps in control to reflect the current CQC inspections approach. The Trust Secretary advised that in considering those updates and in particular, recognising that the well led actions were still to be implemented with significant discussion at the Committee on early audit work and value for money aspects, the Committee recommended a change to the current risk rating to a high 12 and likelihood of three, meaning a high rating.

Non-Executive Director, Linda Chivers informed the Board as the Audit Chair, that the potential for significant weaknesses in governance had been identified; the Audit Committee had been assured by KPMG that there had been no evidence of this, however the potential for this had been identified. She advised that once the audit work and findings were completed, it was expected that this risk would then be reduced. She commented that as the BAF was a live document, this must reflect the above at the current point in time, with the correct narrative in the rationale for BAF1. There would be further discussion at the July meeting of the Audit Committee once the final accounts had been received along with an update on the well led action plan, noting that there was one area that would not be completed until October 2022.

The Chair commented that the information provided within the covering report provided assurance that there was robust review and discussion of the BAF taking place at the Board Committees. The Director of Finance added that the auditors had provided some recent feedback that they were satisfied with the information that they had received and did not consider the risk concerning governance weaknesses to be an issue. Non-Executive Director, Linda Chivers acknowledged this, and commented that she was not concerned regarding the potential risk but asked that it be ensured that the risk be reflected on the BAF at this point in time.

Following a challenge from Non-Executive Director, Linda Chivers concerning a lack of gaps identified against BAF7 it was agreed that the rationale must reflect actions that the Trust was taking noting that there was an emerging landscape across the system where the Trust

did not/could not yet have definitive actions in place due to external uncertainty and this was outside of its control. The Finance and Performance Committee would review BAF7 at its July meeting in detail and would include consideration of this and what information must be reflected within the rationale.

The Chief Executive commented on the cover report accompanying the BAF. He acknowledged the detail that was drawn out from Committee considerations and discussion across the BAF but questioned whether further information was needed around the individual Committee management of the BAF and drawing out further detail. The Trust Secretary advised that this information would be provided within the Committee Chair's reports to the Board but further consideration could be given to this if required.

The Trust Secretary referred to an outstanding recommendation from auditors concerning the BAF to change 'rationale for the current score' to 'actions required to achieve the target risk rating'. She asked the Board to consider this proposal. Non-Executive Director, Linda Chivers commented that she would not like to lose the rationale, but identification of the actions required would be useful. Non-Executive Director, Sally Yeoman commented that the discussion taking place at Committees was important as they were sighted on a level of detail which the Board was not sighted on in the same way and the BAF was providing assurance that the Committees were considering the detail of the actions and reaching a decision on the risk ratings. The Director of Finance commented that the BAF should not contain actions but assure the Board that actions were being taken and it would not be appropriate to reflect a detailed list of actions within the document. Non-Executive Director, Gail Briers commented that the Trust needed to track its actions to achieve its strategic aims and ambitions but that the detail of this did not need to be included within the BAF. She suggested that the Board respond to the auditors to acknowledge this action needed to be considered but that it would not be taken forward in the way in which it had been suggested. Non-Executive Director, Linda Chivers suggested that the Committee Chair reports could include any areas that would not be achieved against the target risks by exception. **The Chair concluded that Committee Chair reports to the Board must clarify the key actions being taken across the BAF going forwards to ensure assurance was being provided on this to the Board. The Board agreed that this should include a focus (avoiding lengthy detail) upon any areas that a Committee identified that would not be achieved against the target risks by exception.**

Medical Director, Ted Adams commented that BAF7 related to strategy in the main and that that there were not many specific financial or performance related areas within this BAF and this was not related to financial strategy. He questioned whether the Finance and Performance Committee was the correct forum to consider this section of the BAF. Non-Executive Director, Linda Chivers highlighted that there was still a need to consider metrics to set out what the Trust was delivering against the strategy. Non-Executive Director, Tina Wilkins considered that the Finance and Performance Committee could consider BAF7 and manage the oversight of this element and had been doing so successfully. It was also noted that the Executive Lead must be updated for BAF7.

35/22 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. He noted that the Trust had received a visit from Amanda Doyle, North West Regional Director on 14 April 2022, which had been positive. The Chief Executive also informed the Board that the Trust took part in a Warrington Apprenticeship, Training and Jobs Fair as a sponsor, which took place on 29 April. The Trust was invited to take part in this by Andy Carter, MP, and the Chief Executive noted that this was a community-based event, alongside other local businesses to encourage and support people into work. This was a key priority for the Trust, having received national recognition for the work undertaken in offering apprenticeship

opportunities to the communities that it served. The Board received the report for information.

36/22 QUALITY - To deliver high quality, safe and effective care which meets both individual and community needs

(i) IQPR

The Board received the report which set out the key areas of performance for the Trust for month 12 (March 2022) across operations, quality, people and finance.

At month 12 there had been new red indicators in month in relation to the Widnes Urgent Treatment Centre (UTC). Four hour waiting times had been exceeded for the first time in two years, however there had been an improvement over recent weeks with a performance of 97% against the target. The appointment model had also now been changed to offer walk in appointments to patients, moving away from the previous telephone triage arrangements. Close monitoring would continue around the targets moving forwards. Non-Executive Director, Tina Wilkins asked whether the Trust would test out if the public were more content with the change in the appointment model at the UTC, recognising the feedback that had been received via the Council of Governors that there had been some confusion concerning access for residents/patients. The Chief Executive commented that engagement with local people would be of key importance to test this out. He advised that there had been communications disseminated to stakeholders within Halton to clarify the arrangements, along with information in the local press and this would continue over the Summer, with a potential update via Halton community radio. The Director of Integration and Collaboration advised that there would be some advertisements via local radio and that he had been linking in with the Communications Lead at One Halton to publicise messages and there would be a range of options utilised, both written and via media/social media to engage with the population. The Chief Executive added that the Trust must also listen to the feedback received from the public concerning the service offer.

Non-Executive Director, Linda Chivers referred to the dental waiters by time band. She acknowledged that there was a plan in place to address the 104 week waiters by the end of July, but noted that there were significant numbers of waiters which did not appear to be a spike, but an increasing trend. She asked if there was a view from commissioners concerning support for the Trust on this matter. Discussion took place concerning this and the Chief Executive proposed that it would be helpful for a trajectory of improvements on waiting times to be included in future reports, which would demonstrate progress being made. It was proposed that this information would be provided to the Board and the Finance and Performance Committee via the IQPR. The Chief Nurse advised that this information was discussed at the Trust performance council at each meeting and this information could be provided. **It was agreed that trajectories of improvements on waiting times moving back to pre-pandemic levels would be included in future reporting to the Finance and Performance Committee and the Board.**

Following a question from Non-Executive Director, Gail Briers concerning the latest position on Information Governance training, the Director of People advised that a report was due to be provided imminently but this had been delayed due to the jubilee bank holiday weekend. There would be a high level table which would provide month on month data on training within the IQPR report going forwards.

(ii) Covid-19 Update Report

The Board received a presentation from the Deputy Chief Operating Officer which included an update on a number of key areas:

The next steps of transition from the pandemic response into recovery: following a letter

issued from the NHS Chief Executive and Chief Operating Officer on 19 May, the pandemic had been reclassified as a level three incident following a sustained decline in community and hospital cases of covid-19. The Deputy Chief Operating Officer explained that the Trust's immediate areas of focus would be delivering timely and urgent emergency care and discharges, providing more routine elective and cancer tests and treatments and improving patient experience as well as lesson learning and building for the future,

New infection, prevention and control guidance and changes: The Deputy Chief Operating Officer reported that NHS Improvement/England guidance had been updated from 1 June. This set out that facemasks were no longer mandatory in non-clinical areas, however patient facing staff were to continue to wear a mask when in contact with patients. Routine symptomatic PCR testing would no longer take place for staff and patients; however staff were asked to continue twice weekly lateral flow testing.

The Trust's command and control structure remained in place; however the structure requirements would be reviewed in the light of national guidance.

An update on internal reset and recovery: The Deputy Chief Operating Officer advised that improving resilience and supporting staff post pandemic was a priority, with learning from this period being embedded. There would be a focus at the Trust performance council concerning recovery and the delivery of activity increasing and reduction of waiting lists. There was also a continued focus around supporting discharge and maintaining activity at the Widnes Urgent Treatment Centre.

The Deputy Chief Operating Officer highlighted that staff sickness had significantly reduced due to covid-19 with 15 cases recorded on 6 June from 118 recorded in January 2022.

The Chief Nurse informed the Board that cases of monkeypox in England had reached 320 in number as at the 8 June 2022. She also reported that she had joined an antibiotic prescribing group which would be undertaking specific work on paediatric prescribing and would have an impact on paediatric services. The Board also noted that a proposal concerning future command and control arrangements was expected imminently, and a number of NHS Trusts had begun to stand down the command and control arrangements, with there also being no current regional structure in terms of bronze, silver and gold command.

Non-Executive Director, Tina Wilkins asked whether the numbers of Trust staff affected by long covid were available. The Chief Nurse advised that there was no requirement for staff to declare this, but a number of staff had informed the Trust which was then able to provide support. She advised that this was currently a small number of staff and they were receiving occupational health support.

The Medical Director noted that there was a further expected peak of covid-19 cases across England with a potential new variant identified.

(iii) Ockenden II Report Update

The Chief Nurse introduced the report which set out that the Ockenden II report published on the 30 March 2022 provided the 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. 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 in a timely manner. The Chief Nurse noted that whilst Bridgewater no longer provided maternity services, there were lessons to be learned for wider service areas. The Trust had reviewed and assessed its position against a number of actions from the Ockenden II report:

- Listening to women and families which can apply to all services.

- Staff training and working together (staff who work together must train together) which can apply to all
- Complex pregnancy pathways which is maternity specific, but the principle applies to all clinical pathways
- Risk assessments in pregnancy, which is maternity specific, but risk assessment applies to all patients
- Informed consent which is maternity specific but can apply to all patients

The Chief Nurse advised that the Trust had in place comprehensive risk assessment processes and escalation processes, a comprehensive complaints process including Duty of Candour and feedback routes for relatives to advise if they were content with the process and the response received. The patient engagement strategy was also in place with a number of different feedback mechanisms. She advised that the e-rostering system would also ensure that the Trust had the right staff in the right place with a competency framework in place and training and development. She added that there was also multi-disciplinary working as part of development of pathways. There were routes in place for staff to raise concerns and auditing on actions to ensure that the desired results and outcomes had been implemented/embedded. The Chief Nurse informed the Board that there were no identified gaps for the organisation in relation to the Ockenden II report and that evidence was available against each of the key areas described above to demonstrate that this was in place. Whilst there were no additional actions to be put into place, the Chief Nurse highlighted that it would be important to continue monitoring of the elements that were already in place. The Board welcomed the report and the assurance that the Trust held the necessary evidence that there were no gaps in relation to the Ockenden II recommendations.

Non-Executive Director, Gail Briers referred to the areas of the Ockenden II review that would be delegated to the Quality and Safety Committee to review and to provide assurances to the Board. She also questioned whether the Trust had undertaken a review of any incidents and complaints from when it provided maternity services to identify if the responses were of sufficient quality and/or if they were appropriate, for example in relation to a response to an incident. **The Chief Nurse agreed that she would undertake a retrospective review of the incidents and complaints received by the midwifery service pre-transfer which would include supporting evidence. The Quality and Safety Committee would receive and scrutinise this report and would subsequently provide assurance on this the Board.**

The Chief Nurse confirmed to Non-Executive Director, Martyn Taylor that interviews would be taking place to appoint a Freedom to Speak Up Guardian for the Trust following the departure from the Trust of the previous guardian and this role had been advertised.

The Board received the report for assurance and noted that the Quality and Safety Committee would receive further information via a retrospective review and would report back to the Board following consideration of this.

(iv) Report from the Quality and Safety Committee held on 21 April 2022

The Board received reports for assurance from the last Quality and Safety Committee meeting from the Committee Chair, Gail Briers.

(v) Independent Inquiry into Child Sexual Abuse (IICSA)

The Board received the report for information and oversight, noting that this had been considered by the Quality and Safety Committee in April. The Chief Nurse commented that the Trust was already aware of the issues highlighted by the IICSA report and confirmed that there were no concerns regarding health, however this did not mean that there were no wider areas for the Trust to consider. The Chief Nurse advised that the learning from this

report had been shared across services within the Trust including the 0-19 services, with a task and finish group in place to review any further areas where the Trust could make a difference.

Non-Executive Director, Sally Yeoman asked if the Trust was proactively looking at trauma informed approaches as part of training and learning. The Chief Nurse advised that this was built into safeguarding training and that some teams had been trained around trauma informed approaches including the family nurse partnerships, safeguarding team, 0-19 services and health visitors. **However, she agreed to clarify whether trauma informed approaches were part of training more widely, including across adult services.**

37/22 SUSTAINABILITY -– to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability

(i) Finance Report

The Director of Finance presented the report to the Board and highlighted the key points. He reported that at month one, the Trust was in line with its financial plan. He noted that CIP was sightly ahead of plan and that there were two elements concerning savings for the year: a CIP element based on 2% required to be delivered recurrently and savings driven by a reduction in covid-19 expenditure. He reported that there had been no capital spend within month one, however all capital spend schemes for the year would commence imminently.

The Board noted that the Trust was continuing a positive performance in relation to the Better Payment Practice Code (BPPC) with a score in month one of 95%. The Trust Chair recognised this as a significant achievement and thanked all involved in this work. She highlighted that Bridgewater was one of the best performing organisations within Cheshire and Merseyside concerning the BPPC. Non-Executive Director, Sally Yeoman highlighted the importance of this in terms of supporting local businesses and suppliers with timely payments of invoices.

(ii) Report from the Finance and Performance Committee held on 28 April and 19 May 2022

The Board received reports for assurance from the last two Finance and Performance Committee meetings from the Committee Chair, Tina Wilkins.

(iii) Report from the Audit Committee held on 27 April and 19 May 2022

The Board received reports for assurance from the Audit Committee meetings which took place in April and May 2022 from Non-Executive Director and Audit Chair, Linda Chivers. She referred to the approval of the external audit fees by the Trust's Council of Governors. She confirmed that KPMG had not been concerned and that the Trust was operating within a contract and framework. More than 50% of the Governors had approved the fee via a majority e-governance vote. Non-Executive Director, Linda Chivers advised that the Trust Secretary had obtained advice concerning the quoracy of future votes which would be taken to the Council of Governors in June 2022 as the Trust Constitution would need to be amended to ensure that the Council was quorate to make future decisions.

38/22 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 Programme Director for Integration and Collaboration provided an update to the Board concerning progress with integration and collaboration development and opportunities across the Trust. This included an update concerning the national and local ICS position. He

reported that following the Health and Care Act receiving Royal Accent in April 2022, the ICSs across England would become formalised from 1 July 2022. He also provided an update on the Mental Health, Learning Disability and Community Provider Collaborative, with work progressing on the development of a strategy and governance arrangements, and discussions taking place with stakeholders to shape those emerging arrangements and an update on place-based work. This was continuing to progress and develop across Halton and Warrington, with governance arrangements, strategies and priorities being developed.

The Deputy Chief Operating Officer provided a verbal update to the Board concerning virtual wards. He explained that as part of national planning guidance, there was a mandate to roll out virtual wards nationally with a responsibility for ICSs to ensure 40 to 50 beds per 100k population. He advised that this was a significant request for health and social care organisations to deliver and there was a key role for the Trust in driving this work forwards. The virtual wards would be supported by digital solutions to provide virtual monitoring to support patients in their own home (formerly known as telehealth). There would also be co-ordinators, virtual ward managers and medical oversight with nurse consultants. There would be a focus on respiratory and hospital at home. The Deputy Chief Operating Officer explained that patients would be able to be admitted to a virtual ward which would avoid the need for hospital admission. Existing resources would be utilised to provide the virtual wards and there was work to standardise the approach across Cheshire and Merseyside led by the ICS. He advised that some virtual wards were expected to be established in Warrington before the Winter, with the continuation of a pre-existing virtual respiratory ward and a frailty would be established next with discussions to take place on this roll out programme. Within Halton, the HIS service would be utilised with the UCR rapid response also being involved in the roll out. The Director of Integration and Collaboration confirmed that the above would be included as part of the digital strategy work. The Director of People also noted that the Trust was taking a leadership role in workforce planning in Warrington and would represent the Trust at place.

Non-Executive Director, Martyn Taylor asked whether there would be additional funding to provide the virtual wards. The Deputy Chief Operating Officer advised that there would be, but this would not be sufficient to deliver the service model that was set out. There was monies available across the system which the Trust would put forward business cases against. The Chief Nurse added that there would also be consideration of delivering services in a different way.

39/22 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 11 May 2022

The Board received a report from the latest People and Organisational Development Committee from the Committee Chair, Abdul Siddique. The Board received and endorsed the People Strategy which was appended to the report.

40/22 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Compliance with Provider Licence

The Trust Secretary presented the Trust's self-certification to confirm that it was meeting the terms of its Foundation Trust licence. She confirmed that the reports had been compiled based on the expectations of the final annual report and accounts and that the self-certifications must be authorised by the Board and published prior to 30 June 2022. The Trust Secretary recommended that the Board approved the self-certifications, on the proviso

that this would be updated following any changes resulting from any final submissions from external auditors.

Non-Executive Director, Linda Chivers highlighted on reference on page two of the self-certification that referred to the Health and Safety Committee; this would be amended to Quality and Safety Committee. The Board approved the self-certification subject to this amendment being made and subject to external audit sign off of the annual report and accounts.

(ii) Terms of Reference

The Board approved its Terms of Reference with the exception of one element around Medical Director voting to be clarified: should both Medical Directors be present at the Board, they would be awarded half a vote each.

The suite of Terms of Reference for the Board Committees would be reviewed and amended and presented back to each Committee during the June/July meeting cycle to be endorsed by each Committee and presented back to the Board in August 2022.

41/22 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

It was agreed that this had been an effective meeting with a good level of debate and opportunities to raise questions and challenges.

It was noted that the Finance and Performance Committee would review BAF7 in depth at its next meeting and undertake a full review of BAF8 to ensure that the information reflected an up-to-date position.

42/22 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. The Board took this opportunity to thank the Lead Governor, Rita Chapman for her significant contributions to the Trust, noting that her tenure would reach an end on 30 July 2022 and this would be her final Board meeting. The Lead Governor commented that this had been a good meeting and noted that the standard of the reports at had been excellent.

43/22 DATE AND TIME OF NEXT MEETING

Thursday 4 August 2022, 10am. Meeting to take place in person with venue details to be confirmed.

44/22 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 an Extraordinary Board Meeting
Held on Monday 20 June 2022, 11am
Virtual meeting held via Microsoft Teams

Present
Karen Bliss, Chair
Linda Chivers, Non-Executive Director
Gail Briers, Non-Executive Director
Sally Yeoman, Non-Executive Director
Abdul Siddique, Non-Executive Director
Tina Wilkins, Non-Executive Director
Martyn Taylor, Non-Executive Director
Colin Scales, Chief Executive
Aruna Hodgson, Medical Director
Nick Gallagher, Director of Finance
Lynne Carter, Chief Nurse
Paula Woods, Director of People
Sarah Quinn, Chief Operating Officer

In Attendance
Rob Foster, Programme Director, Integration and Collaboration
Sam Scholes, Director of Corporate Governance
Lynda Richardson, Board and Committee Administrator

45/22 Apologies for Absence
Ted Adams, Medical Director
Jan McCartney, Trust Secretary

46/22 DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made in relation to items on the agenda.

47/22 (i) ANNUAL REPORT and REVIEW OF ANNUAL ACCOUNTS

The Board received and approved the annual report and accounts subject to any minor amendments required following the auditors finalisation of work. Any elements for further review would be delegated to the Chief Executive, Non-Executive Director and Audit Chair, Linda Chivers and the Director of Finance. It was noted that there were minor amendments to be made to the annual report and governance statement in relation to roles and responsibilities.

The Board approved the letter of representation subject to an amendment within clause 14 which needed to clarify that the Trust did not consolidate its charitable funds on the basis of materiality.

The Board recognised the significant efforts of all staff involved in the production of the annual report and accounts and thanked them for all of their work.

48/22 REVIEW OF ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

The Audit Committee would review the BAF in July 2022 as part of its standing agenda and update this accordingly following the sign off of the annual report and accounts by KPMG including the value for money opinion, receipt of internal audit opinion, and assurance concerning governance.

49/22 DATE AND TIME OF NEXT MEETING

Thursday 4 August 2022, 10am, arrangements to be confirmed

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	25/22iii	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**	This item is being addressed as part of the work to update the corporate governance manual as part of the Well Led actions. These are being monitored at Audit Committee.
09.06.22	34/22	Board Assurance Framework	**BAF7: Rationale to reflect actions that the Trust was taking noting that there was an emerging landscape across the system where the Trust did not/could not yet have definitive actions due to external uncertainty and this was outside of its control.** **Executive Lead to be updated for BAF7.** **Committee Chair reports to clarify the actions being taken across the BAF going forwards to ensure assurance was being provided on this to the Board.**	Jan McCartney	**GREEN**	The Executive Team and recommended updates to the Finance & Performance Committee which have been accepted and are part of the BAF Board Paper Information provided within the reports on the agenda – Board to specify if this is sufficient.

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
09.06.22	36/22i	IQPR	**Trajectory of improvements on waiting times moving back to pre-pandemic levels to be included in future reporting to the Finance and Performance Committee and the Board (this information was currently taken through the performance council).**	Sarah Brennan	**GREEN**	The information on the trajectories was received and reviewed at the Finance and Performance Committee. The detail is not included in the Board version of the IQPR. The trajectories related to the waits in Dermatology, Community Paediatrics (Warrington) and Community Paediatrics (Halton) which are forecast to be cleared by the end of October and the Dental waits over 104 weeks which are forecast to be cleared by the end of July.
09.06.22	36/22iii	Ockenden II Report update	**Quality and Safety Committee to receive a retrospective review of the incidents and complaints received by the midwifery service pre-transfer which would include supporting evidence. The Quality and Safety Committee would then provide assurance on this following scrutiny to the Board.**	Lynne Carter	**GREEN**	This item has been deferred to the Quality and Safety Committee. This has been agreed with the Q&S Chair to be presented in October 2022.

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
09.06.22	36/22v	Independent Inquiry into Child Sexual Abuse (IICSA)	**The Chief Nurse agreed to clarify if the Trust's training and learning proactively included trauma informed approaches.**	Lynne Carter	**BLUE**	It has been confirmed that approaches are used in Trust training and learning.

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**55/22**		
Report Title	**BOARD ASSURANCE FRAMEWORK**		
Executive Lead	Colin Scales, Chief Executive Officer		
Report Author	Jan McCartney, Trust Secretary		
Presented by	Jan McCartney, Trust Secretary		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Purpose

To approve the recommendations received from the Committees of the Board.

Executive Summary

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

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

Previously considered by:

☒ **Audit Committee**	☒ **Quality & Safety Committee**
☒ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☒ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☒ 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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☒ Caring	☒ Effective	☒ Responsive	☒ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	04/08/2022
Agenda Item	55/22		
Report Title	BOARD ASSURANCE FRAMEWORK		
Report Author	Jan McCartney, Trust Secretary		
Purpose	The purpose of the report is to present the recommended updates from the Committees of the Board to update the Board Assurance Framework.		

1. 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. The recommended changes can be found in section 2.

2. CHANGES TO THE BOARD ASSURANCE FRAMEWORK

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

The Audit Committee met on 7 July and reviewed this BAF and the following changes are recommended.

a. The dates are updated in relation to the Audit and VFM opinion

b. Remove 'CQC Well Led Programme' from Assurances

c. The risk score was reviewed. The score was raised in April due to a governance weakness raised by KPMG. This risk was subsequently rebutted, and the Committee agreed to lower the likelihood rating to two. This results in an overall risk rating of 8 (medium) which is the target risk rating.

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

The Quality & Safety Committee met on 23 June 2022. It was recommended that the rationale was updated to reflect the current position of recovery, restoration and service reset.

No further changes were recommended.

2.3 **BAF3 – Managing demand and capacity**

The Quality & Safety Committee met on 23 June 2022 where no changes or updates were recommended.

2.4 **BAF4 – Financial sustainability**

The Finance & Performance Committee met on 21 July 2022 and recommend the following changes;

a. Under Principal Risk, removed 'caused by scale of any recurrent deficit and the effectiveness of the plans to reduce it' and insert, 'Due to the requirement to achieve a break even budget against a backdrop of increasing system pressures, …'

b. Rationale for current score: Remove - Planned deficit for 2022/23. System pressures may result in increased deficit. Insert - Break even budget 2022/23. System pressures may result in a deficit.

c. Detect controls, add 'CIP Council'

d. Gaps in Control, Remove - 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. Insert: The break-even plan submitted has some provision for restoration and recovery but the Trust does not qualify for full reimbursement from the Elective Recovery Fund. This increases the pressures on the Trust in achieving its challenging budget.

2.5 **BAF5- Staff engagement and morale**

The Quality & Safety Committee met on the 23 June, they requested that once a review of the risks around district nursing in Halton and Warrington is complete, this BAF is to be updated. No other changes were recommended.

The People & OD Committee met on 13 July 2022 and suggested the following:

a. Insert 'cost of living crisis'

b. Update Health and Care Act

c. Include temporary milage increase in assurance

d. Remove 'Staff Engagement Group

e. There was no recommendation to amend the risk score

2.6 **BAF6 – Staffing levels**

The Quality & Safety Committee met on the 23 June, they requested that once a review of the risks around district nursing in Halton and Warrington is complete, this BAF is to be updated. No other changes were recommended.

The People & OD Committee met on 13 July 2022 and no changes were recommended.

2.7 **BAF7 – Strategy and organisational sustainability**

The Finance & Performance Committee met on 21 July 2022 and accepted the following changes that were recommended by the Executive Management Team:

a. Minor updates to the principal risk, including updating the Health & Care Act, including reference to system and 'place, and inserting the words 'and clinically'.

b. The rationale for current score was updated to include the strategy refresh and System Oversight Framework.

c. Prevent controls updates to reflect current position.

d. Gaps in control describe the gap as being the yet-to-be-finalised system governance arrangements.

2.8 **BAF8 – Digital Services**

The Finance & Performance Committee met on 21 July 2022 and propose the following updates:

a. Title of BAF to be changed to 'Digital Services'

b. Trust objectives to add 'equality, diversity and inclusion'

c. The principal risk wording has been simplified to align better to the Trust objectives

d. Rationale for current score rewritten to reflect current position with the system

e. Detect Controls section inserted and populated.

f. Prevent controls and assurances updated

g. Risk score reviewed; no change recommended

3. RECOMMENDATION

The Board is asked to approve the changes recommended by the Committees.

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 24 July 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**
BAF 1	**BAF 2**	**BAF 3**	**BAF 4**	**BAF 5**	**BAF 6**	**BAF 7**	**BAF 8**
Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4(C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2(L) = 8, **medium**	Inherent risk rating 5(C) x 5 (L) = 25, significant Current risk rating 5 (C) x 3 (L) = 15, significant Target risk rating 5(C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 4 (L) = 16, significant Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 1 (L) = 4, **low**	Inherent risk rating 5(C) x 4 (L) = 20, significant Current risk rating 5 (C) x 3 (L) = 15, significant Target risk rating 5 (C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 3 (L) = 12, **high** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4 (C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, significant Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 2 (L) = 8, **medium**

Board Assurance Framework (BAF) August 2022 – V1.0 – Board

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

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Executive Officer Deputy CEO / Chief Nurse Last reviewed: July 2022 Audit Committee Last reviewed: July 2022 Risk Ratings reviewed: July 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 2021/22 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 2021/22 • Board, committees (Quality & Safety, Finance & Performance, and People) • Trust continuous improvement plan in place • Internal Audit Plan agreed for 22/23 • Leader in Me • External independent Well Led review • Daily automated data reporting • Governance Structure • Declarations of Interests Register • MIAA governance checklists • 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 (2021/22}

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) August 2022 – V1.0 – Board

BAF 2: **Failure to deliver safe and effective patient care**	**TRUST OBJECTIVES:** • Quality	**RISK RATING:** 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**	**RISK APPETITE:** **MINIMAL**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Chief Nurse / Deputy CEO / Last reviewed: June 2022 Quality & Safety Committee Last reviewed: June 2022 Risk Ratings reviewed: June 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 challenges in relation to recovery, restoration, and service reset following the pandemic If this were to happen it may result in 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) August 2022 – V1.0 – Board

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: July 2022 Quality & Safety Committee last reviewed: July 2022 Risk Ratings reviewed: July 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 and restoration processes 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 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 meeting 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) August 2022 – V1.0 – Board

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: July 2022 Finance & Performance Committee last reviewed: July 2022 Risk Ratings reviewed: July 2022	**Financial sustainability** If the Trust is unable to achieve and maintain financial sustainability. Due to the requirement to achieve a break even budget against a backdrop of increasing system pressures; 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. Break even budget 2022/23. System pressures may result in a 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 • CIP Council **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 break even plan submitted has some provision for restoration and recovery but the Trust does not qualify for full reimbursement from the Elective Recovery Fund. This increases the pressures on the Trust in achieving its challenging budget.

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) August 2022 – V1.0 – Board

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: July 2022 People Committee Last reviewed: July 2022 Risk Ratings reviewed: July 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 and cost of living crisis. 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 Act 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 • 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 • Temporary increase in milage payments **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 (inc. cost of living crisis) – ongoing monitoring, communication, engagement and health and wellbeing services and programmes

Board Assurance Framework (BAF) August 2022 – V1.0 – Board

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

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Chief Operating Officer Last review: July 2022 Quality & Safety Committee Last review: June 2022 People Committee: July 2022 Risk Ratings reviewed: July 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) August 2022 – V1.0 – Board

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 Last reviewed: July 2022 Executive Team July 2022 F&P Committee Last reviewed: July 2022 Risk Ratings reviewed: July 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 Act, 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 and place 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 and clinically unsustainable. **Risks on register 15 plus** No risks at this level	Trust involved in influencing the development of the Integrated Care Boards and Mental Health Provider Collaborative. Trust Strategy 2023 is being refreshed and re-launched. Trust System Oversight Framework (SOF) is segment 2	**Prevent Controls** • Trust Board Oversight – engagement and delivery of Health & Care Act • 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 • Contributing to work across the system in relation to developing Children's Services • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • Chair working within wider system • Exec attendance at Collaborative Commissioning Forum (CCF) • Implementing dental strategy with partners • Board development with Good Governance Institute and NHS Providers **Assurances** • Provider Collaborative member – BW Host Trust, including employing staff • Programme Director – Collaboration and Integration • 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 • Executive Directors hold regular meetings with all key partners and stakeholders • Adaptive reserve contribution
Gaps in controls and assurance: (and mitigating actions) Implementation of revised system governance arrangements, to be finalised			

Board Assurance Framework (BAF) August 2022 – V1.0 – Board

BAF 8:	**TRUST OBJECTIVES:**	**RISK RATING:**	**RISK APPETITE:**
Digital services which do not meet demands of the organisation	• Innovation and collaboration • People • Quality • Sustainability • Equality, diversity & inclusion	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: July 2022 F&P Committee Last reviewed: July 2022 Risk Ratings reviewed: July 2022	**If the Trust does not maintain and develop and adopt digital services to meet the current and future needs of the Trust.** This could impact in our ability to; • deliver key related Trust objectives, • meet operational, regulatory, contractual & reporting requirements • develop and enable new service models. • develop our position as an innovator • collaborate in system place-based developments **Risks on register 15 plus**	Assurance received from DIGIT, Risk Council and Performance Council. Consideration of resource to deliver Digital Strategy and system requirements. Lack of stability in the system. Cyber risks.	**Prevent controls** Digital Strategy 2018–2021 approved by Board Multi layers cyber solutions All current software and hardware solutions supported by the provider Continued migration of services to cloud based solutions **Detect Controls** DIGIT and Digital Programmes Groups Participation and membership of ICS and Place based digital development groups **Assurances** Finance & Performance Committee Audit Committee 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 in place and tested **Audits – Substantial Assurance**: IT Threats & Vulnerability (2020/21) DSP Toolkit (2021/22) 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 CIPHA) 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) August 2022 – V1.0 – Board

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**56/22**		
Report Title	**KEY CORPORATE MESSAGES**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Jan McCartney – Trust Secretary		
Presented by	Colin Scales – Chief Executive		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Purpose

To update the Board concerning key matters within the Trust and the NHS as a whole

Executive Summary

The Board is asked to note the report

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☒ 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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ Caring	☐ Effective	☒ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**56/22**		
Report Title	**KEY CORPORATE MESSAGES**		
Report Author	Jan McCartney – Trust Secretary		
Purpose	To update the Board concerning key matters within the Trust and the NHS as a whole		

1. NON-EXECUTIVE DIRECTOR UPDATES

1.1 The Trust Chair, Karen Bliss has attended a number of meetings - the Race Inclusion Network; Cheshire & Merseyside Trust Chairs meeting; North West System Leaders and Chair meeting, Cheshire & Merseyside ICS Finance Committee and the Regional Roadshow meeting.

Karen also participated in the following sessions:

- Supporting Carers in the Trust, led by the Chief Nurse, as part of the Governor Development Programme.
- GGI NED session on the recommendations of the Messenger Review.
- GGI ICS breakfast webinar on engagement, involvement and connectivity in ICSs.
- Leader in Me event on 1 July 2022

1.2 Non-Executive Director, Linda Chivers accompanied Paula Woods on the Time to Talk session with the Research and Education Team. Linda also attended a GGI NEDs Development session – The Messenger/Pollard Report and a Qlik View workshop set up for members of the Finance & Performance Committee.

1.3 Non-Executive Director, Sally Yeoman held a NED/Buddy meeting with Ted Adams, Medical Director. Sally also met with Clare Duggan on the Chair's appraisal process and also attended the Disability Awareness Day in Warrington.

1.4 Non-Executive Director, Tina Wilkins attended a Voice of the Child meeting. Tina also attended the Leader in Me event on 1 July, participated in a workshop on QLIK View and was part of the shortlisting panel for the staff awards. In the absence of the Chair, Tina accompanied the Chief Executive on the Time to Talk session with the Tissue Viability Nursing (Halton) Team.

1.5 Non-Executive Director, Gail Briers had a 1-1 meeting with the Chief Operating Officer as part of the buddying arrangement and accompanied the Chief Operating Officer on her Time to Talk session with the Comms Team and the Education & Professional Development and Learning & Organisational Development Team.

2. EXECUTIVE UPDATES

2.1 The Chief Executive met with Councillor Baker and Councillor Lloyd-Jones on 13 July to discuss the development of the Urgent Treatment Centre in Widnes.

2.2 On 18 July the Chief Executive sat on the interview panel for the Chair of the North West Leadership & Talent Board and the North West Leadership Academy post.

2.3 Executive and Senior Team Engagement

2.3.1 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 have taken place since the last Board meeting:

2.3.2 The Chief Executive met with the Tissue Viability Nursing (Halton) Team on 13 June. Tina Wilkins and Abdul Siddique accompanied the Chief Executive on this visit. On 20 July the Chief Executive met virtually with the Service Experience Team.

2.3.3 The Director of Finance met with the dental team based at HCRC on 17 June. He also met virtually with the St Helens Wheelchair Service based at Europa Point on 19 July.

2.3.4 The Director of People & OD held a virtual meeting on 16 June with the Research & Clinical Audit Team.

2.3.5 In June, the Chief Operating Officer held virtual meetings with the Comms Team and the Education & Professional Development and Learning & Organisational Development Team. On 12 July the Chief Operating Officer also met virtually with the Information Governance Team.

2.3.6 Medical Director, Ted Adams met with the Halton Stroke Team on 8 June.

2.3.7 The Trust Secretary met with the Community Nursing & Community Matrons South Warrington on 13 June and on the 6 July met with the Warrington Community Paediatricians Team.

2.3.8 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

2.4 Board Sessions/Events

2.4.1 An Extra-ordinary Board meeting took place on 20 June to sign-off the 2021-2022 Annual Accounts and approve the Annual Report.

2.4.2 A Board-Time Out session took place on 27 June. The focus of the session was the 'Impact of Operating at Place in a System' and the 'Digital Strategy (deep dive).

2.4.3 A Leader in Me event took place on 1 July with keynote speaker Professor Damian Hughes. As part of the session, two workshops took place to focus on:

1. What works well currently, but what blockages / challenges do you also face as leaders at work?
2. Thinking about what was discussed in Workshop 1, what will you do to bring about a positive and proactive influence within Bridgewater?

2.5 System Oversight Framework (SOF)

2.5.1 It has been confirmed that the Trust will remain in segment 2 for 2022/23 oversight framework.

3. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

3.1 Since the last Board meeting at total of ten Time to Talk sessions have taken place.

Monthly feedback from the Executive Team is collated and the following examples of feedback from these sessions are provided below:

"Positive team, good discussion and very informative."

"Commitment of the teams Attitude Support for each other Clarity around what their roles are and how they support staff"

"They were extremely positive and talked myself and NED through the work that they did. They talked about the positive impact of what they do, how they do it and went on to confirm that they felt well informed, well supported and were extremely grateful for the investment in a new Audit Management System. Both individuals were extremely proud of what they do and both enjoy working for the Trust"

4. EXTERNAL PUBLICATIONS AND REPORTS

4.1 **National Guidance on Quality Risk Response and Escalation in Integrated Care Systems -** The guidance is to support system leaders as they develop their approach to quality management, providing clarity on how quality concerns and risks should be managed through systems.
NHS England » National Guidance on Quality Risk Response and Escalation in Integrated Care Systems

4.2 **British summer risks becoming even more difficult for the NHS to navigate than winter** - Matthew Taylor, chief executive of the NHS Confederation, comments on the ongoing effects of the heatwave on the NHS.

British summer risks becoming even more difficult for the NHS to navigate than winter | NHS Confederation

4.3 **The COVID-19 inquiry: learning the lesson.** Our view on the situation facing the NHS when the pandemic began, how events unfurled and core considerations for the COVID-19 inquiry.
The COVID-19 inquiry: learning the lessons | NHS Confederation

4.4 The Department of Health and Social Care's new plan for digital health and social care.
A plan for digital health and social care - GOV.UK (www.gov.uk)

5. RECOMMENDATIONS

5.1 The Board is asked to note the report.:

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**57/22i**		
Report Title	**INTEGRATED QUALITY PERFORMANCE REPORT – MONTH 2, 2022-23**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Various – Information Team		
Presented by	Executive Directors		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Purpose

This report summarises the key issues relating to Bridgewater Performance for Month 2, May 2022

Executive Summary

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.

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.

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.

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☒ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☒ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☒ **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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☒ **Caring**	☒ **Effective**	☒ **Responsive**	☒ **Safe**	☒ **Well Led**

Bridgewater Community Healthcare NHS Foundation Trust

Integrated Quality and Performance Report

Information Team
Bridgewater Community Healthcare NHS Foundation Trust
Reporting Period: May 2022 (Month 2)

Contents

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 May 2022.

Within this report

1. KPI Amendments:

KPI	Change	Rationale

2. Recommendations:

The Finance & Performance committee 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 March's validated position.

Responsive (Operations)

There are 2 new green indicators in month relating to dermatology and the Widnes Urgent Treatment Centre so there are only 6 indicators which are now red.

The dermatology service continues to be a significant challenge in terms of operational delivery of activity but there is a significant service improvement work being undertaken and the impact of the service SLAs will be felt over the months ahead.

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 are two new quality indicators reporting as red but little change to the other indicators.

People

Four of the five people indicators are red in month. The PPDR indicator has improved in month.

Making Good Use of Resources (Finance)

There is a positive position reported in relation to finance with the majority indicators reporting as green. This is however against the previous deficit position and not the break-even position so it will need to be revisited for the June position.

2 Operations

Executive Summary

Of the 19 Operations indicators which are reported; 6 are red and 13 are green.

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
- Total time in A&E < or = to 4 hours
- Total time in A&E 95th percentile

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

- 28-day Cancer Faster Diagnosis – deterioration in month
- Referrals to Plan – improvement in month
- Cancellations by service – improvement in month
- Percentage of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway) – improvement in month
- Warrington Activity Variance – Improvement in month
- Halton Activity Variance – above target variance

Overall, there are improvements in the operational indicators in almost all areas. We are starting to see some increasing pressures on the number of referrals received into children's services which are impacting on the 18-week RTTs.

Operations

Actions:

Indicator	Action	Target date	Responsible Committee
% of patients waiting under 18 weeks	Three services now showing breaches of the 18-week RTT – dermatology and community paediatrics in Warrington and Halton. 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

Trust Scorecard

Operations

Code	KPI Name	Target	Trend Line	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93.00%		100% (►)	100% (►)	98.85% (▼)	97.07% (▼)	95.22% (▼)	98.08% (▲)	94.01% (▼)	96.58% (▲)	97.97% (▲)	95.98% (▼)	93.97% (▼)	93.94% (▼)	94.03% (▲)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94.00%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	66.67% (▼)	100% (▲)	50% (▼)	100% (▲)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96.00%		100% (▲)	92.86% (▼)	87.5% (▼)	100% (▲)	83.33% (▼)	100% (▲)	92.86% (▼)	76.92% (▼)	93.33% (▲)	52.94% (▼)	100% (▲)	83.33% (▼)	100% (▲)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85.00%		83.33% (▼)	86.96% (▲)	100% (▲)	100% (►)	91.3% (▼)	80% (▼)	91.67% (▲)	86.96% (▼)	100% (▲)	92% (▼)	86.67% (▼)	95.24% (▲)	96.97% (▲)
OP22	28 day faster diagnosis	75.00%		41.76% (▲)	22.82% (▼)	31.58% (▲)	39.86% (▲)	28.57% (▼)	41.74% (▲)	40.78% (▼)	37.98% (▼)	47.67% (▲)	45.41% (▼)	60.21% (▲)	73.84% (▲)	66.5% (▼)
OP06	Referrals to plan	95.00%		80.84% (▲)	80.31% (▼)	78.83% (▼)	77.97% (▼)	77.7% (▼)	78% (▲)	77.89% (▼)	78.73% (▲)	77.74% (▼)	77.93% (▲)	76.51% (▼)	85.37% (▲)	93.62% (▲)
OP07	Cancellations by service	5.00%		9.07% (▼)	8.36% (▲)	9.23% (▼)	8.82% (▲)	7.77% (▲)	11.92% (▼)	12.99% (▼)	14.06% (▼)	9.27% (▲)	8.7% (▲)	9.18% (▼)	12.69% (▼)	11.47% (▲)
OP08	Cancellations by Patient	5.00%		6.12% (▼)	6.64% (▼)	6.93% (▼)	4.91% (▲)	5.01% (▼)	4.83% (▲)	5.06% (▼)	5.06% (▼)	4.66% (▲)	4.66% (▼)	5.18% (▼)	4.65% (▲)	4.5% (▲)
OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92.00%		72.87% (▲)	86.17% (▲)	88.46% (▲)	81.65% (▼)	76.32% (▼)	67.19% (▼)	60.74% (▼)	56.49% (▼)	53.79% (▼)	54.5% (▲)	60.01% (▲)	57.26% (▼)	61.03% (▲)
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		99.92% (▼)	100% (▲)	99.96% (▼)	99.96% (►)	99.29% (▼)	97.93% (▼)	98.85% (▲)	99.05% (▲)	99.23% (▲)	97.61% (▼)	94.16% (▼)	93.96% (▼)	98.38% (▲)
OP12	Total time in A&E - 95th Percentile	4 Hrs		01:48 (▼)	01:41 (▲)	01:47 (▼)	01:53 (▼)	02:07 (▼)	03:12 (▼)	02:59 (▲)	02:56 (▲)	02:47 (▲)	03:19 (▼)	04:07 (▼)	04:17 (▼)	03:35 (▲)
OP13	A&E Time to treatment decision (median) <=60 mins	60 Mins		00:04 (▼)	00:04 (▲)	00:05 (▼)	00:05 (▲)	00:05 (▼)	00:07 (▼)	00:06 (▲)	00:05 (▲)	00:05 (▼)	00:06 (▼)	00:18 (▼)	00:04 (▲)	00:14 (▼)
OP14	A&E Unplanned re-attendance rate <=5%	5%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.09% (▼)	0% (▲)
OP15	A&E left without being seen <=5%	5%		0% (▲)	0.1% (▼)	0.02% (▲)	0% (▲)	0% (►)	0.11% (▼)	0.1% (▲)	0.14% (▼)	0.07% (▲)	0.03% (▲)	0.13% (▼)	0.11% (▲)	0.41% (▼)
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches	0		47 (▲)	27 (▲)	49 (▼)	6 (▲)	8 (▼)	0 (▲)	0 (►)	2 (▼)	14 (▼)	1 (▲)	2 (▼)	2 (►)	0 (▲)
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score	95%		94.97% (▼)	94.9% (▼)	94.81% (▼)	94.81% (▲)	94.78% (▼)	99.53% (▲)	99.52% (▼)	99.53% (▲)	99.53% (▲)	99.52% (▼)	99.67% (▲)	99.68% (▲)	99.68% (►)
OP18	Halton Maternity Dashboard - Number of red rated areas	0		1 (▼)	0 (▲)	1 (▼)	2 (▼)	2 (►)	2 (►)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
OP19	Warrington Activity Variance	3%		-23.21% (▲)	-24.02% (▼)	-24.84% (▼)	-24.33% (▲)	-24.28% (▲)	-24.87% (▼)	-23.58% (▲)	-23.72% (▼)	-23.17% (▲)	-23.2% (▼)	-23.17% (▲)	-24.3% (▼)	-20.86% (▲)
OP20	Halton Activity Variance	3%		-6.24% (▲)	-4.17% (▲)	-5.18% (▼)	-5.9% (▼)	-5.43% (▲)	-5.27% (▲)	-5.81% (▼)	-3.46% (▲)	-7.87% (▼)	-8.27% (▼)	-6.46% (▲)	15.26% (▼)	12.7% (▲)

Operations: Exception Reporting

Flagged Indicators

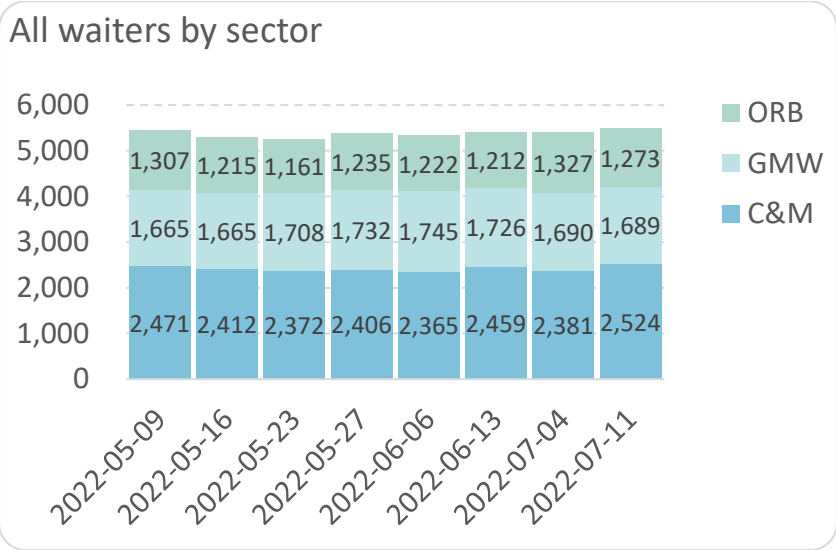
Operations			
OP06	Referrals to plan		Point above upper control limit
OP07	Cancellations by service		Points above upper control limit
OP08	Cancellations by Patient		Points above upper control limit
OP15	A&E left without being seen <=5%		Point above upper control limit
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score		Point below lower control limit
OP19	Warrington Activity Variance		Points below lower control limit

Operations: Exception Reporting

OP20	Halton Activity Variance		Point above upper control limit

Operations: Exception Reporting

SPC Charts



Issue

Dental - Patients waiting by Sector

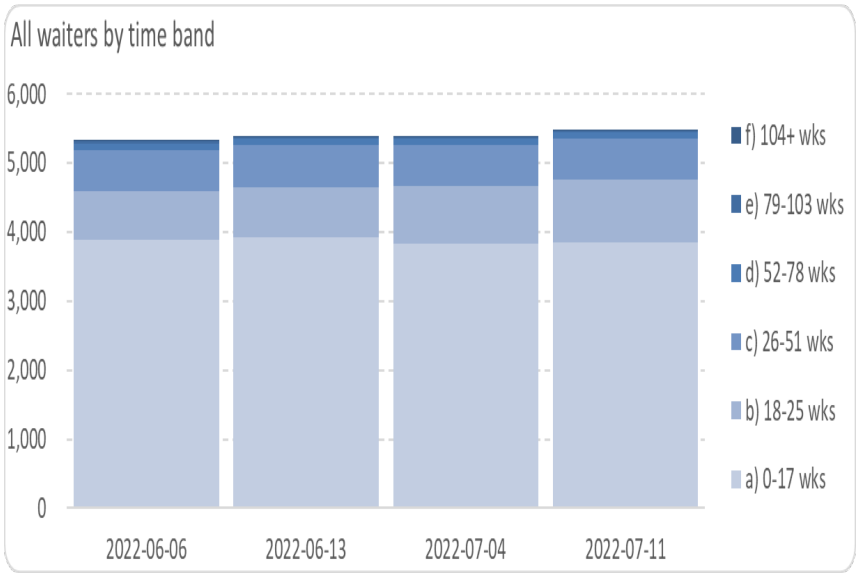
The number of patients waiting for dental treatment has increased in both Greater Manchester West and Cheshire and Merseyside and fallen in Oldham, Rochdale and Bury.

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 considerably and access to General Dental Practitioners has worsened due to a lack of available NHS dentists

Waiting list numbers in Greater Manchester West have only increased slightly despite increases in referrals numbers and there is a new Head of Operations in post in this area to support the management of activity.

Operations: Exception Reporting

SPC Charts



Issue

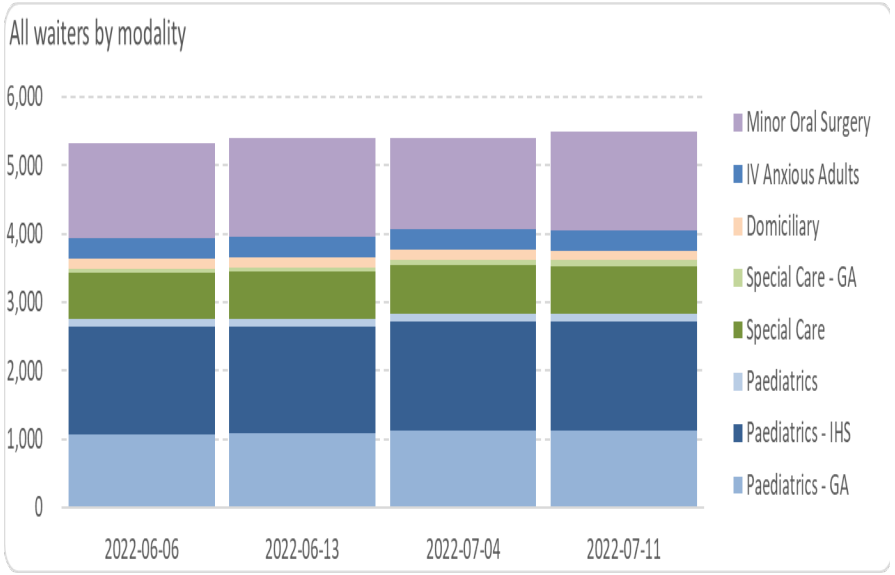
Dental – Waiters by time band

The number of patients waiting 104 weeks plus has fallen steadily over the last few months and we now only have 24 patients waiting over 104 weeks and there are plans in place to clear all of these by the end of July subject to theatre capacity being available. This has been impacted over the weeks with the increased incidence of COVID and anaesthetist and theatre availability.

Waiters by time band						
Sanpshot Date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2022-06-06	3,882	713	596	92	26	23
2022-06-13	3,933	723	598	97	25	21
2022-07-04	3,823	846	593	85	21	30
2022-07-11	3,844	909	606	85	18	24

Operations: Exception Reporting

SPC Charts



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 in Cheshire and Merseyside, Paediatric GA, and Special Care GA.

Waiting times and pathways are monitored on a weekly basis in the dental network.

	Waiters by modality							
Snapshot Date	Paediatrics - GA	Paediatrics - IHS	Paediatrics	Special Care	Special Care - GA	Domiciliary	IV Anxious Adults	Minor Oral Surgery
2022-06-06	1,078	1,568	103	690	51	150	304	1,388
2022-06-13	1,082	1,571	104	698	50	146	309	1,437
2022-07-04	1,127	1,591	113	706	87	151	296	1,327
2022-07-11	1,134	1,581	110	696	90	148	293	1,434

3 Quality

Executive Summary

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

There new red indicators in month are:

- Safeguarding Children Training Level 3
- Patient Experience – Access/Waiting Time

The six indicators which were red in April were 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 Adults Level 2 Training – improvement in month
- Safeguarding Adults Level 3 Training – improvement in month
- Percentage of risks identified as high – improvement in month

Actions:

Indicator	Action	Target date	Responsible Committee
Safeguarding Level 3 – Children's and Adults	• Staff to be supported to participate in training. Additional sessions to be delivered as capacity permits	• Children's Level 3 is now compliant Aim to have Adults Level 3 compliant by end of June 2022	Borough/Directorate Director and Operational Managers

Quality: Exception Reporting

Trust Scorecard

Quality																		
Code	KPI Name	Target		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-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		157 (▼)	165 (▼)	165 (►)	148 (▲)	134 (▲)	167 (▼)	141 (▲)	121 (▲)	170 (▼)	129 (▲)	141 (▼)	117 (▲)	133 (▼)
QU03	% of incidents High impact Level 3-5	7.88%		0.64% (▲)	1.21% (▼)	1.82% (▼)	2.03% (▼)	3.73% (▼)	0.6% (▲)	0.71% (▼)	2.48% (▼)	1.76% (▲)	0.78% (▲)	2.13% (▼)	2.56% (▼)	3.01% (▼)
QU04	% Of Incidents Low impact Level 1-2	68.97%		79.62% (▲)	78.79% (▲)	80% (▼)	72.97% (▲)	82.09% (▼)	76.65% (▲)	78.01% (▼)	80.99% (▼)	77.65% (▲)	86.05% (▼)	89.36% (▼)	85.47% (▲)	89.47% (▼)
QU05	Number of Serious Incidents Reported	9		1 (►)	2 (▼)	3 (▼)	3 (►)	3 (►)	5 (▼)	0 (▲)	4 (▼)	2 (▲)	4 (▼)	4 (►)	2 (▲)	5 (▼)
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% (►)	75% (▼)	100% (▲)	100% (►)	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		8 (▲)	13 (▼)	11 (▲)	9 (▲)	21 (▼)	20 (▲)	25 (▼)	10 (▲)	21 (▼)	16 (▲)	16 (►)	10 (▲)	13 (▼)
QU11	Medication Errors That Caused Harm	6		0 (▲)	0 (►)	2 (▼)	0 (▲)	0 (►)	3 (▼)	0 (▲)	1 (▼)	2 (▼)	0 (▲)	0 (►)	0 (►)	1 (▼)
QU12	Medical Device Incidents	14		13 (▼)	17 (▼)	9 (▲)	1 (▲)	4 (▼)	15 (▼)	7 (▲)	10 (▼)	10 (►)	6 (▲)	3 (▲)	5 (▼)	4 (▲)
Training Compliance																		
QU13	Information Governance	95.00%		78.66% (▼)	83.15% (▲)	81.56% (▼)	83.59% (▲)	82.74% (▼)	81.22% (▼)	80.1% (▼)	79.84% (▼)	79.51% (▼)	83.91% (▲)	85.15% (▲)	84.05% (▼)	87.22% (▲)
QU14	Safeguarding Childrens Level 1	85.00%		88.24% (▼)	82.54% (▼)	85.6% (▲)	84.3% (▼)	85.42% (▲)	83.62% (▼)	80.11% (▼)	85.91% (▲)	86.11% (▲)	86.97% (▲)	86.78% (▼)	86.26% (▼)	87.86% (▲)
QU15	Safeguarding Childrens Level 2	85.00%		86.46% (▼)	86.89% (▲)	84.51% (▼)	84.2% (▼)	83.93% (▼)	81.6% (▼)	73.37% (▼)	74.21% (▲)	73.67% (▼)	72.82% (▼)	73.09% (▲)	68.5% (▼)	75.57% (▲)
QU16	Safeguarding Childrens Level 3	85.00%		80.29% (▼)	81.12% (▲)	65.38% (▼)	65.63% (▲)	76.42% (▲)	74.11% (▼)	84.3% (▲)	85.3% (▲)	85.33% (▲)	84.47% (▼)	84.2% (▼)	85.02% (▲)	83.74% (▼)
QU17	Safeguarding Adults Level 1	85.00%		91.58% (▼)	90.96% (▼)	89.58% (▼)	88.98% (▼)	88.04% (▼)	87.35% (▼)	86.24% (▼)	86.13% (▼)	86.98% (▲)	87.9% (▲)	87.91% (▲)	87.23% (▼)	88.57% (▲)
QU18	Safeguarding Adults Level 2	85.00%		86.97% (▼)	87.74% (▲)	85.38% (▼)	85.09% (▼)	82.76% (▼)	80.14% (▼)	80.2% (▲)	79.09% (▼)	77.84% (▼)	75.62% (▼)	74.6% (▼)	72.97% (▼)	73.63% (▲)
QU19	Safeguarding Adults Level 3	85.00%		44.59% (▲)	45.06% (▲)	33.58% (▼)	33.98% (▲)	35.19% (▲)	33.02% (▼)	44.93% (▲)	44.98% (▲)	46.97% (▲)	47.01% (▲)	47.24% (▲)	51.96% (▲)	53.91% (▲)
Risks																		
QU20	Total Number of risks	258		234 (▲)	237 (▼)	230 (▲)	227 (▲)	222 (▲)	209 (▲)	211 (▼)	213 (▼)	204 (▲)	204 (►)	204 (►)	202 (▲)	203 (▼)
QU21	Total Number of risks identified as High	111		103 (▲)	102 (▲)	98 (▲)	98 (►)	103 (▼)	100 (▲)	101 (▼)	99 (▲)	104 (▼)	104 (►)	104 (►)	102 (▲)	102 (►)
QU22	Percentage of risks identified as High	44.02%		44.02% (▲)	43.04% (▲)	42.61% (▲)	43.17% (▼)	46.4% (▼)	47.85% (▼)	47.87% (▼)	46.48% (▲)	50.98% (▼)	50.98% (►)	50.98% (►)	50.5% (▲)	50.25% (▲)
QU23	Total Number of risks identified as High 12	57		31 (▲)	33 (▼)	31 (▲)	32 (▼)	29 (▲)	26 (▲)	25 (▲)	27 (▼)	22 (▲)	22 (►)	22 (►)	20 (▲)	20 (►)
QU24	Percentage of risks identified as High 12	15.17%		13.25% (▲)	13.92% (▼)	13.48% (▲)	14.1% (▼)	13.06% (▲)	12.44% (▲)	11.85% (▲)	12.68% (▼)	10.78% (▲)	10.78% (►)	10.78% (►)	9.9% (▲)	9.85% (▲)
QU25	Total Number of risks identified as Extreme	21		5 (▲)	3 (▲)	2 (▲)	4 (▼)	3 (▲)	5 (▼)	4 (▲)	4 (►)	4 (►)	4 (►)	4 (►)	3 (▲)	3 (►)
QU52	Percentage of risks identified as Extreme	4.69%		2.14% (▲)	1.27% (▲)	0.87% (▲)	1.76% (▼)	1.35% (▲)	2.39% (▼)	1.9% (▲)	1.88% (▲)	1.96% (▼)	1.96% (►)	1.96% (►)	1.49% (▲)	1.48% (▲)

3

Quality: Exception Reporting

Bridgewater Community Healthcare NHS Foundation Trust

Quality															
Code	KPI Name	Target	Trend Line	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-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%		99.09% (▲)	97.8% (▼)	97.9% (▲)	97.15% (▼)	98.01% (▲)	98.45% (▲)	98.48% (▲)	98.61% (▲)	98.72% (▲)	97.22% (▼)	94.97% (▼)	95.27% (▲)	95.4% (▲)
QU42	Number of Complaints	9		5 (►)	5 (►)	3 (▲)	2 (▲)	1 (▲)	4 (▼)	3 (▲)	1 (▲)	6 (▼)	4 (▲)	3 (▲)	4 (▼)	0 (▲)
QU44	Patient Experience - Dignity and Respect	95.00%		100% (►)	100% (►)	99.29% (▼)	100% (▲)	99.31% (▼)	99.71% (▲)	99.8% (▲)	99.49% (▼)	100% (▲)	99.19% (▼)	99.72% (▲)	98.97% (▼)	100% (▲)
QU45	Patient Experience - Information / Communication	95.00%		100% (▲)	100% (►)	98.7% (▼)	98.92% (▲)	98.8% (▼)	99.71% (▲)	99.49% (▼)	99.33% (▼)	99.03% (▼)	98.39% (▼)	98.58% (▲)	98.97% (▲)	99.03% (▲)
QU46	Patient Experience - Access/Waiting Time	95.00%		97.36% (▼)	97.76% (▲)	97.05% (▼)	97.23% (▲)	96.74% (▼)	97.37% (▲)	97.34% (▼)	97.98% (▲)	99.03% (▲)	97.9% (▼)	96.51% (▼)	97.94% (▲)	94.05% (▼)

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
QU14	Safeguarding Children's Level 1		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

Quality: Exception Reporting

Mandatory Training and PPDR Trajectories

Priority 1
- Safeguarding Children Level 2
- Compliance at 85% by 12th August

Priority 2
- Safeguarding Adults Level 2
- Compliance at 85% by 26th August

Priority 3
- Safeguarding Children Level 3
- Compliance at 85% by 9th September

Priority 4
- Safeguarding Adults Level 3
- Compliance at 85% by 23rd September

Quality: Exception Reporting

Priority 5

- Resuscitation Level 2
- Compliance at 85% by 7th October

Priority 6

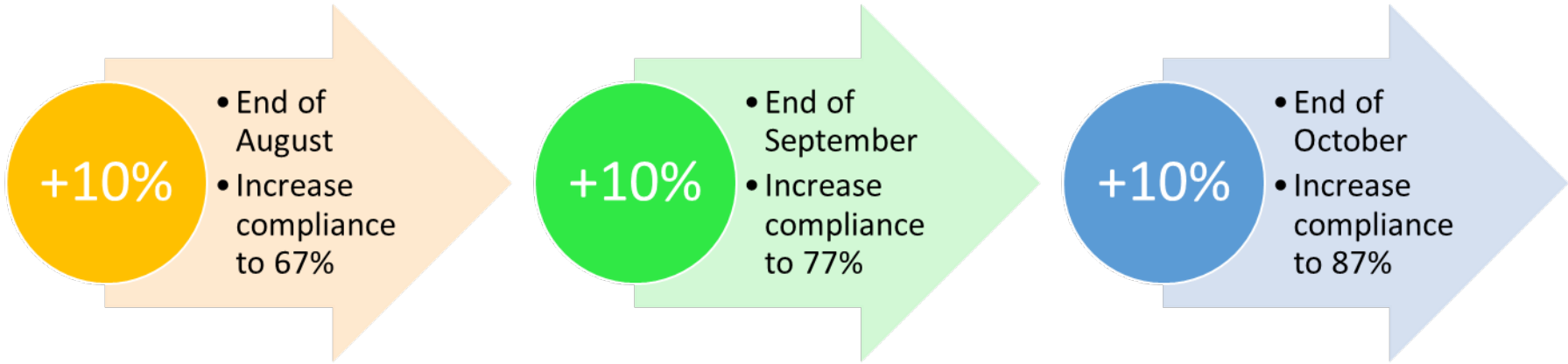
- Resuscitation Level 3
- Compliance at 85% by 21st October

Priority 7

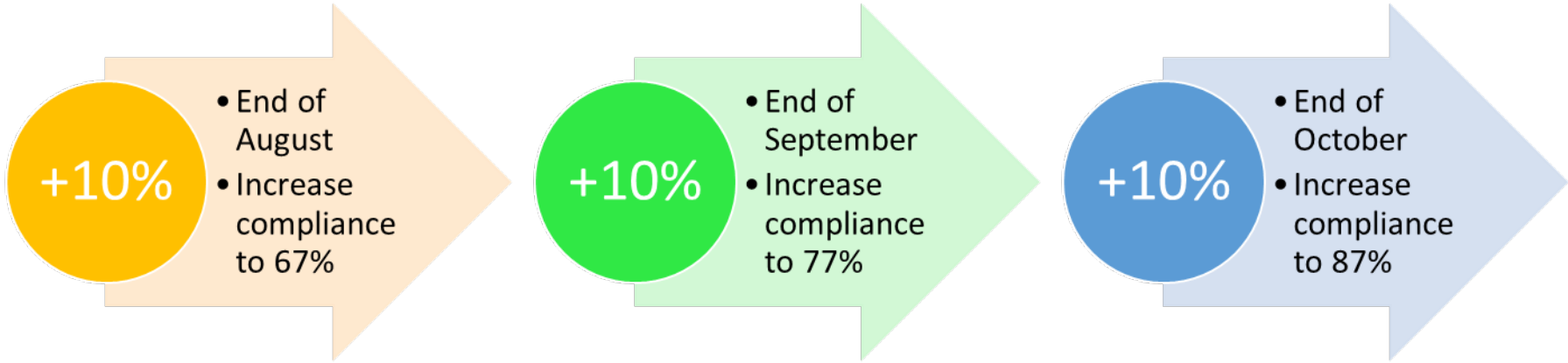
- Infection Prevention Control Level 2
- Compliance at 85% by 4th November

Quality: Exception Reporting

PPDR Compliance Trajectory



Quality: Exception Reporting



4 People

Executive Summary

Four out of five People indicators are shown as red in May 2022.

The four indicators which were red in May 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 – improvement in month

Actions:

Indicator	Action	Target date	Responsible Committee

People

Trust Scorecard

People																
Code	KPI Name	Target		May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
PO01	% Headcount of new starters attending induction programme	95.00%		91.97% (▲)	93.16% (▲)	99.65% (▲)	99.59% (▼)	99.53% (▼)	99.41% (▼)	99.29% (▼)	99.71% (▲)	99.47% (▼)	99.3% (▼)	99.58% (▲)	99.26% (▼)	99.6% (▲)
PO02	Staff turnover (rolling)	8.00%		10.08% (▼)	10.65% (▼)	10.57% (▲)	11.95% (▼)	12.4% (▼)	14.71% (▼)	14.56% (▲)	14.68% (▼)	15.56% (▼)	15.36% (▲)	27.69% (▼)	30.81% (▼)	31.35% (▼)
PO03	% Overall Organisation Sickness rate (rolling)	4.80%		5.32% (▼)	5.44% (▼)	5.56% (▼)	5.68% (▼)	5.84% (▼)	5.92% (▼)	5.98% (▼)	6.25% (▼)	6.45% (▼)	6.67% (▼)	6.83% (▼)	6.01% (▲)	7.01% (▼)
PO04	Sickness absence rate (Actual)	4.80%		6.21% (▼)	6.14% (▲)	6.52% (▼)	6.13% (▲)	6.59% (▼)	6.84% (▼)	6.22% (▲)	7.69% (▼)	7.2% (▲)	6.67% (▲)	6.98% (▼)	5.27% (▲)	7.02% (▼)
PO05	% of staff with a current PDR	85.00%		25.4% (▼)	26.77% (▲)	31.59% (▲)	38.3% (▲)	43.38% (▲)	47.54% (▲)	52.45% (▲)	54.16% (▲)	53.89% (▼)	57.32% (▲)	56.94% (▼)	56.35% (▼)	57% (▲)

Note 1 - in the table above 'P001 % Headcount of new starters attending induction programme' is shown as green since July 2021 but this is because the target was changed from 100% to 95% as agreed by the People Committee in February 2022. Therefore, compliance with this indicator has only been achieved since February 2022.

Note 2 - The rolling turnover is calculated by identifying the number of employees that left the Trust over a 12-month period and dividing this by the average of the average number of employees at the beginning of the period and the end of the period. As Oldham transferred out of the Trust in April the average number of employees at the end of the period reduced and there reduced the overall average and the number of leavers was elevated as the Oldham staff were classified as leavers as they transferred out of the Trust. The actual turnover in month 2 is much lower at 17.5% but is still over the Trust target of 8%.

4 People

Bridgewater Community Healthcare NHS Foundation Trust

Flagged Indicators

People			
PO01	% Headcount of new starters attending induction programme		Point above upper control limit
PO02	Staff turnover (rolling)		Point above upper 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 May 2022 (Month 02). The plan referred to is the final version of the plan submitted to NHSE/I and agreed at Board in April 2022.

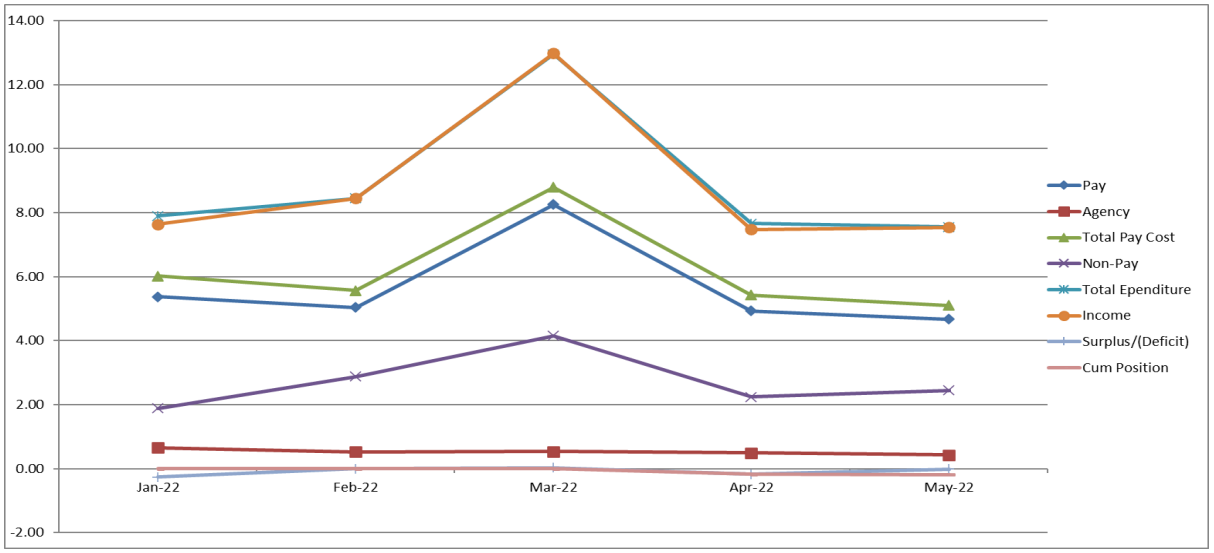
Summary Performance Month 02 2022 23	Month 2 Plan (£M)	Month 2 Actual (£M)	Month 2 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.45)	(7.54)	0.09	(14.90)	(15.02)	0.12	(88.93)	(88.93)
Expenditure - Pay	4.80	4.67	0.13	9.60	9.60	(0.00)	57.60	57.60
Expenditure - Agency	0.41	0.43	(0.02)	0.82	0.92	(0.10)	4.95	4.95
Expenditure - Non Pay	2.33	2.41	(0.08)	4.65	4.65	(0.01)	27.45	27.45
EBITDA	0.08	(0.02)	0.11	0.17	0.15	0.01	1.07	1.07
Financing	0.03	0.04	(0.01)	0.06	0.03	0.03	0.37	0.37
Normalised (Surplus)/Deficit	0.12	0.02	0.09	0.23	0.19	0.04	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	0.12	0.02	0.09	0.23	0.19	0.04	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	0.12	0.02	0.09	0.23	0.19	0.04	1.45	1.45
CIP	0.27	0.16	(0.12)	0.36	0.37	0.00	4.20	4.20
Capital	0.11	0.08	0.02	0.61	0.08	0.53	2.10	2.10
Cash	26.32	26.05	(0.27)	26.32	26.05	(0.27)	25.20	25.20
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Favourable Variance Adverse Variance

Finance

Key Headlines

Rolling Run Rates 2021/22 to 2022/23



Cumulative Performance against NHSE/I Plan – Deficit of £1.449m for the year.

- The Trust is reporting a year-to-date deficit of £0.19m, slightly better than the plan deficit of £0.23m.
- The Trust has a savings requirement of £4.20m (4.50%), split between £1.865m recurrent and £2.332m non recurrent largely driven by the requirement to reduce covid related spend.
- The Trust savings plan to month 2 is £0.36m, which is reported as achieved due to additional income for the Performance / BI SLA with STHK plus some reduced estates costs in Dental.

5 Finance

Bridgewater Community Healthcare NHS Foundation Trust

- Income is £15.02m for the year-to-date - £0.04m above the plan, predominantly due to the STHK income referred to above (Savings/CIP).
- Expenditure is £7.59m for the year-to-date – £0.12m above plan.
- Pay is on plan for the year-to-date at £9.60m.
- Agency spend of £0.92m for the year-to-date against a plan of £0.82m.
- Non pay expenditure is £4.65m for the year-to-date, against a plan of £4.65m.
- Capital charges are £0.03m below plan.

6 Appendix

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.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Committee Chairs Report

Name of Committee/Group:	Quality and Safety Committee	**Report to:**	Board of Directors
Date of Meeting:	23 June 2022	Date of next meeting:	18 August 2022
Chair:	Gail Briers	Parent Committee:	Board of Directors
Members present/attendees:	**Present** Gail Briers, Non-Executive Director and Committee Chair Lynne Carter, Chief Nurse Martyn Taylor, Non-Executive Director Sally Yeoman, Non-Executive Director Ted Adams, Medical Director **In attendance** Eugene Lavan, Deputy Chief Operating Officer Kristine Brayford-West, Director for Safeguarding Services Sue Mackie, Director of Quality Governance Susan Burton, Director of Nursing, Warrington Sam Yates, Director of Nursing for Halton Tania Strong, Interim Head of HR Rachel Hall, Head of Research (for item 51/22 only) Jan McCartney, Trust Secretary (to item 51/22) Sam Scholes, Head of Corporate Governance (from item 51/22) Lynda Richardson, Board and Committee Administrator **Observers** Christine Stankus, Public Governor, Rest of England Diane McCormick, Public Governor, Halton	Quorate (Yes/No):	Yes
		Key Members not present:	Aruna Hodgson, Medical Director Abdul Siddique, Non-Executive Director Sarah Brennan, Chief Operating Officer

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

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Urgent Items	2,3		There were no urgent items of business to be taken. The Committee briefly discussed the current risks for the district nursing service in Warrington and Halton that had been raised at the recent Risk Management Council meeting and agreed that it would consider whether further information or a deep dive report would be appropriate later in the meeting.	This will be the subject of a deep dive at the August meeting.
Deep Dive – pressure ulcers	2, 3		Following an observation in April 2022 that the majority of incidents within the Trust related to pressure ulcers with a slight increase observed during February to April 2022, the Committee had requested a deep dive to further its understanding around how pressure ulcers were managed, any challenges and what plans were in place going forwards. The Committee received a comprehensive report from the Director of Nursing for Halton which captured a point in time between February to April. It was agreed that this provided a good level of assurance with a pressure ulcer steering group in place with a 2022/23 workplan which would be taken through the pressure ulcer operational delivery group and steering group.	There would be further discussions at this Committee concerning the wider pressures on community nursing.
Serious Incidents Compliance Report for Quarter Four	2,3,6		The Committee noted that there had been seven serious incidents over the quarter: four in relation to category three pressure ulcers, two in relation to category four pressure ulcers and one in relation to medical devices.	Further detail was requested on the non-pressure ulcer related incidents reported over the last 12 months. This

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			The Trust had complied with the required 60 working day timescale for serious incident (SI) reporting and had also achieved 100% compliance in reporting all serious incidents within the criteria of the NHS England SI Framework to the Strategic Executive Information System (StEIS) portal within 48 working hours of identification. The Committee welcomed the new format of this report which provided a good level of assurance and included key information that had been requested including the internal processes of management of serious incidents and key areas around lessons learned.	would be provided to the Committee in August. The Committee also requested an update within the next report regarding future requirements for the management of serious incidents within the Trust under the new patient safety framework which was to be implemented.
Report from Risk Management Council/Risk Summary	2,3,6		There had been 18 risks reported related to quality and safety scoring 12 or above on the risk register. The report included a breakdown on the risk themes: the top three themes were: demand and capacity (impact in Dental and Warrington) treatment delay and error (impact in Dental and Warrington) and covid-19 (impact in Warrington and particularly District Nursing). One risk was closed during May 2022: this related to supply chain issues within the community equipment services that was now resolved. A review had been undertaken of the assurance levels for the risks scoring 12 or above and that of the 18 risks, one risk had limited assurance: this was in relation to Infection, Prevention and Control (IPC) assurances but work was ongoing to demonstrate compliance against the IPC code. It was expected that the assurance level would change towards 'moderate' as systems and	The Committee received the report for assurance and agreed that it would maintain a watching brief on the progress of the new IPC system. The Committee again noted the levels of risks in Warrington and Halton District Nursing as part of this report.

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			processes began to be implemented over the next months.	
IQPR (month one – April 2022)	2,3,6		There had been movement in a number of indicators in month from red to green rated: children's safeguarding level three training and compliance with the friends and family test. There were six indicators red rated in April including; incidents, information governance training, safeguarding children training level two and safeguarding adults levels two and three (a focus was being ensured on increasing compliance with training with borough directors supporting staff and teams), percentage of risk identified as high (improvement observed in month).	Discussion took place concerning the triangulation of quality and safety information following identification of a disconnect between information reported on within the Quality Council Chair's report and the IQPR. It was noted that the Performance Council would be considering a performance framework which included activity, performance and quality and safety aspects which would provide a basis for triangulation of information, reading across into the Performance, Risk Management and Quality Councils. This Committee agreed that it would request further detail on the performance framework and how information would be reported following the discussions to take place at the Performance Council and subsequently from the Finance and Performance Committee.
Report from the Quality Council and Quality Council Business Cycle	2,3,6		The Committee received the report and the business cycle. It was acknowledged that there were some areas where the Committee could be better sighted including clinical harms and learning disabilities. Both areas were suggested for inclusion in the deep dive programme.	Following a discussion on the Quality Council business cycle it was agreed that the requirements around reporting on learning from deaths be reviewed and clarified so that the latest guidance and obligations could be met in terms of

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			Highlights from the Quality Council report included: There was a positive position concerning patient experience and feedback being received patients, carers and families since the initiation of the text messaging feedback service. The Quality Council received describing quarter four medicines management incidents. One highlight was around the established diabetes and insulin operational delivery group with a real focus on incidents, competencies and pathways and there would be some aspirational goals concerning how teams were supported with the growing numbers of patients requiring insulin visits. There were no concerns identified regarding antimicrobial stewardship and some positive work had been identified from medicines management and their work to support teams around IV therapies and work within the dermatology service and the implementation of EPR and making changes to templates. The Warrington reports had included information on challenges continuing within the dermatology service with the challenges around routine waiting lists and capacity and demand on the district nursing service and the impact that this was having on staff and their health and wellbeing, as well as the position on pressure ulcers. A report had been received from the waiting list validation group, which described the initial work to develop a standard operating procedure around the waiting lists.	the reporting to the Committee and to the Board. Medical Director, Ted Adams would feedback to the Committee on the requirements. The Committee also agreed that it would receive the six annual safeguarding reports for Children and Adult Safeguarding for oversight. The Committee Chair requested ongoing updates via the Quality Council on the quality and safety issues relating to dermatology, paediatric therapies, paediatric exodontia and the pressure in community nursing.

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Paediatric Improvement Plan	2,3,6		The Committee accepted the report and noted that the outstanding actions were being progressed: There were a number of actions split between Warrington and Halton Boroughs and Medical Director, Ted Adams reported that there were now 20 of 21 actions completed in Halton and 20 of 29 in Warrington with three progressing on schedule and six that had been delayed but actions were in place to progress. He advised that Alder Hey Children's Hospital NHS Foundation Trust was continuing to provide child protection medicals and this was planned to continue and the consultant and speciality doctor posts were planned to be filled. Work was also re-commencing on the Trust wide vision for children's services. Those actions were being monitored at the Quality Council but it was noted that a number of the outstanding recommendations were outside of the Trust's control.	
Trust Improvement Plan Update	2,3		The Committee accepted the report and the update provided on the service improvement plans, which incorporated a number of improvement plans including the CQC action plan. There were no elements to escalate to the Committee and good progress was being made on the plans. It was acknowledged that there was a review at the executive management team on the	

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			future guidance around the CQC's new regime and further information would be presented back to the Committee in due course.	
Service Reset			The Chief Nurse provided a verbal update on the two stages of service reset work to move the Trust from the pandemic to business as usual. Key Performance Indicators (KPIs) would be measured as part of the service reset with reporting to feed into the IQPR via the borough meetings. It would be possible to link through to challenges within a service and the actions that were being taken and the impact of this work. The quality indicators also needed to be identified in terms of the aspects that made an impact on quality and safety in the Trust as a community organisation.	
QIA Report			The Committee received a report from the Chief Nurse and agreed that it had received a good level of assurance on the QIA process, acknowledging that the process had moved into business continuity during the pandemic. It noted its consideration of wider aspects including QIAs around all aspects of transformation and service redesign as well as QIAs around CIP which would be re-emerging with the re-commencement of the CIP process and CIP Council.	

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Clinical Audit Plan			The Head of Research presented a report setting out work to improve and develop the clinical audit plan for the Trust. The plan was refreshed annually and included areas of audit which teams across the Trust wished to see audited throughout the year. The plan consisted of a number of areas including national audits which the Trust was required to undertake, audit requests from commissioners and directors, directorate priorities and clinical interest audits put forward by clinical teams. The plan had been approved by the Quality Council and had been shared with commissioners. the Trust had invested in an electronic package: Audit Management and Tracking (AMAT). The system was just beginning to be implemented but this tool was anticipated to be a time saver for teams and clinicians inputting into audits on an ongoing basis as well as the review and management of NICE.	It was agreed that clinical audits receiving limited assurance and/or with an associated action plan would be specifically noted within the Quality Council reports going forwards.
Quality Account 2021/22			The Committee approved the quality account for 2021/22 and this would be published on the Trust's website. The Committee thanked the Director of Quality Governance and all teams involved for all of their significant work in putting the report together.	
Review of MIAA Audits	2,3,6		The Committee noted that there were no current audits to be reported upon.	

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Carer's Strategy/Plan	2, 3, 6		The Committee received and supported the plan. It was acknowledged there was a potential risk around the Trust's ability to deliver on all aspects of this plan, which would include IT support, recognising that this was a substantial piece of work alongside other current pressures prevalent within the Trust.	An update would be received on progress against the plan in six months' time to track progress against key outcomes and discuss any challenges/barriers as part of work that the Committee could help to influence.
Committee Terms of Reference	1		The Committee reviewed and approved the Terms of Reference subject to some minor changes.	
Business Cycle/Work Plan	1		The Committee approved the business cycle with the caveat that requirements around learning from deaths reporting be clarified: consideration would be given to scheduling of the oversight on delivery of the various strategies within the Committee's remit over its five meetings per year. Medical Director, Ted Adams suggested that the Committee would also have oversight of wider elements of the digital strategy from a quality and clinical perspective.	The Medical Director undertook to raise this with the Programme Director of Integration and Collaboration in advance of the 27 June Board time out session to enable discussion on this as part of the Board considerations on the digital strategy.
Board Assurance Framework	2,3,6		The Committee reviewed the areas of the BAF within its remit: BAF2, 3 and 6:	It was identified that a considerable amount of BAF2 was in relation to the pandemic and there needed to be further reference to recovery, restoration and service reset and there was a re-write required on the rationale. It was agreed that the Chief Nurse would take

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				this into the Executive Management Team for further discussion. It was agreed that BAF3 required an update generally across this section to take the reset work into account. Reference to winter plans also required an update, as well as an incorrect reference to this Committee being stood down. The Chief Nurse advised that following the review of risks around district nursing in Halton and Warrington, this section along with BAF2 and BAF3 would be updated to reflect relevant aspects and impacts. There were no changes made to any of the scores.
Consideration of future Deep Dives	2,3,6		The Committee agreed the following areas for a future deep dive report: Clinical harms – this would be scheduled for the October Committee meeting. Learning disability group - this would be scheduled for the December Committee meeting. Community Nursing in Warrington in Halton – this would be a priority area. This would include the result of the current review work concerning pressures, resources	

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			and demand and operationalisation of the teams. It was agreed that this deep dive would be presented to the August meeting. This could also include service redesign work that was being undertaken with commissioners which was concerning development of a future model. The Committee could discuss future ambitions around this in the future.	
Items to be shared with Board and/or other Committees	1		The review of the performance framework would feed into the Finance and Performance Committee following discussions at the performance council and this Committee would welcome feedback on this from an IQPR perspective.	This will be considered by the Finance and Performance Committee in September and an update will be provided to this Committee in October 2022.
			There would also be discussion at the 27 June Board time out session concerning the Committee's role in terms of monitoring quality and clinical aspects of the digital strategy.	
Risks Escalated. None.				

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Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**58/22i**		
Report Title	**FINANCE REPORT – JUNE 2022**		
Executive Lead	Nick Gallagher – Executive Director of Finance		
Report Author	Rachel Hurst – Deputy Director of Finance		
Presented by	Rachel Hurst – Deputy Director of Finance		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Purpose

To brief the Board

Executive Summary

To brief the Board on:

- Financial position as at Month 3

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☐ **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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ **Caring**	☐ **Effective**	☐ **Responsive**	☐ **Safe**	☒ **Well Led**

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	04 August 2022
Agenda Item	58/22i		
Report Title	FINANCE REPORT – JUNE 2022 – MONTH 3		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on Financial Position as at Month 3		

1. SCOPE

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

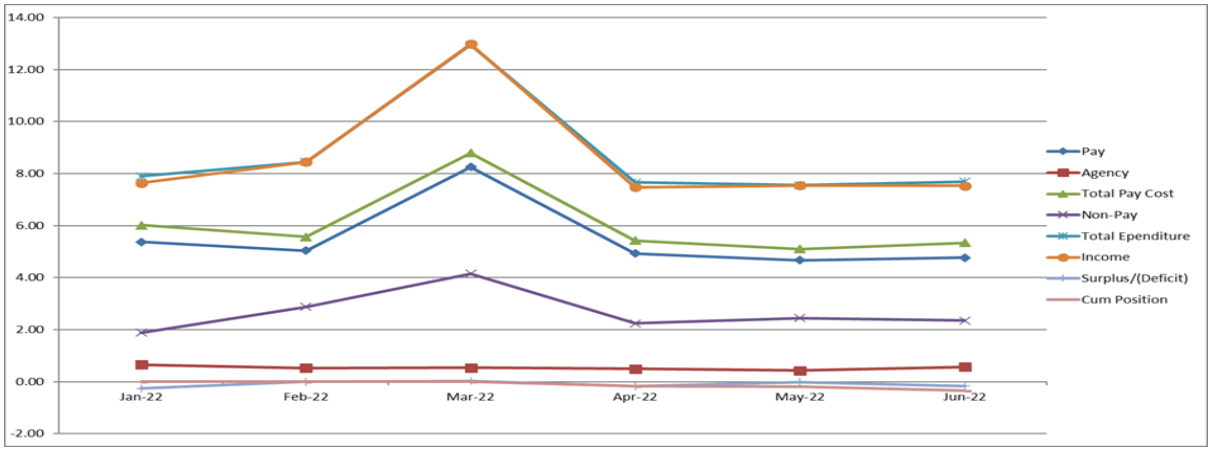
- Financial position as at Month 3
- CIP plans and delivery
- Capital and Cash

2. FINANCIAL POSITION AS AT MONTH 3

2.1 The key headlines for Month 3 are shown in the table below.

Summary Performance Month 03 2022-23	Month 3 Plan (£M)	Month 3 Actual (£M)	Month 3 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.45)	(7.53)	0.08	(22.36)	(22.55)	0.20	(89.96)	(89.77)
Expenditure - Pay	4.80	4.77	0.03	14.40	14.37	0.03	57.60	57.60
Expenditure - Agency	0.42	0.57	(0.15)	1.24	1.49	(0.25)	4.95	4.95
Expenditure - Non Pay	2.32	2.34	(0.01)	6.97	6.99	(0.02)	27.03	27.03
EBITDA	0.09	0.15	(0.06)	0.25	0.30	(0.05)	(0.37)	(0.18)
Financing	0.03	0.01	0.02	0.09	0.04	0.05	0.37	0.18
Normalised (Surplus)/Deficit	0.12	0.16	(0.04)	0.35	0.34	0.00	(0.00)	(0.00)
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	0.16	(0.04)	0.35	0.34	0.00	(0.00)	(0.00)
Other Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.12	0.16	(0.04)	0.35	0.34	0.00	(0.00)	(0.00)
CIP	0.27	0.27	(0.00)	0.63	0.63	0.00	4.20	4.20
Capital	0.14	0.03	0.11	0.75	0.11	0.64	2.10	2.10
Cash	25.79	25.86	0.07	25.79	25.86	0.07	25.20	26.64
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 revised version of the plan submitted to NHSE/I and agreed at Board in June 2022 which reflected a breakeven position and supersedes the previous plan of £1.449m deficit.

2.3 All month 3 run rates are consistent with expectations and previous year comparators.

3. 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 It should be noted that the reduction in Covid spend, although categorised in the plan as non-recurrent, will be recurrent.

3.5 As these cost reductions have already been reflected in the plan and budgets, the spend will be monitored against the reduced Covid budget to ensure delivery.

3.6 As at end of June, expenditure is below budget, although information continues to be collated from budget managers to ensure reporting is complete and accurate.

3.7 The Trust plan to month 3 is £0.63m, which is reported as achieved due to additional income for the Performance / BI SLA with STHK and reduced estates costs in Dental (ORB) and vacancy slippage.

4. FINANCIAL OUT TURN & RISK RANGE

4.1 The NHSE/I guidance expects systems to deliver a cumulative breakeven position at the end of the financial year though the system currently has an underlying deficit.

4.2 This underlying deficit will be monitored centrally in the early parts of this financial year

5. CAPITAL, LOANS, CASH & BETTER PAYMENT PRACTICE CODE

5.1 Total capital expenditure as at 30th June is £0.10m against a plan of £0.75m. The underspend relates to an expected delay to the delivery of a couple of high value schemes, i.e. the Strategic Estates and Altrincham dental schemes, and a change in composition of the capital programme from the original plan submitted

5.2 The majority of capital schemes for 22/23 have been finalised with the remainder expected to be finalised imminently.

5.3 In June there was a net cash outflow of £0.18m with a closing cash balance of £25.87m.

5.4 Total debt as at 30th June is £10.69m excluding bad debt and credit note provisions, of which £7.46m relates to invoiced debt. Overall debt has increased slightly from May, whilst overdue debt has increased by £0.76m, the majority of the increase is due to amounts owed by Oldham Borough Council which are in query.

5.5 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
May-22	95	99.7	99.9
Jun-22	95	99.1	98.6
Year to date performance	95	99.5	99.4

5.6 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. RECOMMENDATIONS

6.1 The Board is asked to:

- Note the contents of this report.
- Note the financial position.

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:	21st July 2022	Date of next meeting:	22nd September 2022
Chair:	Tina Wilkins	Parent Committee:	Board of Directors
Members present/attendees:	**Members:** Tina Wilkins, Committee Chair Linda Chivers, Non-Executive Director Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Nick Gallagher, Director of Finance Sarah Brennan, Chief Operating Officer **In attendance:** Eugene Lavan, Deputy Chief Operating Officer Rachel Hurst, Deputy Director of Finance Rob Foster, Programme Director for Integration and Collaboration John Morris, Deputy Director of Estates Susan Burton, Director of Nursing for Warrington (on behalf of the Chief Nurse) Dave Smith, Assistant Director of IT Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Anita Buckley, Information Team Jan McCartney, Trust Secretary Lynda Richardson, Board and Committee Administrator **Observers:** Rita Chapman, Lead Governor/Public Governor for Rest of England	Quorate (Yes/No):	Yes
		Key Members not present:	Lynne Carter, Chief Nurse

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

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

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Finance	4		Month 3 finance report received and provided assurance. The Committee noted that: • Month 3 22/23 deficit on plan • CIP on plan • Maintenance of improvement in BPPC performance • Healthy cash position • Small 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 continuing. The Committee noted that further detail would be added to future reports to cover the new agency rules and cap from September. The Committee noted that the reduction in COVID spend would be badged as recurrent savings going forward. The Committee to raise the issue of surplus cash - due to capital constraints and breakeven plan the Trust has no control over this - at the Board /Trust Chair to the ICS. The Committee agreed to close the action relating to this. The Committee noted the recent announcement regarding pay award and that this was to be fully funded to providers, however awaiting further details.
Finance	4		2022/23 Annual Plan update	The Committee noted the paper presented for completeness.

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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		Chair's report from CIP Council was received. This provided an update to the programme.	The Committee noted the recurrent and non-recurrent targets and the proposed allocation across services. The Committee noted the update and progress to date. All CIP plans will be subject to a QIA/EQIA.
Finance	4		Grip and Control update noted.	The Committee noted the update given and the move to utilise the HfMA sustainability self-assessment toolkit to come to September F&P and then to Audit Committee in October prior to review by MIAA.
Performance	4,8		IQPR for month 2 was received by the Committee	The committee noted that of the 19 indicators, 13 are now green which is an improvement from the previous month. However, concerns were noted with the increase versus the target of referrals into children's services particularly speech and language and community paediatrics and the consequent impact on 18-week RTT performance for community paediatrics in Halton and Warrington and Dermatology in Warrington. The Committee discussed that the revised quality indicators for the IQPR had not been implemented and the Chair of the Q&S Committee advised that these need to be revisited by the

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				Q&S committee. The COO advised that there were also indicators in the SOF that needed to be added to the IQPR. It was suggested that an IQPR Update paper is presented at Committee in September with the proposed new indicators and that a refresh of the performance framework is presented in November 2022 to reflect any changes to performance management.
Performance	4,8		The Chair's report from Performance Council for month two was received.	The Committee expressed concerns regarding the level of detail contained within the report. They felt that the report did not reflect the work being undertaken by Performance Council and the RAG ratings were not included as had been previously requested by the Committee and included on the agenda. Taking all these factors into consideration, the Committee did not feel able to accept the report on its own, as assurance.
Performance	4,8		Dermatology update paper was received by the Committee.	The Committee were assured by the report and by the progress made to date.
Digital	8		The Committee received the Chair's report from DIGIT.	The Committee noted that the number of video consultations had dropped off. DIGIT would be reviewing this at the next meeting.

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			Digital Strategy was received and noted. Committee feedback on the Qlik workshop.	The Committee recommended the adoption of the Digital Strategy by the Board. The Committee recommended a Board development session to understand the requirements of performance information by the Trust and the different uses of data.
Estates	4		The Committee received and noted the Estates update. Green Plan – the Committee received and noted this paper.	The Committee noted that the legal case regarding Irwin Road had resulted in costs awarded to the Trust. The Health and Care Act came into force from 1st July 2022. The Committee noted that the Trust would be monitored against delivery of the Green Plan objectives. However, the funding of the pay award referenced elsewhere could be a potential risk due to cost pressures.
Audit	4		The paper was received and noted.	The Committee approved an extension to the outstanding internal audit recommendation regarding update of the debt management policy. The Committee noted the ISA260 action plan and completion dates would be firmed up over the next 6 to 8 weeks.
Risk	4		The paper was received and noted.	

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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 reviewed BAF 4 in light of the approved break even plan for the Trust. This will go to Board for review and approval. The Committee noted the risk remains the same. A full review took place and will go to the Board for review and approval. The Committee undertook a full review of BAF 8 and will go to the Board for review and approval.	
Governance	4,7,8		Committee Terms of Reference Committee Business Cycle	The Committee approved the updated Terms of Reference and recommended them to the Board for approval. The Committee approved the Business Cycle and recommended it to the Board for approval.	
Meeting Review – The observer – The lead Governor commented that it had been a very good meeting with good challenge and debate. The Committee expressed its thanks to the lead governor as they were due to step down (term ended) at the end of July 2022. The Committee noted that the meeting is lengthy and aiming to reduce the meeting by half an hour for the September meeting.					
Risks Escalated – None **Actions delegated to other Committees** – The Committee recommended the Finance paper for approval by the Board Surplus Cash as highlighted above to be raised at ICS level - through Board/Trust Chair.					

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Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

HfMA Sustainability self-assessment toolkit to go to Audit Committee in October. The Committee recommended a Board development session to understand the requirements of performance information by the Trust and the different uses of data. The Committee recommended the Digital Strategy for adoption by the Board	

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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:	7 July 2022		Date of next meeting:	27 October 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 Sarah Brennan, Chief Operating Officer Jan McCartney, Trust Secretary Louise Thornton, Senior Financial Accountant, Gareth Pugh, Assistant Director of Finance Gary Baines, MIAA Audit Engagement Manager Adrian Poll, Senior Audit Manager, MIAA Phillip Leong, Anti-Fraud Specialist, MIAA John Blewett, Audit Manager, 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 Lynne Carter, Chief Nurse / Deputy Chief Executive Ted Adams, Medical Director (with consent of the Chair) Debbie Weir, Financial Controller James Boyle, Director, Public Sector Audit, KPMG Rachel Hurst, Deputy Director of Finance

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given	Action/decision
Declarations of Interest	1		The Committee Chair advised that was no longer involved with Chorley and South Ribble CCG, due the disestablishment of CCGs. This therefore removed any potential conflict of interest with wither the CCG or KPMG, who had provided Internal Audit services to the CCG. An update had been provided to the Trust but had not yet been included in the Register of Interests	Noted

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e- Governance initial reviews of the draft Annual Report and Annual Governance Statement	1		Confirmation was received that a members and colleagues had been invited to comment on the two documents prior to final review and approval	Assurance received
e-Governance to note the approval of a number of additions to the Registers of Interest under Chairs action	1,4		Confirmation was received that the Chair had approved for publication a number of additional declarations of interest. These were included in the papers for the meeting on 7 July for completeness	Assurance received
IG Training Compliance	1,8		The Committee received confirmation that as at 30 June the Trust had achieved 95% compliance and had therefore been able to achieve the required level.	Assurance received
Well-led – Monitoring of Action Plan	1		The Committee received the updated Well-led Action Plan and assurance that the delivery of the agreed Action Plan was progressing. The evidence associated with each action has been audited as part of the external audit on Value for Money and reported as part of the year end audit findings. The Committee discussed how the impact of the actions would be scrutinised and at what stage Facere Melius may be invited to undertake a follow up review. The Committee also discussed the anticipated change in the proposed new regime for CQC assessment of both individual Trusts and systems and agreed it may be beneficial to ask that this be included as a Board session in October.	Each Committee to continue monitoring delivery of actions relating to their sphere of activity Trust Secretary to discuss with the Chair the potential for a board session to consider the proposed new CQC monitoring regime
Terms of Reference	1		Following the Trust wide review of Board and Committee Terms of Reference these will be shared with the Board as part of comprehensive paper from the Trust Secretary for approval.	Terms of Reference were agreed for recommendation to the Trust Board. It was agreed to remove the Medical Director from the list of members but ensure that they were aware of a standing invitation to

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				attend should there be items pertinent to their portfolio. It was also agreed that the Chief Operating Officer or Deputy would attend all Committees to ensure connectivity.
Review of BAF and Corporate Risk Register systems and processes	1		In addition to a 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 clean Value for Money Opinion from KPMG which had rebutted the potential for significant weakness in Governance and the audit of the delivery of the Well Led Action Plan that the Committee would recommend the current Risk Score should be decreased to 4x2 (8) In considering the assurance paper covering the Corporate Risk Register processes it was agreed that the paper would in future include an update on the proposed move from the Ulysses system to Datix and that it also focusses more on the process and outputs, including items referred to Board Committees by the risk Management Council. This would prevent any duplication of discussion at both Audit Committee and Board Committees. Assurance was received from Martyn Taylor, who has attended 2 Risk Management Council meetings as part of his induction that the meeting was well run and process robust	Assurance received Current Risk Score on BAF 1 to be decreased to 4x2 (8)
Registers of Interests	1		The Committee received updates on new declarations of interest from staff and subject to final assessment of the risk of 3 individual declarations agreed the registers could be published.	Assurance received

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			It was noted that MIAA are currently undertaking a review of Conflicts of Interest – the early draft report received by the Trust Secretary indicated "significant assurance".	
Review of Losses, Special Payments and Waivers	1,4		Proposed bad debt write offs totalling £4,142.40 were noted and assurance received that all possible recovery options had been exhausted. It was noted there had been 2 Special Payments, linked to 1 case. The Committee were assured that due process had been followed for all 7 waivers, which were documented. The Committee requested a trends analysis on salary overpayments for the next meeting.	Assurance received
IR35	1,4		The Committee received a written 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 and that the final report was imminent.	The final report is delayed and thus prevents full assurance being received that the Trust has applied IR35 appropriately.
Management Responses to External Audit ISA260 recommendations	1,4		Due to timing of receipt of the final ISA260 at year end formal Management Responses had not been included. These were considered by the Committee and the Finance and Performance Committee will be asked to oversee the implementation of agreed actions.	Finance and Performance to oversee implementation of agreed actions
Mersey Internal Audit Agency Progress Report	1,4, 8		The Committee considered the findings of the Data Security and Protection Toolkit mandated audit which covered the 10 National Data Guardian's Security Standards. Overall Substantial Assurance was received.	Assurance received. Substantial Assurance level of the mandated DSPT Audit to be added to the BAF 8
Update of Fit and Proper Person Audit Recommendations	1		The Committee were assured that a number of recommendations had been actioned although 2 had had their due date extended from 31 May to 31 July.	Assurance received

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Anti-Fraud report	1,4		The Committee received the regular progress report. It was noted that the submission of the Counter Fraud Functional Standard Return (CFFCR) took place on the 6th of June 2022, in line with the set national deadline. The Trust received a green rating against all 13 components comprising the CFFSR. The contribution of the Anti-fraud specialist to the review of a number Trust policies was noted.	Assurance received
Risks Escalated – None from the meeting				

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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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**58/22iv**		
Report Title	**FINANCIAL IMPACT OF PAY AWARD ANNOUNCEMENTS**		
Executive Lead	Nick Gallagher – Executive Director of Finance		
Report Author	Rachel Hurst – Deputy Director of Finance		
Presented by	Rachel Hurst – Deputy Director of Finance		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Purpose

To brief the Board

Executive Summary

To brief the Board on:

- Financial impact of pay award announcements
- Risks identified within the report

To be assured that the mitigations / controls identified are appropriate and effective

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☐ **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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ **Caring**	☐ **Effective**	☐ **Responsive**	☐ **Safe**	☒ **Well Led**

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	04 August 2022
Agenda Item	58/22iv		
Report Title	FINANCIAL IMPACT OF PAY AWARD ANNOUNCEMENTS		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial impact of pay award announcements		

1. EXECUTIVE SUMMARY

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

- Financial impact of pay award announcements
- Risks identified within the report, and;

To be assured that the mitigations / controls identified are appropriate and effective

2. PAY AWARD ANNOUNCEMENTS

2.1 The government announced on Tuesday 19th July 2022 that it was accepting the recommendations of all the NHS pay review bodies.

2.2 The review covering staff on Agenda for Change (AfC) recommended: "A £1,400 consolidated uplift for all AfC staff to their full time equivalent salary. The £1,400 uplift should be enhanced for the top of Band 6 and at Band 7 so it is equal to a 4 per cent uplift for those staff."

2.3 Overall, this is equivalent to a 4.8 per cent annual increase. However, because – with the exceptions of the uplifts at band 6 and 7 and increases for living wage for band 1 and some people at band 2 – this is a flat £1,400 across all bands, those in higher bands will receive a lower percentage pay rise.

2.4 Very Senior Managers (VSM) will receive 3 per cent; with a further 0.5% to ameliorate the erosion of differentials and facilitate the introduction of the new very senior managers framework. (Funding for these staff groups comes out of local budgets).

2.5 Eligible doctors and dentists will receive an increase of 4.5 per cent, as recommended by the Doctors' and Dentists' pay review Body. The award does not cover those "already in multi-year deals", such as junior doctors.

2.6 The consolidated pay uplift will be backdated to April after ministers accepted the recommendations of the independent NHS pay review bodies in full.

3. FINANCIAL IMPACT

3.1 The Trust is awaiting further details which have not yet been issued. However, based on what has been issued to date the following points are to note.

3.2 Current allocations included in budgets were based on a 3 per cent uplift.

3.3 The letter from NHS England (NHSE) (attached) confirmed that systems and providers would be funded in full for the pay award on top of existing allocations. This will be allocated to systems and NHS England commissioners.

3.4 Commissioners are expected to reflect this increase in their contracts with Trusts in line with a 1.7 per cent uplift to tariff.

3.5 The total cost not covered in current allocations is estimated at £2 billion.

3.6 For 2022-23 only this is also expected to cover Local Authority health care contracts.

4. FINANCIAL IMPLICATIONS

4.1 NHSE stated that the additional cost will require the Department of Health and Social Care (DHSC) and NHSE to reprioritise centrally held budget lines including national technology programmes, Community Diagnostic Centres (CDC) etc.

4.2 Further details are awaited in order to understand the financial implications for the Trust.

5. RECOMMENDATIONS

5.1 The Board is asked to:

- Note the contents of this report.
- Note the financial impact and potential implications.

Classification: Official

Publication reference: PAR1863

To:
- Trust and Foundation Trust Financial Directors
- ICB Financial Directors
- Trust and Foundation Trust Chief Executives
- ICB Chief Executives and Chairs

cc.
- Regional Financial Directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

20 July 2022

Dear colleagues,

RE: 2022/23 Pay award

The Government has yesterday announced that it is accepting the recommendations of the Doctors' and Dentists' Remuneration Body (DDRB), the 35th report of the NHS Pay Review Body (NHSPRB), and the 44th report of the Senior Salaries Review Body (SSRB). Further details can be found here.

It is right that the essential work of frontline NHS staff responding to the pandemic and recovering services is recognised and rewarded. It is also an operational necessity if we are to retain the staff needed to make further inroads into the COVID-19 backlog and continue to respond to significant operational demands.

Systems and providers will be funded in full for the pay award on top of existing allocations. As a result you can continue to focus on operational demands, including urgent and emergency care and recovering COVID-19 backlogs.

We are also taking this opportunity to set out the actions we will be taking to reduce agency expenditure that have been developed in collaboration with system partners (Annex A) as part of our ongoing commitment to deliver the best possible value for every pound of taxpayer funding.

Funding the pay award

We will allocate an additional c£2bn to systems and NHS England commissioners to cover the additional cost of the pay increase for 2022/23 above the level included in existing allocations. Systems and NHS England commissioners are expected to reflect this increase in their contracts with trusts in line with a 1.7% uplift to tariff. The allocation will also take account of cost increases on services provided by non-NHS providers, and

the additional costs of providing education and training. Funding must be flowed appropriately to all providers.

The additional cost will require NHSE and the Department to reprioritise centrally held-budget lines including national technology programmes. Details will be set out shortly. These savings will allow the NHS to focus on frontline patient care this year but will impact on the ability to deliver on specific plans and goals. We will reflect on these additional factors with Government as we continue work to update the Long Term Plan over the summer.

Capacity to support performance

Recognising the current set of demands on systems, it is also now critical that we continue to increase capacity in and out of hospitals to support performance and patient flow, particularly for emergency services. We are working with all of you on capacity plans for ambulance delays and long waits in Emergency Departments as part of the current operational response and ahead of winter. We will confirm funding and plans to support these goals including for virtual wards over the coming weeks. Agreed plans will be funded.

Recovering COVID-19 backlogs

We are asking systems to continue to focus on mental health services, using resources provided through the Mental Health Investment Standard and transformation funding; and to reduce long waits, where systems should continue to focus on ambitions for 104 weeks, 78 weeks, and cancer over the rest of this year—building on the good progress so far. As COVID-19 infection rates fall we will need to target recovery of activity so that we can return to better than pre-pandemic levels.

Thank you for all that you and your staff are doing to look after patients and deliver value for taxpayers. We have seen the busiest May and June in our emergency departments, have dealt with successive waves of COVID-19 pressure, continued to protect the population through the vaccination programme, are seeing around 10% more patients in general practice than before the pandemic, and decreased the number of the longest waiters by more than 80%.

Yours sincerely,

Julian Kelly
Chief Financial Officer
NHS England

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**59/22**		
Report Title	**INTEGRATION & COLLABORATION**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Rob Foster – Programme Director Collaboration and Integration Sarah Brennan – Chief Operating Officer		
Presented by	Rob Foster – Programme Director Collaboration and Integration		
Action Required	☐ **To Approve**	☒ **To Assure**	☒ **To Note**

Purpose

To provide an update on progress to date

Executive Summary

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.

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☒ 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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ Caring	☐ Effective	☒ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	04 August 2022
Agenda Item	59/22		
Report Title	INTEGRATION & COLLABORATION		
Report Author	Rob Foster – Programme Director Collaboration and Integration Sarah Brennan – Chief Operating Officer		
Purpose	To provide an update to the Board in relation to integration and collaboration		

1. 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. ICS UPDATE

National

2.1 Integrated Care Systems (ICSs) became statutory bodies on 1st July 2022. This marks the launch of 42 ICSs across the country, alongside the closure of all Clinical Commissioning Groups (CCGs)

As reported previously, each of the 42 ICSs have been appointing officers to the senior roles in their respective Integrated Care Boards. Furthermore, senior appointments have been made across the new 'place-based arrangements' of our respective systems.

The NHS Oversight Framework for 2022/23 replaces the NHS System Oversight Framework for 2021/22, which described NHS England and NHS Improvement's approach to oversight of integrated care boards (ICBs) and trusts.

This framework outlines NHS England's approach to NHS oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS operational planning and contracting guidance.

It also reflects the significant changes enabled by the Health and Care Act 2022 including the formal establishment of Integrated Care Boards and the merging of NHS Improvement (comprising of Monitor and the NHS Trust Development Authority) into NHS England.

The Framework describes how the oversight of NHS trusts, foundation trusts and integrated care boards will operate. This supports the ambition for system-led delivery of integrated care, in line with the direction of travel set out in the NHS Long Term Plan, Integrating care: Next steps to building strong and effective integrated care systems across England and the Government's white paper on integration – Joining up care for people, places and populations.

Oversight metrics

A set of oversight metrics has been published, applicable to integrated care boards, NHS trusts and foundation trusts, to support implementation of the framework. These will be used to indicate potential issues and prompt further investigation of support needs and align with the five national themes of the NHS Oversight Framework: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.

The new Framework came into force from 1 July 2022. As part of the update work to the Integrated Performance and Quality Report (IQPR) any relevant indicators to community services will be proposed for inclusion in the IQPR. A paper will be taken to the Finance and Performance Committee in September and then onward to Board in October 2022 for approval.

2.2 Cheshire & Merseyside

Across Cheshire & Merseyside (C&M), the ICB (which will be known as NHS Cheshire & Merseyside) has appointed to the senior place-based roles. Further place-based roles will be appointed too over the coming months, as the new ICB arrangements are implemented

The table below shows the senior place-based roles in Warrington & Halton.

Role	Warrington	Halton
Place Director	Carl Marsh	Anthony Leo
Associate Director of Finance & Performance	David Cooper	Nigel Gloudon
Associate Director of Quality & Safety Improvement	Denise Roberts	Denise Roberts
Associate Director of Transformation & Partnerships	TBC	Phillip Thomas

3. 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. PLACE UPDATE

4.1 Both Warrington Together and One Halton continue to progress and develop, with an expectation that the pace of change will start to accelerate with the appointment of the place-based teams.

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

4.3 The place-based partnerships in Halton & Warrington continue to work together to design and develop initiatives to meet the needs and demands on all our services. This includes (not exhaustive):

- Community Rapid Response services,
- Virtual Wards,
- Intermediate Care,
- Acute Discharge,
- Integrated Community/Neighbourhood Team working, and
- Single Point of Access.

A critical aspect of all work is understanding and addressing Health Inequality challenges that exist. To this end, the Bridgewater team have engaged with System P, to bring a focus to both the methodology of change and the unique data to support and aid our work.

Given the progress being made in place and the ICB, the Programme Director will look to develop a revised ICB Dashboard moving forward, to present regular updates on key metrics across the system, our places and our teams.

5. ENGAGEMENT

5.1 To maximise the opportunities presented by the ICS changes, the Bridgewater Transformation Unit are scoping the development an internal transformation programme, which will further enhance our staffs voice in shaping and influencing service and place visions moving forward.

5.2 This will feed into both the place-based work, as well as the development of the new Quality & Place Strategy from April 2023.

5.3 Closely aligned to this, as well as staff engagement, engagement with our patients and local citizens will be critical; both from a place-based perspective, but also our Strategy development. To this end, the Q&P Patient Experience Group, with representatives from our Council of Governors, will lead the design and shaping of how we further embed the citizen voice in our work moving forward.

6. RECOMMENDATIONS

6.1 The Board is asked to Note the contents of this report.

Committee Chair's Report

NHS
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Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	13 July 2022	Date of next meeting:	14 September 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 & Organisational Development Mike Baker, Deputy Director of Communications and Engagement Tania Strong, Interim Head of Human Resources Kathryn Sharkey, Head of Workforce Adie Richards, Education and Professional Development Lead Susan Burton, Director of Nursing, Warrington, deputising for Lynne Carter, Chief Nurse Denise Bradley, Unison Bridgewater Branch Secretary & Staff Side Chair Sarah Brennan, Chief Operating Officer, left part-way through the meeting Eugene Lavan, Deputy COO, joined in part-way through the meeting for Sarah Brennan Jan McCartney, Trust Secretary	Quorate (Yes/No):	Yes
		Key Members not present:	Lynne Carter, Deputy CEO/Chief Nurse (Deputy in attendance) Sally Yeoman, Non-Executive Director

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	Helen Hollett, Head of Leadership and Organisational Development Ruth Besford, Equality and Inclusion Manager **Observers** Rachel Game, Governor Observer		

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			The Trust Secretary presented the Terms of Reference for approval and onward escalation to Board for overall approval. Sam Scholes has supported a piece of work to review all the Terms of Reference. Chief Operating Officer will now attend all People Committee meetings to ensure operational connectivity.	The Committee agreed the TOR for onward approval at Board.
COMMITTEE BUSINESS CYCLE REVIEW			The Annual Business Cycle was presented by the Trust Secretary as per the request at the May 2022 Committee. It was agreed that this would be tabled annually. It was noted that it has been agreed that Tina Wilkins has been assigned as Deputy Committee Chair.	The Committee endorsed the annual business cycle.
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 and the Chief Operating Officer advised that she had been working with the Associate Directors to agree a plan to address the compliance gaps with a similar approach to that taken with Information Governance, whereby target was met.	The Committee were assured on the progress and governance around the management of risks through Risk Council. It was agreed that the Communications Risk in relation to the MMDA SLA would be referred to Finance and Performance Committee. Updates will be provided at future meetings.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			A new risk was presented by the Deputy Director of Communications and Engagement in relation to an SLA with Mid Mersey Digital Alliance (MMDA). Due to forthcoming changes in MMDA there is a possibility that the support and functionality they provide for the staff intranet will come to an end later this year. If an SLA extension isn't agreed, the building of a new intranet will be an unaccounted cost pressure to the Trust (estimate of £25,000.) This is recently come to light and the Deputy Director of Communications and Engagement is working with IT to fully scope out the issue and work up some potential solutions. Paula Woods, Director of People advised that she would link in with Nick Gallagher, Director of Finance, who is aware of the issue. It was agreed that this should be discussed at DIGIT and referred to Finance and Performance Committee.	
IQPR – PEOPLE INDICATORS	5, 6 and WLR 9		The 5 IQPR people indicators were presented to the Committee for month 2. An 'as is' position was included to mitigate the delays in receiving timely information due to meeting cycles. 4 of the 5 People Indicators were reporting as red – the exception being Induction which is reporting green. 2 of the 5 indicators slightly improved in month 2, however PDR's, Sickness and Turnover still remain adrift from the Trust target. Papers presented later in the agenda outlined the actions being taken to address those indicators that remain below the Trust target.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings. A meeting between the Director of People and Tina Wilkins to review the data in relation to staff turnover in more detail.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			The Director of People updated on a People Directorate meeting which took place in that week to look at how what we can do to support the people indicators moving in the right direction. There is lots of appetite in the Directorate with some really good ideas which will be considered and taken forward. Tina Wilkin suggested that she meet with the Director of People to consider the data in relation to Turnover outside of the Committee meeting.	
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. **Messenger Report** – A Government review of health and care leadership has recommended a single set of 'core leadership and management standards' for NHS Managers. The review was extensive in its scope, covering all parts of the system and utilising a 'listen and learn' approach to engage with a diverse range of stakeholders. The report acknowledges the complexity of the system and its structure, as well as the pressures the NHS currently faces in tackling a backlog in care against the backdrop of significant staff shortages. It also recognises the important relationship between driving improvement in leadership and the positive effects on productivity and efficiency. NHSE/I's Interim Chief People Officer has confirmed to the NHS People Profession that, together with partners, they will consider the	The Committee noted the report and its contents. Further updates on the workstreams will be provided in future meetings as they progress. It was agreed that the AHP Strategy would be escalated to board for overall approval.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			recommendations set out in the report, and then develop a co-created roadmap for implementation. An initial review of the recommendations has been undertaken internally, identifying what we have currently, recognising that they may be subject to change and replaced by national guidance. **Rugby League Cares –** The Director of People presented data in relation to over 500 staff across various Teams having accessed RLC since January 2022, providing wellbeing support to staff. RLC have worked with us on an approach to obtaining feedback to support a full evaluation of all the of their programmes which is still being rolled out and will feature in my next update report. The feedback forms have gone out to Teams. **Continuing Professional Development (CPD) Funds – Trust allocation of £258k -** We have received confirmation of the 22/23 allocation to us in line with the ministerial announcement of £150m increased investment in continuing professional development (CPD) for nursing associates, nurses, midwives, and allied health professionals (AHPs). Our CPD allocation for 22/23 is: £258,000 We are required to submit our 22/23 CPD investment plans to HEE by 31st July 2022. Our plans must align to HEE's 5 key enablers: workforce transformation - supply, upskilling, new roles, new ways of working and leadership. **Our Just Culture Journey: Metrics Framework -** A paper went to Trust Board in June outlining our proposed Metrics	

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Framework which received endorsement. A refresh of some of the data presented has been undertaken and presented to the Committee. **Allied Health Professionals' Workforce Development Programme (AHPs) – AHP Workforce Strategy -** A Workforce Strategy for AHPs has been developed and presented to the Trust's Executive Management Team (EMT). It was presented to the Committee for onward reporting to Board. The AHP Workforce Strategy will be branded in line with the recent refresh of the branding that has been carried out by the Trust's Communication & Engagement Team. **Bridgewater's Career Ambassadors -** The Health Career Ambassador's Scheme encourages people working and/or studying in healthcare to volunteer as little as one hour per year to speak in schools about their roles or participate in careers events and activities. This Career Ambassador Scheme is managed by the Careers and Apprenticeship Team who regularly invite new members of our workforce to join the register of Bridgewater Career Ambassadors and frequently receive event invites from local schools, colleges, and local voluntary sector organisations including youth groups. Invites are shared with Ambassadors and those who are interested and able to attend can volunteer their time. Events include talks, careers and job fairs, and mock interviewing. **Leader in Me – 01st July 2022 -** The event took place as planned on Friday the 1st of July. Our Guest Speaker was	

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Committee Chair's Report

NHS
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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Professor Damian Hughes – "Liquid Thinker". Damian is an international speaker and a best-selling author. He helps organisations and teams create a high-performing culture through change psychology. The all-day event was highly interactive and included two workshops. Damian presented the following topics: - Unlocking the DNA of a high performing culture - The psychology of high performance - The winning mindset The event will be evaluated, and the feedback will be analysed to inform further programmes of work. Updates will be provided in future reports. **Leadership Development Programme – Operational Managers -** The Programme was provided to the Committee in a previous Director Update report. Since then, the Programme was launched on the 16th of June 2022 for both Operational Managers and Borough Directors**.** **Transfer of Services (TUPE): Bringing Transactional Training Services back in house -** Our transactional training services are outsourced and provided to us by way of a service level agreement with Warrington & Halton Hospitals (WHH). 3 months' notice has been served to bring the service back in house to support the integration of the function within the People Directorate as a whole. The contract runs to 31st October 2022.	

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			The respective Leads are now engaging on the smooth transition of the service back in house which will determine if there are staff aligned to the contract at WHH who would be subject to the TUPE regulations. **Block 10 at Halton Hospital, Runcorn – Base of OD, EPD and Library & Knowledge Service Staff -** The Trust's OD, EPD and Library Services Teams are based at Block 10, Halton Hospital in Runcorn. This arrangement was consulted on and put in place when our path of travel was a transaction with WHH. The pandemic resulted in staff working from home for the majority of time. As part of the Trust's Reset Programme, we will be consulting with staff to relocate them to Spencer House and/or Europa whilst our estate utilisation review is underway. **Sally Yeoman MBE -** Congratulations to Bridgewater's Non-Executive Director, Sally Yeoman who was awarded an MBE in the Queen's Platinum Jubilee Honours for services to the community in Halton and St Helens. A fabulous achievement and an asset to the Trust, and an honour to have Sally as an active and valued member of the People Committee.	
PEOPLE STRATEGY AND PEOPLE PLAN – PEOPLE OPERATIONAL DELIVERY PLAN REPORT			The People Plan and Promise: People Operational Plan Report was presented to information and assurance. The paper focused on the progress of the four People Operational Delivery Groups (PODs) that have been established to deliver on the NHS People Plan and People Promises, along with other People agendas. The report highlighted the key workstreams underway to support delivery of the People Plan. The four PODs are:	

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			1. Recruitment and Retention 2. Health and Wellbeing 3. Education and Professional Development and; 4. Culture and Leadership It was discussed how the report with evolve over time, focussing on outcomes and impact.	
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET OF 4.8%	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 June 2021 to 30 May 2022 was 7.00% compared to 01 June 2020 to 30 May 2021 (5.36%). The trust sickness absence target is 4.8%. Over the rolling 12-month period, rolling sickness absence rates has increased month on month from 5.44% to 7.00%. Actual sickness absence % rate has fluctuated month on month from June 2021 to May 2022. All cases were being managed with HR Manager input. Formal meetings were taking place in line with the monthly requirements, taking into consideration medical specialist appointments and most recent Occupational Health reports. Support is offered in regard to returns to work at the earliest date for staff. This included potential short-term reductions in hours, stress risk assessments and suggested adjustments from Occupational Health. Long term sickness absence is managed via the use of monthly review meetings held by the line Manager with HR support as required, occupational health input and the option	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			for a case conference with occupational health for complex cases.	
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. It was noted that there had been a slight increase in Employee relations cases since the last report – all these related to Lapsed Registrations. A piece of work is underway to understand the regulatory bodies processes to establish whether there are links between the lapsed registrations and an anomaly with their process of registration. It was noted that 2 long term cases had recently closed. There had been 3 Freedom to Speak up concerns raised since the last report which is reassuring in relation to staff having an understanding as to how they can raise concerns. 1 was immediately dealt with and closed, 2 are ongoing.	The report was noted by the Committee.
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.	The report was noted and the Committee were assured on the progress.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Dental Services training has taken place. There is ongoing work to support the Dental services to go live onto the system with configuration to the system on hours and annual leave calculations for non-agenda for change staff. 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 at the 3rd May Allocate supported a kick off meeting to commence the process and project plan is in place to implement the system. The Trust continue to meet with NHSI to update on the progress implementation of the system within a community organisation. Due to our successful roll out, we are presenting on the 6th of July 2022 at the regional Northwest NHSI conference.	Next report to contain information with regards to the benefits being realised as a result of the system implementation.

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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 asked that the next report have some information contained with regards to the benefits being realised as a result of the system implementation.	
HR POLICIES AND PROCEDURES	5		The progress with the review and approval of HR Policies and Procedures was provided for information and assurance purposes. No policies were reviewed or updated during May and June 2022. Fit and Proper Persons Test and Staffing Levels and Temporary Staffing Solutions policies will have minor amendments endorsed at the July 2022 HR Policy Group. Full review of the following policies will take place in August 2022: Absence Management Policy Overpayment/Underpayment Policy Overtime Policy Freedom to Speak Up: Raising Concern Policy (formerly titled the Whistleblowing Policy) JCC and LNC have now been re-established and so final ratification of all HR Policies will take place via this route going forward.	The Committee noted the content of the report.
EQUALITY, DIVERSITY AND INCLUSION ***(i)*** **Objectives and action plan updates** ***(ii)*** **Workforce Disability Equality Standard (WRES)**			The following reports were presented by Ruth Besford, EDI Lead: • An update on the Six High Impact Areas for Equality Action Plan 2022 – 23 for information and assurance	The Committee approved both mandated documents for submission and overall approval/sign off at Board.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
(iii) **Workforce Race Equality Standard (WDES)**			• Two mandated annual reports for approval and escalation to Board in July: ➢ Workforce Disability Equality Standard report 2022 (WDES). ➢ Workforce Race Equality Standard report 2022 (WRES). **Six High Impact Areas for Equality Action Plan 2022**: No actions are behind plan with the exception of Reciprocal Mentoring. The Committee is aware that suggestions are being considered as to alternative options following the withdrawal of this programme from the NHS Leadership Academy offer. **Workforce Disability Equality Standard report 2022 (WDES):** Full report was tabled with the following highlighted: Results are mixed with some improvements and some deterioration. Positively, we had 222 responses from staff with a disability or long-term condition - our highest ever response rate. The report is being shared with Enabled members in June 2022 for their comments and thoughts. We undertook a review of recruitment policy and process with Enabled members for Disability Confident in early 2022; a little more work is needed on review of retention, but the action plan in development, along with the Six High Impact Areas for Equality Action Plan, links into all the metrics where we would like to focus for improvement.	Consideration of additional questions in the staff survey in relation to reporting of protected characteristics. Request for the WRES and WDES to be overlaid in the form of a dashboard.

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Committee Chair's Report

NHS
Bridgewater Community Healthcare
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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			Workforce Race Equality Standard report 2022 (WRES). Full report was tabled with the following highlighted: The results for this standard are generally more positive with improvements across many indicators. The two areas where we saw a slight backward slide was in recruitment, one of our best results last year, and discrimination. Once again we had our greatest number of respondents to the NHS Staff Survey, 45 Black, Asian, or minority ethnic staff responded to the questions, this is roughly half the overall representative workforce and therefore reflects a similar response rate to the overall survey. We have provided an update on our Race Disparity Ratio results as at 31st March 2022. This is data two years on from the ratio results issued by NHS England for action planning to improve – they used 2020 figures for their calculations. It can be seen in the report that while our results have moved into the better ratings set out by NHS England we are not yet showing consistency of improvement, of which we are hopeful through our planned actions The improvements seen in the WRES no doubt reflect the efforts concentrated in this area, and our action plans, including the anti-racism action plan currently being drafted with the Race Inclusion Network should continue to see us deliver co-designed actions that improve workplace experience for Black, Asian, and minority ethnic staff.	

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			The report has been shared with network members for comments.	
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. There was a discussion in relation the Disability at Board level with a view to Board setting the example for reporting. It was highlighted that an exercise had taken place following this being highlighted at a previous committee and it was noted that this was self-reporting. It was requested that we consider additional questions in the staff survey in relation to reporting and the Director of People advised she would look into this with our Staff Survey provider. It was also asked whether there was a possibility for results in relation to the WRES and the WDES to be overlaid to understand whether there are consistencies/or not. The Trusts EDI lead advised that she would look into the possibility of a dashboard type report.	
PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE *including deep dives:* ***(i) Other Organisation's PDR and S&MT***	5 and 6 and WLR 7		The Committee noted the contents of the report and the associated agreed actions. M2 compliance with Mandatory Training shows 13 requirements at green, 7 at amber and 2 at red. There is an overall slight increase in compliance from the month 1 position in 21 modules.	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.

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
methods/approaches to achieve compliance ***(ii) Continued non-compliance considerations*** ***(iii) The Trust's learning offer***	and 8		There is a small decrease identified in 1 module, Safeguarding Children level 3. PPDR compliance has remined static at around 57% last month and is still significantly adrift of the 85% target. 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 01st May 2022. The monthly reports have shown a steady increase in compliance; however the 85% compliance has not yet been achieved. The safeguarding teams continue to deliver regular instructor led training sessions for the level 3 requirement and attendance has shown an improvement. • Data Security Awareness compliance to be 95% in all teams by 01st 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%. As per the commitment to providing the most up to date information to the Committee, as at 30th June	• A review of what other high achieving Trust's 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.

	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
			2022, it is pleasing to confirm that the Trust achieved the 95% target. • 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. Managers have been requested to allocate time in the E-Roster system for the completion of mandatory training to support better operational planning. As requested the Committee were provided with a comparison in Bridgewater Mandatory Training compliance with that of three of our neighbouring NHS Trusts with the purpose of recognising whether the current challenges impacting on our mandatory compliance figures are reflected across other Trusts, and also to identify any areas of high compliance and explore how this has been achieved by way of best practice sharing. Within the reports each Trust has reported on an overall mandatory training compliance percentage rather than providing a percentage figure for individual subjects. Each Trust also applies a slightly different filter to the overall compliance percentage calculation. In order to provide an equivalent overall percentage for comparison purposes a calculation has been applied to the May 2022 Bridgewater mandatory training data, applying the same filters that have been applied to each other Trust. The data collected showed that when the same filters are applied to the Bridgewater data as to the other Trusts	

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Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
			considered, the compliance percentages calculated are higher than that of Mersey Care, WHH and St Helens and Knowsley NHS Trusts in all but one section. For the role essential mandatory training comparison between Bridgewater and Mersey Care, at 76.63% the Bridgewater percentage calculation is 8.32% lower than that of Mersey Care Community Division compliance percentage of 84.92%. Our EPD Lead has reached out to Mersey Care to discuss how they have achieved this and hopes to have a meeting scheduled very soon. Also requested from People Committee in May 2022, a report was provided to outline the mandatory training and continuing professional development training offers provided by the Bridgewater from April 2021 until the end of May 2022, along with an outline of staff uptake within that period and a projection of some of the training already planned for the coming year.	
TALENT MANAGEMENT AND SUCCESSION PLANNING	5		The Talent Management and Succession Planning paper was presented by Helen Hollett, Head of OD for information and assurance purposes. The North West Leadership Academy Mary Seacole local Programme continues to be offered within Bridgewater as part of the Mersey and Cheshire Network Following the restructure of operational services, an Operational Managers development programme has been developed to support current and aspiring Operation Managers.	The Committee noted the reports and were assured on the progress and plans

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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 first line managers development offer is being developed to support current and aspiring Team Leaders as part of succession planning. Development is planned to be completed by September 2022. The internal coaching network has now been stepped up following suspension during the pandemic. Internal coaches are receiving external coaching supervision to refresh skills. Staff continue to utilise the Health Care Leadership Appraisal Model as part of personal career development. Scope for Growth is being rolled out across the NHS with the expectation that all NHS staff will have access to a career conversation by April 2024 and this will be embedded in organisations for an annual review. Bridgewater is an early adopter of this model. The report outlines progress of Scope for growth within the organisation.	
STAFF ENGAGEMENT AND RECOGNITION UPDATES	5 and 6		The Staff Engagement and Recognition Updates paper was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. The report highlighted the content of work delivered at pace in relation to the following: **Staff Survey Action Planning**: • At a Trust wide and Directorate level. • Each Directorate and Corporate lead is responsible for updating their action plan each month • Presented to local Finance, Workforce and Performance Meetings • Onward reporting into Performance Council	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;
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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
			Discontinuing of the Staff Engagement Steering Group: Due to the introduction of the POD's, the Staff Engagement agenda will now be picked up in the Culture & Leadership POD. The discontinuation of the Steering Group will avoid duplication of effort. **Reward and Recognition Package:** A report was tabled in relation to proposed changes to the Trusts reward and recognition package to support the People Promises. **2022 Bridgewater Thank You Awards:** Hybrid event will take place on 21st September 2022 at Haydock Park. Nominations opened in April under the following categories: • Clinical Employee of the Year • Non-Clinical Employee of the Year • Clinical Team of the Year • Non-Clinical Team of the Year • Innovation & Excellence Award • Kindness & Compassion Award • Partnership/Collaboration Award New of the 2022 Thank You Awards, staff achieving 25 and 40 years service in the NHS will be recognised at the event.	
MIAA INTERNAL AUDIT UPDATE – WITHIN REMIT OF THE PEOPLE COMMITTEE	5 and 6		No audits to update on at this 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

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	5 and 6		A review of BAF5 was undertaken. It was noted that the results the Cost of Living Crisis should be added with local mileage rates added as the control measure. It was discussed that opportunities for agile working can be added in terms of mitigations. Remove Staff Engagement Steering Group	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 Committee Terms of Reference - Allied Health Professionals' Workforce Development Programme (AHPs) – AHP Workforce Strategy - Workforce Disability Equality Standard report 2022 (WDES) - Workforce Race Equality Standard report 2022 (WRES)	Items for escalation noted by Committee Chair.
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.	
Risks Escalated **None**				
•				

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	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

NHS Workforce Disability Equality Standard

For 31 March 2022

Quality first and foremost

Contents

Executive Summary

All NHS providers are required to complete an annual Workforce Disability Equality Standard Report (WDES) as part of the NHS Standard Contract.

The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality for staff with a disability.

In line with national requirements this report should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October annually.

Before the report is published results must be submitted to NHS England by 31st August, these results are then analysed and compared with results from all other providers to establish a picture of progress made nationally and regionally in the NHS.

Both our results and report are shared with our Enabled Staff Network prior to submission and publishing for insight, discussion, and ideas sharing. This took place at the network meeting on 6th July 2022.

The key findings and metrics for this report submission are outlined below - each point is compared to the previous reporting in 2019 to 2021.

Contact details are provided at the end of this report, and if you have any questions or comments or wish to receive the information in this report in another language or format such as BSL please contact us using these details.

Throughout this report we have tried to avoid the use of acronyms, but we have replaced Workforce Disability Equality Standard with WDES throughout for ease.

Workforce numbers and self-reporting of disability

- In 2022 our WDES analysis shows that of 1,722 staff included in the final count, 52 members of staff have positively stated they have a disability on the electronic staff record.
- This is 3% of the overall workforce, a slight increase of 0.3% from 2021.
- Disabled staff are very slightly over-represented in both clinical and non-clinical staff groups, but significantly under-represented in medical and dental roles.

Recruitment

- In 2022 disabled applicants have a 0.69 likelihood of being appointed from shortlisting compared to not disabled staff. A likelihood figure below 1.0 is a positive one for disabled applicants.
- We remain challenged in the self-reporting of data at appointment stage, with an increase of 84 appointed staff not reporting their disability status on the electronic staff record, up from just 2 not known records at shortlisting stage. We appreciate and respect that this is personal choice.

Capability

- There were no members of staff with a disability, long term condition or illness in formal capability processes related to performance in the period April 2020 to March 2022, this remains the same as previous years.
- There was one member of staff in formal procedures related to ill health during this two-year period. This is the first year this type of procedure has been required, previous WDES reporting focused on performance related capability only. The managing and handling of capability due to ill health includes individual support.

Board representation

- As in previous WDES reporting years there are no members of the Board, executive or non-executive, who have self-reported a disability.
- This means that Board under-represents the 3% of the workforce who are disabled.

Staff Survey 2021 Metrics:

Harassment, bullying and abuse

- Experience of harassment, bullying or abuse from managers has improved by 1.6% since 2020, but there is a gap of 7.7% with staff without a disability, long term condition or illness.
- Experience of harassment, bullying or abuse from other staff has increased by 1.3% from 2020, and there is a gap of 6.1% with staff without a disability, long term condition or illness.
- Experience of harassment, bullying or abuse from patients/family/carers has increased by 0.1% since 2020, and a gap of 9.9% with staff without a disability, long term condition or illness remains.
- Significant deterioration in the percentage of staff with a disability, long term condition or illness reporting instances of bullying, harassment and abuse, down 19.8% since 2020, and a gap of 15.1% with staff without a disability, long term condition or illness.

Career progression and equal opportunities

- A deterioration of 3.3% for staff with a disability, long term condition or illness reporting that they feel the Trust provides equality of opportunity for career progression, 51.8% compared to 60% of staff without a disability, long term condition or illness.
- This indicator was amended in 2021 to reflect the not sure/not applicable responses, previously just yes and no replies were aggregated, this has had a big impact on this figure for all Trusts, however previous years have been recalculated to reflect this update so the decrease in positive reporting is correct.

Feeling under pressure to be in work while unwell

- A further 8.7% of staff with a disability, long term condition or illness reported feeling pressured by managers to attend work while unwell, presenteeism. This was a total of 28.3% compared to 10.1% of staff without a disability, long term condition or illness.

Feeling valued and engaged by the Trust

- After an improvement in 2020 this metric has seen a deterioration in 2021, a reduction of 4.5% of staff with a disability, long term condition or illness feeling their contribution is valued by the Trust.
- There is a gap of 14.6% with staff without a disability, long term condition or illness.

Having support and adjustments made in the workplace

- A slight decrease in the numbers of staff with a disability, long term condition or illness stating that adequate adjustments had been made to support them in the workplace, 73.4% compared to 75.8% in 2020.

Staff Engagement

- This figure has remained largely consistent since reporting began in 2019 for both staff with and without a disability, long term condition or illness.
- For staff with a disability, long term condition or illness the figure is 6.6, and 0.1 drop since 2020. For staff without a disability, long term condition or illness the figure has increased by 0.1 to 7.3.

Our Results – 31 March 2022

We have provided in Table1 a summary of our results against the ten metrics of the WDES.

Table 1: Showing WDES Results for 2022

Metric						
1. Percentage of staff in each AfC Band 1 9 or Medical and Dental pay grades, compared with the percentage of staff in the workforce overall. Disaggregated by non clinical staff, clinical staff, and medical and dental staff. ***Note rounding up of numbers may mean a slightly higher figure than 100% is seen in the below. A * means that numbers are below 10 and therefore not published for data protection.***						
	Non clinical			**Clinical**		
	Disabled	**Not Disabled**	**N/S**	**Disabled**	**Not Disabled**	**N/S**
AfC1 4	10	219	52	*	224	91
AfC5 7	*	77	22	27	630	158
AfC8a 8b	0	14	*	*	40	22
AfC8c VSM	*	12	13	0	*	*
	Medical and Dental Grades:					
Consultants	0	*	*			
Non Consultant Career Grade	0	52	19			
Trainee Grades	0	0	0			
2. Relative likelihood of being appointed from shortlisting across all posts	0.69 times more likely to be appointed if you are not disabled					
3. Relative likelihood of entering capability processes	No formal capability procedures related to performance No formal capability procedures related to ill health for staff with a disability					
4. A) Percentage of staff experiencing bullying, harassment, and abuse from patients/relatives/public in last 12 months	27.5% Disabled 17.6% Not Disabled					
Percentage of staff experiencing bullying, harassment, and abuse from managers in last 12 months	12.8% Disabled 5.1% Not Disabled					
Percentage of staff experiencing bullying, harassment, and abuse from staff in last 12 months	18.7% Disabled 12.6% Not Disabled					

Continued….

Metric	
B) Percentage staff reporting bullying, harassment, and abuse in last 12 months	40.5% Disabled 55.6% Not Disabled
5. Percentage believing the Trust provides equal opportunities for career progression and promotion	51.8% Disabled 60.0% Not Disabled
6. Percentage feeling pressure by manager to attend work even when feeling unwell	28.3% Disabled 10.1% Not Disabled
7. Feeling valued by the Trust	35.5% Disabled 50.1% Not Disabled
8. Satisfaction that reasonable adjustments made to support them in their work	73.4% Disabled
9. A) Staff engagement score (Disabled staff only)	6.7 Disabled 7.3 Not Disabled
B) Have you taken action to facilitate the voices of Disabled staff	Yes
10. Percentage difference between Board membership and overall workforce Disaggregated by voting and non voting members	-3.0% Disabled -32.0% Not Disabled 35.0% Not Stated
Trust Overall Workforce: **Disabled: 52 (3.02%)** **Non Disabled: 1281 (74.39%)** **Unknown: 389 (22.59%)**	

Metric 1: Staff Pay

This metric looks at pay, what percentage (%) of Disabled staff are in each of the pay bands 1 to 9, in medical and dental posts, and very senior manager posts (including executive and non executive board members).

These figures are compared with the overall workforce.

For our analysis we have looked at the numbers and percentages of disabled staff by pay band in non-clinical, clinical, and medical and dental staff groups.

It must be noted, and this can be seen in the overall workforce totals in table 3 that our workforce has reduced significantly over the last 4 years as place based integrated care systems have started to form and services have moved under the control of the local hospital Trusts. It is therefore pleasing to note in 2022 that the overall percentage of disabled staff, and the actuals in non-clinical and clinical roles have increased very slightly.

We are however under no illusions, our self-reporting of disability is much lower than that reported through the anonymous NHS Staff Survey, 26.1%, and the numbers of staff with self-reports of disability in higher pay bands and medical and dental roles are very low.

The difference with the Staff Survey can be partly explained as the question asked differs from that in the electronic staff survey – long term condition or illness as opposed to disability. And disability and long-term conditions are statistically more likely to be acquired during working life with the staff record being a mere snapshot in time on commencement in a role, unless updated by the staff member. This is an important distinction, and we keep working to improve self-reporting by staff appreciating that this is their personal choice.

Due to the very low numbers in non-clinical roles any statistical analysis is difficult, we can see that the numbers of staff who have self-reported they are disabled drops as you move above the first pay cluster bands of under band 1 to band 4. Within pay cluster bands 5 to 7 the percentage of disabled staff drops to 2.9%, below the overall workforce total. Above that pay cluster the very small numbers overall make data too likely to be changed by a single individual.

There are more staff in clinical roles who have self-reported being disabled, 38 in total. The majority are within pay band cluster 5 to 7, at 3.3%. Pay cluster band 8a to 8b is above the overall workforce, but again data is too likely to be influenced by the small numbers of staff in this group overall.

There are no staff with a self-report of disability in medical and dental roles.

The table to follow shows the numbers of Disabled non-clinical and clinical staff since 2019 when WDES reporting began. Medical and dental staffing has not been shown as figures for disabled staff over the years have remained below 10.

For reference the very senior manager roles relate to executive and non-executive Board members, all other senior leaders are paid within Agenda for Change pay bands.

Table 2: Showing Disabled Non-Clinical and Clinical Staff by Pay Band 2019 to 2022

	Disabled Non Clinical Staff				Disabled Clinical Staff			
	2019	2020	2021	2022	2019	2020	2021	2022
All Agenda for Change Pay Bands	29	14	12	14	71	43	34	38
Very Senior Manager	0	0	0	0	0	0	0	0

And to follow is a breakdown of the percentage of disabled staff and the overall workforce total from 2019 to 2022.

Table 3: Showing the percentage of disabled staff in the workforce from 2019 to 2022, as well as the total overall workforce for those years

	2019	2020	2021	2022
Percentage Disabled Staff Overall	3.42	2.78	2.72	3.02
Overall Workforce Total	3,016	2,048	1,730	1,722

In 2021 and 2022 the North-West NHS England talent team have hosted a series of talent surgeries for staff from protected characteristic groups, these have been promoted to our Enabled staff network members.

Within the Enabled meetings we have discussed issues such as barriers to career progression, and we have also shared ideas about roles that could be developed to improve engagement and support for disabled staff. These discussions have helped shape the Six High Impact Areas for Equality Action Plan, and the Disability Confident Action Plan.

In 2022-23 each Trust borough is being mandated to develop a staff survey action plan, based on the borough/directorate level results from 2021 in the NHS Staff Survey, and in collaboration with staff in these services – all action plans should be developed based on what staff feel is needed and achievable to improve their workplace experience against the metrics in the survey. Career progression and equal opportunities is one area where there are clear differences for staff with disabilities, see metric 5, and at borough level.

Metric 2: Recruitment

This metric looks at recruitment, to see how more likely non disabled applicants are to be successful and to be appointed when compared to Disabled applicants.

(A likelihood figure above one would show that non disabled applicants are more likely to be appointed than Disabled applicants).

Our likelihood figure for this year is 0.69. This means that disabled candidates are 0.69 times more likely to be recruited than not disabled candidates, this is a positive result, any likelihood figure below 1 for this indicator shows a greater likelihood of appointment for disabled applicants.

The table below shows our likelihood figure for this metric since 2019. It can be seen that we have made steady progress in this metric since the 2020, and certainly in 2022 we have recruited more shortlisted disabled applicants than in any of the previous years.

However, the numbers of not stated records remain an issue, at shortlisting stage just 2 applicants do not state whether they are disabled or not, this jumps to 84 at appointment.

As stated earlier this is a self-reported field and it is down to the individual as to whether they provide us with their information. We will be engaging with staff from the point of issuing their unconditional offer of employment letter to encourage reporting and detailing the benefits to staff of this, and understanding any barriers or concerns that prevent staff from stating whether they are disabled or not.

Table 4: Showing Recruitment Likelihood Result and Totals Recruited 2019 - 2022

Recruitment 2019 2022				
	2019	**2020**	**2021**	**2022**
Likelihood	1.45	3.03	1.5	0.69
Total Disabled Staff Recruited	13	*	*	17
Total Non Disabled Staff Recruited	352	210	174	199
Total Not Stated Staff Recruited	-	40	55	84

In early 2022 we took part in an NHS England Disability Confident pilot programme with The Shaw Trust and Indeed. As one of only a handful of Trusts selected we were supported to review our current practice and submit to the next Disability Confident level.

With the support of Enabled network members we undertook a full review of recruitment policy and process, and were pleased and prooud to be awarded Disability Confident Leader level in March.

We know that there is a lot to do still and best practice from within the Trust and beyond is to be explored further, in particular, work to understand the experience and barriers for people with autism.

We have a considerable action plan that we will deliver with the support and guidance of our Enabled members, this will be reported to the Recruitment and Retention people operational delivery group, and through this to Board ultimately. There is a lot to do, but with concerted effort we hope to re-achieve level 3 leader status in 2024, and more importantly to improve the workplace opportunities and experience of disabled staff.

Metric 3: Capability

This metric looks at formal capability processes in the Trust, at how more likely Disabled staff are to be involved in formal processes when compared with non disabled staff.

(A likelihood figure above one would show that Disabled staff are more likely to be in formal capability processes than non disabled staff).

In 2022 for the first time two different capability procedures are to be reported to NHS England in the WDES submission:

- Capability based on performance
- Capability based on ill health

In 2020 to 2022, the two-year period required, there were no disabled staff within formal capability processes for performance issues.

During that same period there were no disabled staff within formal capability processes for ill health.

However, as stated earlier, disability is a self-reported field in staff records, and may not be updated by the staff member. Our legal duty as an employer is to make reasonable adjustments for staff who we know, or could reasonably be expected to know, would meet the legal definition of disability. Capability, and ill health retirement or dismissal would suggest that the staff member would meet the legal definition of disability. So whilst this indicator is 0.0 for likelihood of disabled staff in formal capability processes due to ill health we know this is purely based on a staff record, and our human resources colleagues will have taken steps to make reasonable adjustments and support the staff member throughout.

Metric 9b: Staff Engagement

a) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

Yes. We established our (Dis)Ability and Wellbeing Network (DAWN) in summer 2020.

In spring 2022 members voted on a name change to reflect a more positive and identifiable image for their network, Enabled was the final chosen name. The Enabled Network meets monthly via Microsoft Teams and the EDI lead for the Trust also works closely with Network members who wish to discuss issues or ideas outside of the Network meetings.

The network has an executive sponsor, the Director of Finance, who is supportive of the aims and activities of the network, this has for example included the centralisation of funding for staff reasonable adjustments.

In early 2022 Enabled members supported the review and self-assessment of recruitment practices that led to our achievement of Disability Confident Leader. We are now working together to develop a stretch action plan to ensure we progress and retain this in two years when we will be reviewed once again by external bodies.

Equality action plans for 2022-23 include the development of further governance for the network, such as the appointment of a Chair, and agreement of annual aims and objectives. In addition, the consideration of development on an equality council to further allow the voices of all the staff networks to come together with senior leaders to discuss equality and inclusion experiences, issues, and ideas, and holding leadership to account on delivery of equality action plans.

The Enabled members have supported analysis and review of the WDES 2022 data and have provided comment and feedback.

Metric 10: Board

This metric looks at our Board of Directors, and what the difference is, in percentage, compared with the workforce.

The following table shows both the numbers of staff at Board level and the percentage difference between our Board membership and our overall workforce. A minus figure shows under-representation compared to workforce and a positive figure over-representation.

Table 5: Showing Board Disability Representation Compared to Overall Workforce Representation

	Disabled	Non Disabled	Unknown
Board	0	6	8
Difference	-3.0%	-32.0%	35.0%

NHS Staff Survey 2021 Results

It should be noted that NHS Staff Survey metrics relate to the survey undertaken September to December 2021, published 30th March 2022.

Metric 4a: Bullying, Harassment and Abuse Patients, Relatives, and the Public

This metric compares the percentage of Disabled staff compared to non disabled staff experiencing harassment, bullying or abuse from:

1. **Patients/their relatives/members of the public**
2. **Managers**
3. **Other colleagues**

(NHS Staff Survey 2020)

1. Patients/service users, their relatives, or other members of the public:

The table to follow shows the results for this indicator from 2018 (WDES 2019) to 2021 (WDES 2022). The results for Bridgewater are shown in the top of the table, the results for comparator community Trusts in the bottom half of the table.

It can be seen that results for disabled staff have not sustained improvement over 4 years for either Bridgewater or our comparators. For both groups of staff our results are broadly similar, but the small differences mean that the gap in Bridgewater staff experience is bigger than in our comparator Trusts.

222 disabled staff responded to this survey question, our biggest response rate since 2018 when the Trust had a workforce roughly double what it is today.

Table 6: Showing the percentage of disabled and not disabled staff experiencing bullying, harassment, or abuse from patients, families, or the public from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	31.1	28.7	27.4	27.5
Not Disabled	25.3	21.6	16.6	17.6
Gap	5.8	7.1	10.8	9.9
Benchmark				
Disabled	31.2	29.5	26.6	26.8
Not Disabled	23.0	23.3	20.7	19.5
	8.2	6.2	5.9	7.3

2. Managers:

Our next table details the experience of harassment, bullying, or abuse from managers experienced by disabled and not disabled staff in the NHS Staff Survey 2021.

It can be seen that both in Bridgewater and our comparator community Trusts the results have improved over the last 3 years, and we mirror quite closely the benchmark results.

For Bridgewater, however, the gap between disabled and not disabled staff has grown, demonstrating that experiences of these incidents in the workplace for not disabled staff are improving quicker than for disabled staff.

219 disabled staff members responded to this question, again our highest number of responses since 2018.

Table 7: Showing the percentage of disabled and not disabled staff experiencing harassment, bullying, or abuse from managers from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	12.2	15.2	14.4	12.8
Not Disabled	7.8	9.8	7.2	5.1
Gap	4.4	5.4	7.2	7.7
Benchmark				
Disabled	14.6	15.1	14.8	12.2
Not Disabled	8.6	7.6	6.9	6.5
	6.0	7.5	7.9	5.7

3. Other colleagues:

The next table, on page 14, looks at harassment, bullying, and abuse from colleagues in the workplace, again comparing the experiences of disabled and not disabled staff, and showing in the lower half of the table the results from our comparator Trusts.

Bridgewater has remained generally below the average for comparator groups for both disabled and not disabled staff, but we aren't showing a sustained and impactful improvement. Any improvement in both Bridgewater and nationally is slow.

The gap between disabled and not disabled staff in Bridgewater is generally smaller than our comparators, but this is more reflective of the larger number of not disabled staff reporting these experiences rather than any great improvements made.

There was again a good response rate with 219 disabled staff answering this survey question.

Table 8: Showing the percentage of disabled and not disabled staff experiencing harassment, bullying, or abuse from colleagues from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	21.6	20.7	17.4	18.7
Not Disabled	11.4	11.2	11.6	12.6
Gap	10.2	9.5	5.8	6.1
Benchmark				
Disabled	22.5	22.3	19.2	19.0
Not Disabled	12.8	12.2	11.6	10.7
	9.7	10.1	7.6	8.3

Metric 4b follows 4a and asks how many staff who experience, or witness harassment, bullying, or abuse go on to formally report it. This is a key metric as while we can put policy and process in place we can only understand if it is working through the qualitative and quantitative data we receive.

Metric 4b: Bullying, Harassment and Abuse Reporting

This metric compares the percentage of Disabled staff compared to non disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.

(NHS Staff Survey 2020)

There are a number of reporting routes for these behaviours; for those from patients, families, and the public the formal route is via incident management and the Ulysses system. This was updated in summer 2021 to make it easier for staff to report these incidents, and for this data to be pulled from the system for our review. We should, in the NHS Staff Survey 2022, be able to review these reported incidents more effectively against the staff survey results.

Where these incidents relate to staff behaviour there are several routes that can be taken, these include raising formally with HR and Staff-side, raising through the Freedom to Speak Up Guardians and Champions, informally or formally with managers, and anonymously or not through the anti-bullying and harassment reporting form online.

Our last table for this metric looks at the percentage of disabled and not disabled staff reporting harassment, bullying, or abuse in the 2021 staff survey.

We can see by the data in this table that after a significant improvement in 2020 the percentage of disabled staff reporting harassment, bullying, or abuse through formal processes has fallen significantly by 19.8% in 2021. This is a disappointing figure, and it will be important in the coming year to engage with staff to understand the reasons for this, as reporting does not match the incidents.

Results in our comparator Trusts are better, and the gap in results between disabled and not disabled staff is much smaller. We will seek to reach out to these Community Trusts in 2022 to understand their processes and culture so that we can learn from what they are doing that is impacting so well on this metric.

Table 9: Showing the percentage of disabled and not disabled staff reporting experiences of harassment, bullying, or abuse from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	45.6	47.6	60.3	40.5
Not Disabled	52.0	51.7	48.3	55.6
Gap	6.4	4.1	12.0	15.1
Benchmark				
Disabled	54.1	53.7	56.8	55.7
Not Disabled	55.3	57.2	57.5	58.1
Gap	1.2	3.5	0.7	2.4

So, what are we doing about this?

We committed to becoming a Just and Learning culture in 2021 with a number of staff attending training provided by Mersey Care NHS FT and Northumbria University. These staff are the Just Culture Ambassadors and are drawn from across the Trust, clinical and non-clinical.

A key learning point delivered in the training by Mersey Care was that they would, if they could go back, implement Just Culture alongside the civility and respect programme they now run in the Trust.

With this learning in mind civility and respect is a key workstream for us running alongside Just Culture, and aligned to equality, diversity, and inclusion, Trust values, and health and wellbeing.

Staff engagement is taking place throughout 2022 as processes are developed and experiences and outcomes understood. The network members will be a key part of this work, and the themes from discussions held with Enabled members are reported to the Just culture lead.

We of course have policy and process in place regarding equality, our equal opportunities, and dignity and respect at work policy both detail harassment and bullying, legal definitions, and protection for staff. These results however show that there is still work to do to embed civility and

respect in the workplace, and our conversations with network members tell us that the behaviours we need to be tackling are the micro-aggressions from staff and managers in the workplace.

Metric 5: Equal Opportunities

This metric looks at the percentage of staff believing that the trust provides equal opportunities for career progression or promotion.

(NHS Staff Survey 2020)

The next NHS Staff Survey metric looks at career progression.

In 2021 the analysis of the metric was updated to bring in the not applicable/don't know responses. This has had a significant impact on all Trust results, for Bridgewater this has meant bringing down the overall score from in the 90%'s in previous years to 58.1% in 2021.

We can see from looking at overall scores that there has been an increase in the numbers of staff responding no to this question, up to 7.9%, our worst ever figure.

The table to follow looks at the responses from disabled and not disabled staff from 2018 to 2021, previous years results have been refreshed to now include the not applicable/don't know responses.

Unlike in our comparator Trusts we have not seen consistent improvement in this metric for disabled staff, either in the reported result or in reduction of the gap with not disabled staff. The results for that group have remained around the 60% mark throughout.

In our comparator Trusts the results have slowly improved for both staff groups over the last 3 years. An understanding of their approach and practice may support us to develop in this area.

Table 10: Showing the percentage of disabled and not disabled staff reporting equal opportunities for career progression from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	51.0	48.5	55.1	51.8
Not Disabled	60.9	60.6	59.6	60.0
Gap	9.9	12.1	4.5	8.2
Benchmark				
Disabled	55.6	55.2	59.2	60.1
Not Disabled	61.0	61.2	65.0	65.1
Gap	5.4	6.0	.8	5.0

As stated previously we promote opportunities to our staff network members, but we know from conversations with Enabled members that when they do undertake these career development opportunities there can be a lack of understanding and support from some line managers, and often no career pathway at the end, meaning that staff have to leave the Trust to progress.

We know this is an issue not just in Bridgewater but also in other smaller Trusts, but we need to consider and implement solutions so that we can retain these committed, experienced, and valuable staff.

It is understood that this metric can tie in very closely to other staff survey results not reported here. Discrimination from managers for example can lead to a lack of opportunities, whether that is a conscious decision, or one based on an unconscious bias or belief about abilities. In the 2021 survey 7.8% of disabled staff reported experiencing discrimination from staff or line managers, compared to 3% of not disabled staff – while the results don't give detail of the nature of this discrimination we should be mindful of the impacts it can have.

As part of the Disability Confident Action Plan, we will undertake a review of retention and career development in Bridgewater with our Enabled members. This will allow our final action plan to address workplace experience from end to end.

Metric 6: Presenteeism

This metric looks at the percentage of Disabled staff compared to non disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

(NHS Staff Survey 2020)

This metric looks at the percentage of staff feeling pressured by their manager to attend work while feeling unwell, the table to follow details these results.

A very disappointing result this year, both in the percentage of disabled staff reporting this, and in the gap in experience between disabled and not disabled staff.

Our comparator Trusts have seen a steady improvement for both disabled and not disabled staff over the last few years, but Bridgewater has seen a fluctuating pattern every year.

This metric will be reviewed in 2022 - 23 to understand the experience of disabled staff, and the beliefs and feelings of line managers. We need to ascertain what pressures do both feel that impacts on this metric. We know the NHS nationally is wrestling with waiting lists and a return to normal service delivery following two years of the Covid pandemic, but this isn't borne out in the figures from our comparators. We need to understand what they are doing that we aren't, and if there is anything we can learn from them and implement.

Table 11: Showing the percentage of disabled and not disabled staff reporting pressure from manager to attend work while feeling unwell from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	25.7	27.2	19.6	28.3
Not Disabled	18.7	16.7	19.5	10.1
Gap	7.0	10.5	0.1	18.2
Benchmark				
Disabled	29.2	25.8	24.9	22.4
Not Disabled	18.9	16.7	17.9	14.3
Gap	10.3	9.1	7.0	8.1

There is a second NHS Staff Survey question that just asks if staff attended despite feeling unwell; subtly different to the question reported here, and difficult to put a reason behind as there will be a pressure from somewhere for staff attending while unwell, whether that is from personal belief, from a worry about letting colleagues down, worry about the needs of the services and patients, fear of absence management processes, etc.

The results for this question in 2021 where 68.3% of disabled staff, and 48.2% of not disabled staff. This is again a big gap between the 2 groups.

The Disability Confident Action Plan will look at how we can embed supporting policy and practice in Bridgewater so that staff don't feel this personal or line manager pressure to attend work while unwell. And this will be really important for disabled staff who though generally may have no different pattern of sickness absence than not disabled staff, may face extra need for time off to manage a long term or progressive condition, to attend hospital appointments, to recover from treatments etc.

Staff health and wellbeing is a top priority for the Trust and we offer staff a wide range of support.

Metric 7: Feeling Valued

This metric looks at the percentage of Disabled staff compared to non disabled staff saying that they are satisfied with the extent to which their organisation values their work

(NHS Staff Survey 2020)

Our next table looks at how staff feel they are valued for their input, looking at the differences for disabled and non-disabled staff, and also the average for these groups in community Trusts.

The table shows that the percentage of disabled staff reporting positively for this metric has fallen in 2021, and the gap with not disabled staff has widened. This is disappointing after the improvements in 2020.

In our comparator Trusts there has been a similar if not as marked deterioration this year.

220 disabled staff responded to this question, our highest number of respondents since 2018.

Table 12: Showing the percentage of disabled and not disabled staff reporting that they feel their work is valued by the Trust from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	34.7	32.9	41.0	35.5
Not Disabled	45.4	48.6	49.1	50.1
Gap	10.7	15.7	8.1	14.6
Benchmark				
Disabled	39.8	42.4	47.5	43.0
Not Disabled	51.3	53.8	56.1	54.2
Gap	11.5	11.4	8.6	11.2

Metric 8: Reasonable Adjustments

This metric asked the percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work. (Note: Only includes responses from staff who stated that they had a long term condition or disability in the Survey questions.)

(NHS Staff Survey 2020)

Metric 8 looks at whether the Trust has made adequate reasonable adjustments to support disabled staff in the workplace. There is no comparison to not disabled staff as there is no legal duty to make reasonable adjustments for people who aren't disabled – that said considering support for all staff is good practice and people have other challenges, such as caring responsibilities, that can impact on them in work.

The duty to make reasonable adjustments is both anticipatory, (considering what might eliminate barriers and implementing these actions), and proactive (meeting individual and specific needs). What is reasonable varies and a set of questions embedded within our Manager's Guide to Supporting Staff With Disabilities guide sets these out as examples.

Table 13 shows the results for disabled and not disabled staff from 2018 to 2021. It can be seen that as a Trust we have also shown a lower result than our comparator Trusts, but both groups have been unable to demonstrate a sustained improvement, with the figure fluctuating from year to year.

Table 13: Showing the percentage of disabled staff reporting that the Trust has made adequate reasonable adjustments for their needs from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	70.3	75.8	75.8	73.4
Benchmark				
Disabled	77.4	77.0	81.5	77.4

A key part of the Six High Impact Areas for Equality Action Plan, and the Disability Confident Action Plan is reasonable adjustments – budget, policy, process, training, and support.

Metric 9a: Staff Engagement

The staff engagement score for Disabled staff, compared to non disabled staff and the overall engagement score for the organisation.

(NHS Staff Survey 2019)

Our final figures look at the staff engagement theme, this is made up of several questions that look at for example looking forward to going to work, and enthusiasm about the role; being able to use initiative and contributing to improvements; and importantly recommending the Trust as a place of work or for treatment.

It can be seen that the results for both groups of staff in Bridgewater and in our comparator Trusts have changed little in the 4 years of WDES reporting. Disabled staff in Bridgewater consistently report lower than not disabled staff, and staff overall.

Table 14: Showing the percentage of disabled and not disabled staff reporting positively in the staff engagement theme from 2018 to 2021. Also showing the results for comparator Trusts for the same period.

	2018	2019	2020	2021
Bridgewater				
Disabled	6.6	6.6	6.8	6.7
Not Disabled	7.2	7.1	7.2	7.3
Gap	0.6	0.5	0.4	0.6
Benchmark				
Disabled	6.8	6.9	7.0	6.9
Not Disabled	7.2	7.4	7.4	7.3
Gap	0.4	0.5	0.4	0.4

Action Plan

As referenced within this report we have two action plans that relate to the WDES and the workplace experience of disabled staff.:

- Six High Impact Areas for Equality
- Disability Confident Action Plan 2022 - 24

Both plans can be viewed on the Trust webpage at:

https://bridgewater.nhs.uk/aboutus/equalitydiversity/equalityact2010/

We have reviewed the national WDES 2021 report and are looking at the best practice examples given to understand how they, and the recommended actions can be embedded within our own action plan. This includes:

- Self-reporting on ESR, and the touchpoints where this can be updated, and setting a disability declaration target for the next 3 years
- Embedding staff network governance and voice
- Raising awareness, sharing stories, and hosting events
- Equality dashboard development – updated quarterly and reported to People Committee
- Reasonable adjustments and workplace support project
- Recruitment pathway, including review for autism friendly policy and practice
- Civility and respect programme
- Disability retention review, in partnership with Enabled network members.

We know we have work to do. Our results in this report show some improvements, but also some lack of consistency in improvement and in some areas a deterioration. As we work to improve, we are committed to working alongside our disabled staff, and we thank them here for their dedication both to their roles and to supporting us in our disability equality journey.

Thank you for taking the time to read our 2022 WDES report. Should you have any queries or questions or if you would like to request the contents of this report in another language or format, please contact our Equality & Inclusion Manager in the first instance, details below.

Contact Details

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Bridgewater Community Healthcare
NHS Foundation Trust

NHS Workforce Race Equality Standard

For 31 March 2022

Quality first and foremost

Contents

Executive Summary

All NHS providers are required to complete an annual Workforce Race Equality Standard Report (WRES) as part of the NHS Standard Contract.

The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality for staff from a Black, Asian, or minority ethnic background.

In line with national requirements this report should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October annually.

Before the report is published results must be submitted to NHS England by 31st August, these results are then analysed and compared with results from all other providers to establish a picture of progress made nationally and regionally in the NHS.

Both our results and report are shared with our Race Inclusion Network prior to submission and publishing for insight, discussion, and ideas sharing. This took place at the network meeting on 19th July 2022.

The key findings and metrics for this report submission are outlined below - each point is compared to the previous reporting in 2015 to 2021.

Contact details are provided at the end of this report, and if you have any questions or comments or wish to receive the information in this report in another language or format such as BSL please contact us using these details.

Throughout this report we have tried to avoid the use of acronyms, but we have replaced Workforce Race Equality Standard with WRES throughout for ease.

Workforce numbers and self-reporting of race/ethnicity

- As at 31st March 2022 there were 1,722 staff in scope for the annual WRES reporting. This excludes some staff – bank, unpaid external secondment, and career breaks, to ensure consistency with previous years.
- Of these 5.75% were from Black, Asian, and minority ethnic backgrounds as self-reported on ESR.
- 3.54% of staff records were unknown ethnicity.
- 4.5% of non-clinical staff were from Black, Asian, and minority ethnic backgrounds; 4.54% of clinical staff, and 30.1% of medical and dental staff. This disparity in medical and dental is reflected nationally.

- In the mandated race disparity ratio figure we saw the following results:
    - Disparity ratio for Black, Asian, and minority ethnic staff from lower to middle pay bands was 1.24
    - Disparity ratio for Black, Asian, and minority ethnic staff from middle to upper pay bands was 1.45
    - Disparity ratio for Black, Asian, and minority ethnic staff from lower to upper pay bands was 1.80. More detail on this in the indicator 1 section

Recruitment

- In 2021 – 2022 we recruited 300 new staff, of these 7.8% were from Black, Asian, or minority ethnic backgrounds. This compares with 5.75% of the overall workforce.
- The likelihood figure reported in the WRES is 1.19, this means that if white you are 1.19 time more likely to be successful at interview than Black, Asian, or minority ethnic staff.
- This is a deterioration from 2021 when our result was 0.61 likelihood – a figure below 1 reflecting a better outcome for Black, Asian, and minority ethnic applicants.

Disciplinary

- The number of staff entering formal disciplinary processes from April 2020 to March 2022 was small, less than 20.
- The likelihood figure for 2022 is 0.0, there were no Black, Asian, or minority ethnic staff in formal disciplinary processes in this period.

Non-mandatory training and career development opportunities

- The likelihood figure to 2022 is 0.57, this means that Black, Asian, and minority ethnic staff are more likely to access these opportunities than white staff. This is an improvement from 2021 when the likelihood figure was 1.09.

Board representation

- Compared to the overall workforce the percentage of Black, Asian, or minority ethnic members, either executive or non-executive was over-representative, however caution should be used due to the small numbers of staff involved.
- There were a small number of Board members whose ethnicity was not self-reported on the electronic staff record. We appreciate that this is their personal choice.

Staff Survey 2021 Metrics:

Harassment, bullying and abuse

- The experience of harassment, bullying or abuse for Black, Asian, or minority ethnic staff from patients, their relatives, or the public improved significantly in 2021, down 8.1% to 22.2%, and the gap with white staff narrowed to 2.1%.

- The experience of these behaviours from colleagues also improved, down 2.3% to 13.3, with white staff reporting a figure for the same experiences of 16.9%.

Career progression and equal opportunities

- An improvement of 17.8% was reported for staff from Black, Asian, or minority ethnic staff, but at 51.1% there still remained a gap of 7.8% with white staff who reported 60% agreeing the Trust providing equitable opportunity for career progression.
- This indicator was amended in 2021 to reflect the not sure/not applicable responses, previously just yes and no replies were aggregated, this has had a big impact on this figure for all Trusts, however previous years have been recalculated to reflect this update so the increase in positive reporting is correct.

Discrimination from managers and colleagues

- This indicator saw a small deterioration, to 13.3% from 12.1%. And the gap with white staff where 3.6% reported these experiences widened by a further 2%.

Our Results – 31 March 2022

We have provided in the table to follow a summary of our results against the nine indicators of the WRES 2022.

Table 1: Summary WRES Results 2022

Indicator						
1. Percentage of staff in each AfC Band 1 9 or Medical and Dental pay grades, compared with the percentage of staff in the workforce overall. Disaggregated by non clinical staff, clinical staff, and medical and dental staff						
	Non-clinical			**Clinical**		
	White	**Black, Asian, or minority ethnic**	**Not stated, or unknown**	**White**	**Black, Asian, or minority ethnic**	**Not stated, or unknown**
Under AfC Band 1	*	*	0	0	0	0
AfC1	0	0	0	0	0	0
AfC2	94	*	*	39	*	*
AfC3	131	*	*	121	*	*
AfC4	40	*	0	133	*	*
AfC5	41	*	*	245	18	*
AfC6	32	*	*	341	16	15
AfC7	15	*	*	168	*	*
AfC8a	10	0	*	59	0	*
AfC8b	*	*	0	*	0	0
AfC8c	11	0	0	*	*	0
AfC8d	*	0	0	0	*	*
AfC9	*	0	0	0	0	0
VSM	*	*	*	*	0	0
	Medical and Dental Grades:					
Consultants	*	*	*			
(senior medical manager)	*	0	*			
Non Consultant Grade	45	20	*			

Continued….

Indicator continued….	
2. Relative likelihood of being appointed from shortlisting across all posts	1.19 times more likely to be appointed if you are White
3. Relative likelihood of entering formal disciplinary processes	0.0 times more likely to enter formal disciplinary processes if you are Black, Asian, or minority ethnic
4. Relative likelihood of accessing non mandatory training/CPD	0.57 times more likely to access this training if you are Black, Asian, or minority ethnic
5. Percentage of staff experiencing bullying, harassment, and abuse from patients/relatives/public in last 12 months	Black, Asian, or minority ethnic 22.2% White 20.1%
6. Percentage of staff experiencing bullying, harassment, and abuse from staff in last 12 months	Black, Asian, or minority ethnic 13.3% White 16.9%
7. Percentage believing the Trust provides equal opportunities for career progression and promotion	Black, Asian, or minority ethnic 51.1% White 58.9%
8. In the last 12 months personally experiencing discrimination from manager/team leader/other colleagues	Black, Asian, or minority ethnic 13.3% White 3.6%
9. Percentage difference between Board membership and overall workforce **Disaggregated by voting and non voting members**	White -17.4% Black, Asian, or minority ethnic 7.6% Not Stated 9.8%
Trust Overall Workforce: **Black, Asian, and minority ethnic: 99 (5.75%)** **White: 1,562 (90.7%)** **Not stated: 61 (3.5%)**	

Indicator 1: Staff Pay

This indicator looks at pay, what percentage (%) of White staff and Black, Asian, or minority ethnic staff are in each of the pay bands 1 to 9, in medical and dental posts, and very senior manager posts (including executive board members).

These figures are compared with the overall workforce.

Table 2 below shows the aggregated details for overall staff percentage by ethnicity as at 31st March from 2015 to 2022.

It can be seen that the percentage of Black, Asian, and minority ethnic staff has risen fairly consistently since reporting began in 2015, this is despite the overall reduction in workforce size by nearly half as a result of changes to the NHS moving care into place-based organisations.

Importantly the numbers of unknown staff records have also reduced, as this is a self-reported field it is personal choice as to whether to state your ethnicity, so it is good to see staff feel confident to do this.

Table 2: Showing the percentage of the total workforce by ethnicity from 31st March 2015 to 31st March 2022. Also showing total workforce each year in numbers.

	2015	2016	2017	2018	2019	2020	2021	2022
Black, Asian, and minority ethnic	2.5	2.4	2.6	2.8	3.0	5.7	5.4	5.75
White	95.6	93.5	90.8	90.6	89.9	89.1	90.5	90.7
Not known	1.9	4.1	6.6	6.6	7.2	5.1	4.2	3.5
Total Staff	3,325	3,251	3,305	3,005	3,016	2,048	1,730	1,722

The full details by pay band are shown in Table 1, the WRES summary, so below we have just given brief details by pay band cluster before we move onto the race disparity ratio results for March 2022.

- The numbers of Black, Asian and minority ethnic staff in non-clinical roles is low overall, just 19 members of staff in total. Of these the majority are in pay band clusters under band 1 to 4, and bands 5 to 7.
- There are 55 Black, Asian, and minority ethnic staff in clinical roles, excluding medical and dental. Of these more than half are in pay cluster 2, bands 5 to 7. These are the majority of clinical roles in the Trust, the district nurses, health visitors, allied health professionals etc.

Black, Asian, and minority ethnic staff are slightly under-represented in the top two pay band clusters, at 3.6% of the minority ethnic workforce in clinical roles.

- Medical and dental staff are paid in a different pay scale to other staff. Black, Asian, and minority ethnic staff are over-represented compared to the overall workforce in this group at 30% of staffing. 6% of staff in this group are consultant level, and 24% non-consultant career grade medical and dental staffing.

Race Disparity Ratio

The race disparity ratio action plan was mandated for all Trusts by NHS England in summer 2021. Nationally the WRES 2020 data was used to calculate individual Trusts race disparity ratio as at 31st March 2020. This information was sent to all Chief Executives with instructions on what was expected next – the reduction of the ratio to 1.5 or below.

Trusts are required to understand their data in relation to race disparity in pay and career progression, and set targets and actions to level up representation so that it is reflective across the whole Trust. For us, this target is 5.4% and a stretch target higher than this is our aim. The mandate allows Trusts 4 years to reach or exceed its targets, with improvements expected to be evidenced in March 2025.

The disparity ratio looks at the likelihood of progression of white, and Black, Asian, and minority ethnic staff from the lower pay bands (bands 1 –to 5), middle (bands 6 to 7), and upper (bands 8a to 9). Very senior manager grades, and medical and dental staffing are excluded from this calculation.

Our race disparity action plan is linked to our overarching Six High Impact Areas for Equality Action Plan, with annual actions lifted from this to allow achievable yearly progress.

As at 31st March 2022 our race disparity ratio is:

Table 3: Showing the Trust's race disparity ratio for career progression from March 2020 to March 2022. Figures show are likelihood of Black, Asian, and minority ethnic staff progressing up the Agenda for Change pay scale.

	Lower to Middle	Middle to Upper	Lower to Upper
March 2020	1.13	2.08	2.35
March 2021	1.32	1.35	1.78
March 2022	1.24	1.45	1.8

We identified 5 areas to focus on to improve the race disparity ratio, these are referenced below:

- Under-representation in Agenda for Change bands 6 and 7 (based on overall Black, Asian, or minority ethnic staff of 5.38% as at March 2021).
- Under-representation in Agenda for Change band 8a (based on overall Black, Asian, or minority ethnic staff of 5.38% as at March 2021).
- Under-representation in administrative, additional clinical, and nursing roles

- International recruitment
- Internal recruitment

Non-Clinical Staff:

The table below details the numbers of Black, Asian, or minority ethnic staff in non-clinical roles from 2015 to 2022. It can be seen that numbers are small and are relatively unchanging.

Table 4: Showing the numbers of Black, Asian, and minority ethnic staff in non-clinical roles as at 31st March 2022.

Black, Asian, and Minority Ethnic Non Clinical Staff								
Pay Band	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
All AfC Pay Bands	18	18	16	20	19	15	16	18
Very Senior Manager	0	0	0	0	0	0	0	*
Where figures are below 10 an * is used to protect personal identities								

Clinical Staff:

The next table shows our clinical workforce from 2015 to 2020. It can be seen that numbers of Black, Asian, and minority ethnic staff are higher in clinical roles, but the overall percentage in Agenda for Change pay bands remains quite low. Medical and dental is over-representative of Black, Asian, and minority ethnic staff, reflecting a similar pattern to elsewhere in the NHS, and highlighting the vital contribution made by both British and overseas minority ethnic staff in health care.

Table 5: Showing the numbers of Black, Asian, and minority ethnic staff in clinical roles as at 31st March 2022.

Black, Asian, and Minority Ethnic Clinical Staff								
Pay Band	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
All AfC Pay Bands	42	39	44	31	52	49	51	55
Very Senior Manager	0	0	0	0	0	*	*	0
Medical and Dental (All)	22	20	25	24	18	53	25	25
Where figures are below 10 an * is used to protect personal identities								

We are engaging with our Race Inclusion Network to better understand the barriers to career progression in Bridgewater, and more information can be found under indicator 7, equal opportunities for career progression.

Indicator 2: Recruitment

This indicator looks at recruitment, to see how more likely White applicants are to be successful and to be appointed when compared to Black, Asian, or minority ethnic staff.

(A likelihood figure above one would show that White applicants are more likely to be appointed than Black, Asian, or minority ethnic applicants).

Our likelihood figure for this year is 1.19, this means that white candidates are more likely to be appointed from shortlisting than Black, Asian, or minority ethnic candidates. The table to follow details our results in this indicator from 2014/5 to 2021/22.

Table 6: Showing the likelihood figure for Black, Asian, or minority ethnic candidates being successfully recruited from shortlisting compared to white candidates. The results are from the years 2014/15 to 2021/22,

Recruitment of Black, Asian, or minority ethnic Staff 2015 2022								
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Likelihood	1.85	1.72	1.30	1.24	1.28	1.39	0.61	1.19
Total Black, Asian, or minority ethnic Staff Recruited	12	24	31	24	23	13	36	23
Total White Staff Recruited	241	532	498	418	395	224	310	276
Total Not Stated Staff Recruited	*	160	120	30	10	17	*	*
Where figures are below 10 an * is used to protect personal identities								

The results show that after a great improvement in 2021 we have returned to similar figures to previous years. This is especially disappointing as the national WRES 2021 report highlighted Bridgewater as one of the top 10 Trusts in this indicator in England.

A number of actions within our overarching Six High Impact Areas for Equality focus on recruitment, this includes a refresh of job descriptions and person specifications; adverts; alternative recruitment options; diverse recruitment panel membership; embedding equality and inclusion within interview questions; and strengthening accountability for recruiting panels.

We have in the past successfully run work programmes alongside the Job Centre to offer placements for people who have struggled to find work; we hope as the pandemic pressures and restrictions ease to restart this programme.

We have also looked at international recruitment and the learning and best practice shared by other NHS Trusts. At this stage we are unable to support international recruitment on the basis that there would be a requirement to travel extensively. We do not have facilities such as accommodation that would aid successful recruitment and settle in overseas workers. That said,

we have not ruled this out for the future and are exploring partnership options with other Trusts in our area.

All recruitment work is undertaken through the recruitment task and finish group. This reports into the Recruitment and Retention 'People Operational Delivery' Group. One of four PODs, this is our main People Plan delivery group for this area of workforce experience.

Indicator 3: Disciplinary

This indicator looks at disciplinary processes in the Trust, at how more likely Black, Asian, or minority ethnic staff are to be involved in formal disciplinary processes when compared with White staff.

(A likelihood figure above one would show that Black, Asian, or minority ethnic staff are more likely to be in formal disciplinary processes than White staff).

Our result for this year is 0.00; there were no Black, Asian, or minority ethnic staff in formal disciplinary processes between 1st April 2020 and 31st March 2022. The table below shows the results from 2015 to 2022:

Table 7: Showing the likelihood of Black, Asian, or minority ethnic staff entering formal disciplinary processes for the two years up to reporting date. Figures are shown for the periods 2013/15 to 2020/22

Black, Asian, or minority ethnic Staff Formal Disciplinary 2015 2022								
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Likelihood	6.46	4.93	3.83	1.99	2.72	2.40	0.00	0.00

While our results for the last three years have shown an improvement we know that this could change at any time. This is as a result of the small numbers of both Black, Asian, and minority ethnic staff overall. The total numbers of staff in formal disciplinary at just 1 individual can change the results significantly.

A key part of the NHS People Plan, and WRES: A Model Employer requirements set out by NHS England is to reduce the numbers of minority ethnic staff in formal disciplinary, an area where nationally these staff are over-represented and more likely to face harsher outcomes. In addition, there is an expectation that Trusts implement Just and Learning Culture programmes.

In autumn 2021 Bridgewater's Just Culture Ambassadors undertook 6 days training with Mersey Care NHS FT and Northumbria University. A steering group is established, reporting into the Culture and Leadership People Operational Delivery Group, and workstreams have commenced on reviewing data, policy, communications etc. There is a lot still to do but our Trust Board, the Ambassadors, HR, and Staff-side colleagues are all committed to embedding a Just Culture in the Trust. A significant amount of work has been undertaken to date and we are seeing positive trends in our employee relations activity.

Indicator 4: Non Mandatory Training and Development

This indicator looks at non mandatory training and development opportunities, and how more likely White staff are to take part in these opportunities compared to Black, Asian, or minority ethnic staff.

(A likelihood figure above one would show that White staff are more likely to take part in these opportunities than Black, Asian, or minority ethnic staff).

In 2022 the likelihood figure for Black, Asian, and minority ethnic staff accessing non-mandatory training and development opportunities was 0.57, this means that these staff were more likely than white staff to access these opportunities.

The table below shows the results for this indicator since 2015. It can be seen that while our results have never been significantly worse for Black, Asian, and minority ethnic staff, we haven't as yet managed to get to a consistent point of progress year on year.

This is a difficult indicator to gather data and evidence for as so many opportunities are informal or not recorded. We have this year looked at and recorded data for staff accessing apprenticeship opportunities, and those undertaking maths and English qualifications. We also looked at staff accessing career conversations and other potential routes to development, and we have included these where it is clear that opportunities, such as Care Certificate training, have commenced.

Table 8: Showing the likelihood of Black, Asian, and minority ethnic staff accessing non-mandatory training and career development opportunities, compared to white staff. Figures are shown from 2015 to 2022.

Black, Asian, or minority ethnic Staff Undertaking Non Mandatory Training and Development 2015 2020								
	2015	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**
Likelihood	0.0	0.55	0.90	1.10	1.74	0.60	1.09	0.57
	No data available							

Talent management and career development opportunities for Black, Asian, and minority ethnic staff are key actions within our Six High Impact Areas for Equality Action Plan, which links back to the Race Disparity Ratio targets and action plans mandated nationally.

The Trust is an early adopter of the national Scope for Growth programme, this will ensure all staff have access to career conversations and this will be embedded in the annual review for all. While other early adopters of the national programme are focusing on staff at Agenda for Change Band 8b and above due to small numbers we have taken a different approach and we will be working with defined staff from diverse staff groups and pay bands.

The Scope for Growth model is founded on the belief that knowing an individuals personal aspirations in fundamental to understanding the required development that will maximise career development opportunities. That said, while this is an excellent opportunity for all staff we are

mindful of the deficit model of career progression for minority ethnic staff – it may not be lack of talent, skill, qualifications etc. that is holding an individual back, there can be other factors as play such as managerial barriers, bias, or discrimination. So we are talking to our Race Inclusion Network members about career progression, and our lead for the programme has spoken twice at meetings and met members individually.

Indicator 9: Board

This indicator looks at our Board of Directors, and what the difference is, in percentage, compared with the workforce

The Trust Board has 15 executives and non-executives in total. As a result we are unable to give details by ethnicity as information is personally identifiable.

The Board is over-representative of Black, Asian, and minority ethnic staff compared to overall workforce totals. The Board is also over-represented in not known staff records for ethnicity, though members have been supported to update their equality details if they wish to do so. As stated earlier, we appreciate that this is personal choice.

The figures can be seen in Table 1 on page 6.

Our Board is committed to equality, diversity and inclusion, anti-racism, and the support and enablement of staff voice through the staff networks. Both executives and non-executives, and public governors sponsor and attend the staff networks. Overall responsibility for equality rests with the Director of People and Organisational Development, who leads on action plan setting to meet the strategic equality objective of the Trust. The Race Inclusion Network is ably chaired and actively sponsored by one of the Joint Medical Directors for Bridgewater.

NHS Staff Survey 2021 Results

Indicator 5: Bullying, Harassment and Abuse Patients, Relatives, and the Public

(NHS Staff Survey 2021)

Bullying, harassment, and abuse of staff by patients, their family members, and the public is sadly not an uncommon occurrence in the NHS nationally.

The annual NHS Staff Survey asks all staff if they have experienced any of these incidents in the last 12 months. This information is then split by ethnicity to give us results that allow us to compare the experiences of Black, Asian, and minority ethnic staff, and white staff locally and nationally.

The national Workforce Race Equality Standard 2021 report (looking at data up to 2020), shows that nationally the percentages for both groups of staff have barely altered over the six years of reporting reviewed.

Regionally the North West has shown a similar pattern of fluctuating results as other regions, but is in 2020 at least reporting the lowest percentages of both groups of staff experiencing these incidents.

Due to the larger numbers involved the national report can review and publish data in more detail to start to understand experiences of these incidents by more specific ethnicities. The report data clearly demonstrates that these incidents are not experienced by Black, Asian, or minority ethnic staff as a homogenous group, there is a range of experiences.

The report also shows that there are significant differences for staff from Gypsy, Roma, and Traveller backgrounds, with these staff reporting much higher incidents than any other staff group; this is a group that is included within the white staff grouping in local reporting but clearly have a very different workplace experience that the white British majority of staff.

In 2022- 23 Bridgewater is holding an event for Gypsy, Roma, Traveller History Month in partnership with colleagues in other local Trusts, inviting staff to a virtual lunch and learn session hosted by Irish Community Care based in Liverpool.

The Race Inclusion Network is planning for Black History Month 2022, using the theme Change Makers to demonstrate and support all staff to feel informed and equipped to manage and support when incidents such as these occur.

The Network has also supported the Trust on development of the We Say No To… campaign to highlight the Trust commitment that no member of staff, patient, or family member should be subjected to racism, homophobia etc. either in the course of their work or when accessing a Trust service. This project will be rolled out as part of the Just and Learning/Civility and Respect programme in 2022-23.

The figure below shows the Bridgewater results for this indicator from 2015 to 2021. It can be seen that after a significant deterioration in 2017 – 2020 we are finally and hopefully on the right track to improving workplace experience for staff.

45 Black, Asian, or minority ethnic staff responded to this question, our highest ever response rate and quite representative in the staff survey numbers of the overall workforce.

Table 9: Showing the percentage of staff experiencing bullying, harassment, and abuse from patient, families, and public from 2015 to 2021. Also showing the average for community Trusts in this period.

Bridgewater	2015	2016	2017	2018	2019	2020	2021
Black, Asian, minority ethnic staff	0.0*	23.0	28.6	37.5	28.0	30.3	22.2
White staff	28.0	29.0	25.8	26.0	23.1	18.2	20.1
*Note: Figure too low to report for Black, Asian, or minority ethnic staff in 2015							
Benchmark	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Black, Asian, minority ethnic staff	25.0	24.0	26.9	26.1	23.7	23.4	24.3
White staff	26.0	24.0	23.4	25.7	25.2	21.9	20.6

Indicator 6: Bullying, Harassment and Abuse Other Staff

(NHS Staff Survey 2021)

This indicator asks a similar question to indicator 5, but this time looks at these incidents from staff.

The 2021 national report shows that the difference in experience of these incidents between Black, Asian, and minority ethnic staff, and white staff is greater than the experiences of incidents from patients, family members and the public.

This is also reflected in the regional data; and again as above for more distinct ethnic background there are differences across groups. About half of staff, male and female, from Gypsy, Roma, and Traveller backgrounds have experienced these incidents from colleagues and managers in the national data.

The data for Bridgewater shows an improving figure for Black, Asian, and minority ethnic staff after a big jump in 2019. Consistently since 2017 white staff have reported greater incidents of this nature in the NHS Staff Survey. Again 45 Black, Asian, and minority ethnic staff responded, our biggest survey response to date.

Table 10: Showing the percentage of staff experiencing bullying, harassment, and abuse from other staff from 2015 to 2021. Also showing the average for community Trusts for this period.

Bridgewater	2015	2016	2017	2018	2019	2020	2021
Black, Asian, minority ethnic staff	0.0*	26.0	21.4	16.7	20.0	15.6	13.3
White staff	23.0	24.0	20.4	17.5	20.8	17.8	16.9
*Note: Figure too low to report for Black, Asian, or minority ethnic staff in 2015							
Benchmark	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Black, Asian, minority ethnic staff	24.0	24.0	21.8	24.0	23.8	22.9	20.0
White staff	22.0	18.0	18.6	19.6	19.6	16.9	15.9

Indicator 7: Equal Opportunities

(NHS Staff Survey 2021)

The figure to follow shows the percentage of Black, Asian, and minority ethnic, and white staff who feel the Trust provides equity of opportunity in career progression.

As stated earlier in the executive summary this indicators results analysis was updated in 2021 to bring in the not known and not applicable responses. As the national report only shows amended figures back to 2017, and the results have changed significantly across all Trusts following this amendment, we haven't detailed 2015 and 2016 results in the table below.

The national 2021 report is using the old indicator data and it is therefore difficult to compare ourselves against that this time. The report is clear however that once again experience is felt different across different ethnic groups, with Gypsy, Roma, Travellers, Black Caribbean, and Black Other staff all reporting much lower positive experiences in their workplace. For these groups positive responses were around 30% lower than the national average results.

In 2021 the Royal College of Nursing undertook a survey of its members, and a similar response was seen with Black, Asian, and minority ethic members reporting less opportunity to develop in their careers, but with responses varying across ethnic minority groups. Analysis was undertaken on the barriers to career progression, with the top ones being limited numbers of opportunities available, particularly in some specialisms. But 1 in 5 reported that it was lack of manager support that had held their careers back, and some horror stories reported of not sure failure to support

advancement in their own Trust but also blockages to progressing by moving to new organisations.

We have discussed career development and barriers to opportunities and progression with the Race Inclusion Network members, and in 2021 the Head of Leadership and Organisational Development attended network meetings to discuss career development, talent conversations, and leadership opportunities, options which we understand members have since taken up.

In addition, we share national and regional offers for Black, Asian, and minority ethnic career progression, training, coaching, health and wellbeing etc.

Our WRES: Race Disparity Ratio action plan details the actions we are committed to undertaking up to 2025 to improve career development opportunities, and representation across all staff groups and pay bands.

We are also committed at Board level to the North West BAME Assembly anti-racism framework. This specifies stretch opportunities for staff, and action that we are exploring as we undertake our gap analysis and action planning with our Race Inclusion Network and Board.

The data for Bridgewater shows that after a significant deterioration in 2020

Table 11: Showing the percentage of staff who feel the Trust provides equal opportunities for career progression from 2017 to 2021. Also showing the average for community Trusts for the same period.

Bridgewater	2017	2018	2019	2020	2021
Black, Asian, minority ethnic staff	50.0	48.0	48.0	33.3	51.1
White staff	55.6	59.1	58.4	60.1	58.9
Benchmark	**2017**	**2018**	**2019**	**2020**	**2021**
Black, Asian, minority ethnic staff	47.3	47.5	47.8	46.8	50.3
White staff	61.7	60.7	62.5	66.3	66.0

Indicator 8: Discrimination

(NHS Staff Survey 2021)

The final table for WRES 2022 shows the percentage of staff reporting incidents of discrimination from managers or colleagues in the previous 12 months. The national WRES report for 2021 shows once again a lack of improvement in this indicator for staff, and the gap between the two groups in 2021 was 10.5%. In the North West the pattern reflected that nationally with an increase in these experiences reported through the staff survey for Black, Asian, and minority ethnic staff from 2018. It can be seen in the table to follow that in Bridgewater we have seen a pattern of fluctuation both internally and also when benchmarking against our comparator Trusts.

In this national report once again for this indicator there were differences by ethnic group, with only white British staff reporting under the overall result. Highest reported incidents were in both men and women from the Gypsy, Roma, Traveller communities, with women who identified as Black Other close behind, indeed the experiences of women from all Black identities was significantly worse than for Asian, mixed, and white identities.

Our conversations with the Race Inclusion Network have helped us to identify some areas for action. This includes the work referenced earlier around career progression, and also the Just and Learning Culture, and Civility and Respect projects briefly referenced earlier. These are looking at the staff experience pathway based on embedding the Trust values within the culture; embedding fairness but also accountability, providing support and training, and enabling honest and support conversations that will improve equity of experience across policy, process, behaviours, and the intangibles of workplace cultures.

Table 12: Showing the percentage of staff who report facing at least once incidence of discrimination in previous 12 months, from 2015 to 2021. Also showing results for comparator Trusts for same period.

Bridgewater	2015	2016	2017	2018	2019	2020	2021
Black, Asian, minority ethnic staff	*	**6.0**	**11.1**	**8.3**	**16.0**	**12.1**	**13.3**
White staff	4.0	7.0	8.1	4.4	4.9	4.4	3.6
*Note: Figure too low to report for Black, Asian, or minority ethnic staff in 2015							
Benchmark	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**
Black, Asian, minority ethnic staff	12.0	4.0	12.1	10.7	12.2	13.5	12.7
White staff	5.0	11.0	5.5	4.9	4.3	4.3	4.3

Our Action Plan 2022/23

As a Trust we agreed in 2022 our Six High Impact Areas for Equality Action Plan, this sets out our equality plans in four action sets:

- Culture
- Modernising recruitment
- Identifying and developing talent
- Developing equality, diversity, and inclusion skills and awareness

The actions for 2022 – 23 include:

- Board development – session being planned for September looking at anti-racism, and bias
- Equality awareness for all staff, including:
    - Ramadhan – March 2022
    - Understanding privilege and becoming an ally – April 2022
    - Gypsy, Roma, Traveller History Month – June 2022
    - Black History Month: Change Makers – October 2022
- Operational managers training programme, including equality and Just Culture
- Conversations about race training development
- Ethnicity pay gap review
- Equality accountability and embedding SMART actions for strategic equality objective
- Embedding staff network governance and voice

In March 2022 the Board committed to the North West Black, Asian, and Minority Ethnic Assembly's Anti-Racism Framework. We are working with our staff network to map and identify gaps before we co-design an anti-racism action plan for Trust delivery.

We know we have work to do. Our results in this report show some improvements, but also some lack of consistency in improvement and in some areas a deterioration. As we work to improve, we are committed to working alongside our Black, Asian, and minority ethnic staff, and we thank them here for their dedication both to their roles and to supporting us in our race equality journey.

Thank you for taking the time to read our 2022 WRES report. Should you have any queries or questions or if you would like to request the contents of this report in another language or format, please contact our Equality & Inclusion Manager in the first instance, details below.

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Ruth Besford *(Equality & Inclusion Manager)* ruth.besford@nhs.net

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST

ALLIED HEALTH PROFESSIONS STRATEGY AND WORKFORCE PLAN

2022-2024

Quality first and foremost

Foreword

Introduction from the Chief Nurse and Chief Allied Health Professionals Lead

As a Trust we appreciate that Allied Health Professionals (AHPs) have a unique set of skills that reach across peoples' lives. This makes them well placed to lead and support the changes needed to deliver our updated Quality and Place Strategy and wider NHS priorities.

This strategy will give our AHPs the opportunity to be creative and innovative, working across systems and sectors. It will enable our AHPs to work in partnership with others to meet the demands of providing high quality evidence-based care. It established a programme of key priorities for the next 18 months that will enable AHPs across the Trust to meet the challenges of changing care needs.

The NHS Long Term Plan recognises that AHPs are working independently across the system and have a significant role to play in the future design, leadership, and delivery of services.

I am delighted to present Bridgewater's Allied Health Professions (AHP) Strategy and Workforce Plan 2022 – 2024. The adoption of this strategy within Bridgewater acknowledges and values the contribution that our AHPs make to improving peoples' lives and I give it my full support and commitment.

Lynne Carter Chief Nurse and Chief Allied Health Professional.Lead

Contents

Plan on a Page – Allied Health Professionals Workforce Strategy and Plan 2022-2024

The breadth of Allied Health Professionals skills and reach across people's lives and organisations make them ideally placed to lead and support transformative change.

Our vision: To create an inclusive, diverse, and sustainable Allied Health Professionals workforce that delivers the highest quality, holistic, evidence-based health care to meet the needs of the population served by Bridgewater Community Healthcare NHS Trust.

Grow -Inspire the population we serve to embark on AHP careers, promoting diversity and stimulating growth of the AHP workforce.

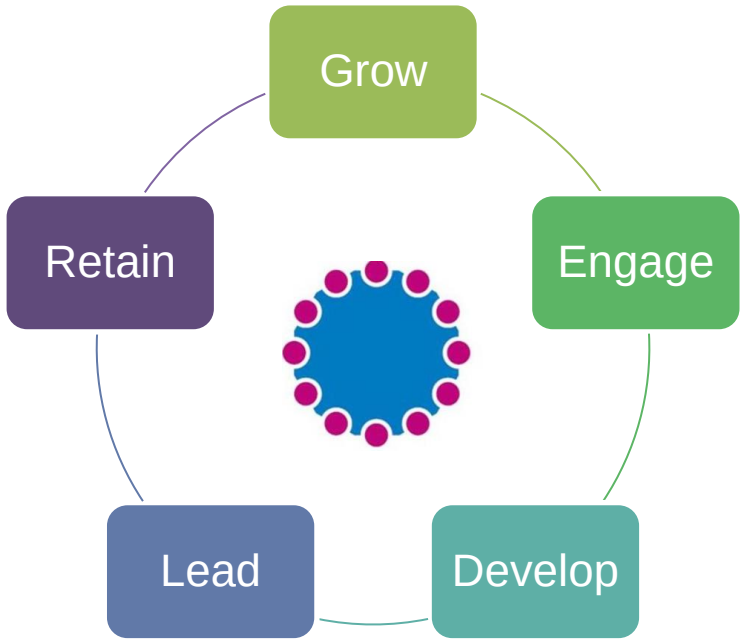
Engage- Engage with our AHP workforce, ensuring they are connected to key programmes of work and are enabled to effectively contribute to service transformation.

Develop- Support the development and delivery of high-quality integrated care that is safe, responsive and close to home. Making sure our AHPs are equipped with the right knowledge and skills to continually improve the quality of care they deliver.

Lead- Promote the benefits AHP leadership can bring to the organisation and explore and develop leadership development opportunities.

Retain- Ensure AHPs are used effectively and to their maximum potential, optimising retention of AHPs within the organisation.

Objectives



NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Introduction

Allied Health Professions (AHPs) form the third largest professional group in the NHS. They are highly skilled, autonomous, registered professionals who form a key part of care delivery across a range of settings such as hospitals, community, housing, justice, education, private and voluntary services. Within Bridgewater Community Healthcare NHS Foundation Trust (hereby referred to as Bridgewater) there are 162 full time equivalent (FTE) AHPs and 30 FTE AHP support staff. They work in collaboration with other professions and agencies across the community to provide person-centred, holistic, preventative, integrated care, working within and across boundaries to improve health and wellbeing and outcomes of care for people with co-morbidities.

The purpose of this strategy is to:

1. **Provide a simple and clear framework for all AHPs** in Bridgewater to align and contribute to the work of Bridgewater and its ambition to support people and families to live healthy lives, accessing health and wellbeing services when and where they need them.

2. **Maximise the impact AHPs can have** in addressing the NHS Long Term Plan (LTP), We are the NHS: People Plan 2020/21 - Action for us all (2020), the National AHP Strategy 2017-2022: AHPs into Action (2017)and the Bridgewater Quality and Place Strategy (2022) and associated strategic workforce plans.

3. **Ensure that Bridgewater provides an AHP workforce which meets the needs of its service users, carers, and families** by ensuring sustainability and growth in the supply of AHPs in Bridgewater.

This AHP strategy was designed around Bridgewater's overall strategic aims to:

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

Background

National Drivers

AHPs have enormous potential, often unrealised, to transform care. The breadth of AHPs skills and reach across people's lives and organisations make them ideally placed to lead and support transformative change. The **NHS Long Term Plan (2019)** established the need to increase staffing in the NHS, placing a focus on the need to increase the number of nurses, midwives, and Allied health professionals. This plan highlighted a need to focus on growth and retention of the NHS through workforce development encouraging a modern employment culture. **The NHS: People Plan 2020/21 – Action for us all (2020)** highlights the continued work necessary to grow the AHP workforces and reform the way we educate and train clinicians for a more flexible modern NHS.

The **National AHP Strategy: AHPs into Action (2017)** sets out a national collective vision of how AHPs can contribute to the transformational change required, this is defined in the infographic within appendix 1 and will be further supported and developed by the new AHP Strategy due to be launched in June 2022.

Regional Drivers

As set out in the Cheshire and Merseyside Workforce Strategy (2019 -2024) we acknowledge the increasing demand for services and the need to transform the way we work to provide the best care we can.

Data extracted from the Heath Education England (HEE) E-Portal illustrates the increase in demand for for AHPs across the North West to meet demand. For example, clinical projections established in 2022 illustrate a need for approximately 400 additional Physiotherapists across the North-West region in order to meet the expected population health demand.

To achieve this and the additional demands, we understand that the workforce needs to be at the heart of this transformation and needs to be fully engaged and supported.

The AHP Strategy, vision and its associated objectives have been developed in line with the four strategic priorities of the 'Delivering quality health and care services in Cheshire and Merseyside. Bridgewater's Workforce Strategy: 2019 -2024 Health and Care Partnership Cheshire and Merseyside (2019) illustrated in Appendix 2.

Local Drivers

The Bridgewater Quality and Place Strategy (2022) sets out a firm commitment to developing and supporting the workforce so that they are equipped with the right knowledge and skills to continuously improving quality of care for patients and service users.

Bridgewater's Quality Strategy states 'We want to ensure that patients , their families, communities and stakeholders receive the right care, in the right place and at the right time and that we support staff to facilitate this,

Allied Health Professions (AHPs) are an integral part of multidisciplinary working, for the benefit of service users and carers. As an organisation Bridgewater's strategic objectives make clear aspirations to:

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

The AHP strategy aims is to ensure that all staff who work for the Trust strive to be outstanding in all they do and that they believe that we are all focused on providing safe care, which is responsive, caring, and effective in terms of providing good outcomes for patients.

Who are the Allied Health Professional Workforce?

In the UK there are fourteen allied health professions with protected titles that are regulated by the Health and Care Professions Council.

The AHPs

- Art Therapist
- Dietitians
- Drama Therpists
- Music Therapists
- Occupational Therapists
- Operating Department Practitioners
- Orthoptists
- Osteopaths
- Paramedic
- Physiotherapists
- Podiatrists
- Prosthetists and orthotists
- Diagnostic and Therapeutic Radiographers
- Speech and Language Therapists

The AHP workforce is made of registered and non-registered staffing. AHP support workers, senior support workers , assistants and assistant practitioners work in, with and alongside the allied health professions, providing high quality, life changing care across a range of acute and community services.

The Allied Health Professionals Workforce in Bridgewater

Within Bridgewater, the following AHPs currently make up our workforce::

- ✓ Podiatrists
- ✓ Occupational Therapists
- ✓ Physiotherapists
- ✓ Speech and Language Therapists

Each of the professions and their role are briefly described below:

Podiatry

Podiatrists help to keep the population mobile and active and prevent foot conditions from deteriorating. They enable better health for the population and support people to be pain free, active, and remain in work. Podiatry is intrinsic to multiple care pathways and podiatrists liaise between community, residential, domiciliary, and acute and primary care settings. Podiatrists are degree educated clinicians, who manage a wide range of conditions including complex foot ulcers in people with high-risk long term medical conditions such as diabetes and peripheral arterial disease. Podiatrists deal with the assessment, diagnosis and treatment of the lower limb. They are qualified to deal with soft tissue musculoskeletal (MSK) and systemic conditions which manifest in the lower limb and foot. They work with people suffering from a wide variety of conditions affecting the lower limb and foot including complex biomechanical and structural dysfunction; those with osteoarthritis or rheumatoid arthritis and those with dermatological disorders. Podiatrists work collaboratively with their patients, carers, GPs, consultants, other healthcare professionals and AHPs to enable lifestyle changes and support the best health outcomes possible.

Occupational Therapy

Occupational therapists work with people of all ages and backgrounds who are affected by accident, physical and mental illness, disability or ageing. They:

- Provide help and training in daily activities, such as bathing, dressing, eating, gardening, working and learning
- Offer advice on adapting the home or workplace to meet service-user or carer needs.
- Assess and recommend equipment, such as mobility aids, wheelchairs and artificial limbs and, if needed, advise on special devices to help around the home, school or workplace
- Help children with disabilities to build their confidence, enabling them to take part in school activities
- Work with organisations to improve employees' performance

Occupational Therapists can help people of all ages when the everyday activities, such as getting out of bed in the morning, getting washed, preparing meals, going to work or school, become difficult. Accident, illness, disability and ageing can turn everyday activities into challenges which reduce independence and undermine a sense of identity. Occupational therapists recognise that being able to perform these daily activities is crucial to health and wellbeing. Occupational therapists enable people to manage activities that are important to them independently.

Physiotherapy

Physiotherapists are autonomous practitioners, with expertise in the use of physical and psychosocial approaches to rehabilitation, optimising independence and quality of life. Physiotherapy is a science-based profession and takes an evidenced approach to 'whole person' health and wellbeing. Physiotherapists use a range of interventions including movement, physical activity, manual therapy, education and advice. Physiotherapists work with a wide range of patients including those with; musculoskeletal, cardiovascular and neurological conditions. Physiotherapists also contribute to and lead services for patients with cancer, dementia, mental health problems, chronic pain and incontinence.

Speech and Language Therapy

Speech and language therapists (SLTs) provide life-improving treatment, support and care for children and adults who have difficulties with communication, eating, drinking or swallowing. SLTs assess and treat speech, language and communication problems in people of all ages to help them communicate better. They also assess, treat and develop personalised plans to support people who have eating and swallowing problems. Using specialist skills, SLTs work directly with clients and their carers and provide them with tailored support. They also work closely with teachers and other health professionals, such as doctors, nurses, other AHPs and psychologists to develop individual treatment programmes. SLTs play an important role in public health including screening and early identification of speech and swallowing difficulties. For example, they identify children with early language delays and provide targeted support to children with communication difficulties who live in areas of social disadvantage. SLTs also support the rehabilitation and enablement of people with acquired and developmental conditions, such as people with learning disabilities or individuals who have experienced a stroke. SLTs provide care for children and adults in community settings which helps to prevent unnecessary hospital admissions and decrease the need for crisis management of conditions such as dysphagia

Workforce Data and Intelligence

The following workforce data and Intelligence has been collated from:

- Electronic Staff Record (ESR) data
- Updates provided by Health Education England via the Cheshire and Merseyside Workforce Information and Analysts
- Heath Education England E-Product Portal.
- Model Hospital Tool

Bridgewater total AHP registered staff in post: **137.4 WTE** with a **headcount of 162 staff.**

The following table illustrates a breakdown of the information about each of the AHP disciplines within Bridgewater.

A breakdown of AHP disciplines within Bridgewater:

Podiatry					
Total staff in post	Headcount	Age band	Retirement risk	Agenda For change (AFC) Banding	Ethnicity
21.5	25	36% aged 50-54 8% 55 and over	8 %	8% band 5 68% Band 6 20% band 7 4% band 8+	Asian: 4% Mixed: 4% White: 92%
Occupational Therapy					
Total staff in post	Headcount	Age band	Retirement risk	AFC Banding	Ethnicity
57.7	65	18% aged 35-39 20% aged 55 and over	20%	22% band 3 2% Band 4 14% band 5 45 % band 6 18% Band 7	Asian: 2% Black : 2% Mixed: 3% Not stated: 2% White: 92%
Physiotherapy					
Total staff in post	Headcount	Age band	Retirement risk	AFC Banding	Ethnicity
43.9	51	29% aged 40-44 16% aged 55 and over	15.69%	6% band 5 53 % band 6 24% Band 7 18% band 8+	Asian: 4% Black : 2% Not stated: 2% White: 92%
Speech and Language Therapy					
Total staff in post	Headcount	Age band	Retirement risk	AFC Banding	Ethnicity
25.2	32	31% aged35-39 38% aged 25-34	9.375%	28% band 5 28 % band 6 44% Band 7	Asian: 6% Not stated: 6% White: 88%

Turnover of AHPs in the last 12 months as detailed on the Model Hospital system:

National Median: 13.1%

Peer median: 12.6%

Trust value: 9%

Bridgewater are below the National median and peer median for turnover of AHPs. The top reason for leaving the organisation has been cited as voluntary resignation- to follow a better reward package.

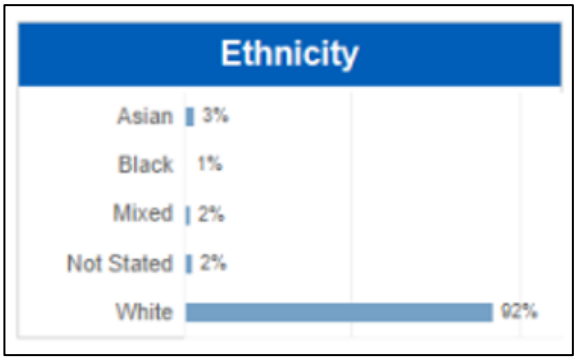
Average AHP working age: 42 years old

Retirement risk: 13.52%

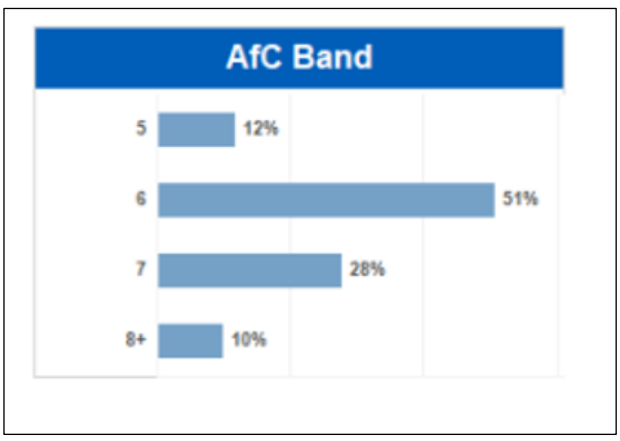
AHP Vacancy rate: 11.76%

Gender: 85% of our AHP staff are female and 15% male.

Ethnicity: 92% of AHP staff are white.



Agenda for change banding: 51% of our AHPs are band 6, over 80% of our staff are band 6 and above. 12% of our staff are band 5



The Workforce Challenges

The data highlights the following challenges to the AHP workforce and

- Bridgewater are a smaller community organisation with small number of AHPs and support workers.
- Smaller sized teams can limit the career opportunities available to the AHP workforce which may limit the attraction for future careers.
- Recruitment is a challenge as it is Nationally and as such we need to be innovative and explore development of the skill -mix of services.
- We need to continue to development practice education placements for student learners exploring innovative approaches to student placements.
- We need to develop opportunities for those returning to practice ensuring all the talent pool is fully explored.
- Preceptorship is in its early stages within the organisation and needs to be fully rolled out across the Trust.
- We need to maximise the opportunity of the apprenticeship levy.
- We need to raise the profile of AHPs across the organisation.

What do AHPs offer to service-users and Carers?

The National Strategy for Allied Health Professionals: AHP into Action (2017) sets out a collective AHP commitment and priorities and the impact these will deliver for patients, carers, communities, and populations.

The Impact of the effective and efficient use of AHPs are as follows. To:

1. Improve the health and well-being of individuals and populations.
2. Support and provide solutions to general practice and urgent and emergency services to address increasing demand.
3. Support integration, addressing historical service boundaries to reduce duplication and fragmentation.
4. Deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.

Within Bridgewater our AHPs provide the following:

Our Offer

- Person-centred approaches
- Promotion of self-management and prevention
- Goal orientated care focusing on self-care, rehabilitation and recovery
- Promotion and protection of the interests of service users and carers.
- Skills to enable service -users to participate in life more fully
- A range of rehabilitation and recovery focussed specialist interventions

Our Aspiration

- To improve quality of life
- To continually develop skills in how to analyse the best way to help service users
- To enable service users to achieve their potential
- To set realistic expectations.
- To ensure our standard of practice is high.
- Deliver evidence based /informed practice
- To have competencies in place for each field of practice

Our Delivery

- Early intervention to maximise service user skills and develop potential.
- Working with service-users and others involved in their care to address their needs in the best way possible, supporting integration, to reduce duplication and fragmentation
- To enable a quickening of the recovery journey, as a result of expert AHPs assessment skills and positive therapeutic risk taking to improve patient outcomes.

The Quality of our AHP Care

Service users, carers, and the public, can be assured that AHP practice in Bridgewater is of a high standard.

- ✓ Qualified AHPs must be registered with their regulatory body, the Health Care Professions Council (HCPC).

- ✓ AHPs work must meet HCPC national Standards of Conduct, Performance and Ethics (2016)and profession specific HCPC Standards of Proficiency.

- ✓ AHPs must meet Standards of Continuing Professional Development (CPD), which involves undertaking and providing evidence of engaging in regular CPD activities which enable them to formally declare their competence to practice every two years.

- ✓ Competent and skilled AHP support staff perform delegated duties on behalf of registered AHP staff.

- ✓ We have in place an embedded culture of professional supervision and appraisal for all AHP staff, to ensure that AHP practice is continuously reviewed in line with the Bridgewater Clinical Supervision Policy

The Strategy

The purpose

1. Provide a simple and clear framework for all AHPs in Bridgewater to align and contribute to the work of Bridgewater and its ambition to support people and families to live healthy lives, accessing health and wellbeing services when and where they need them.

2. Maximise the impact AHPs can have in addressing the NHS Long Term Plan (LTP), We are the NHS: People Plan 2020/21 - Action for us all (2020), the National AHP Strategy (2017-2022): AHPs into Action the Bridgewater strategic workforce plans.

3. Ensure that Bridgewater provides a workforce which meets the needs of its service users, carers, and families by ensuring sustainability and growth of the AHP workforce in Bridgewater

Consultation

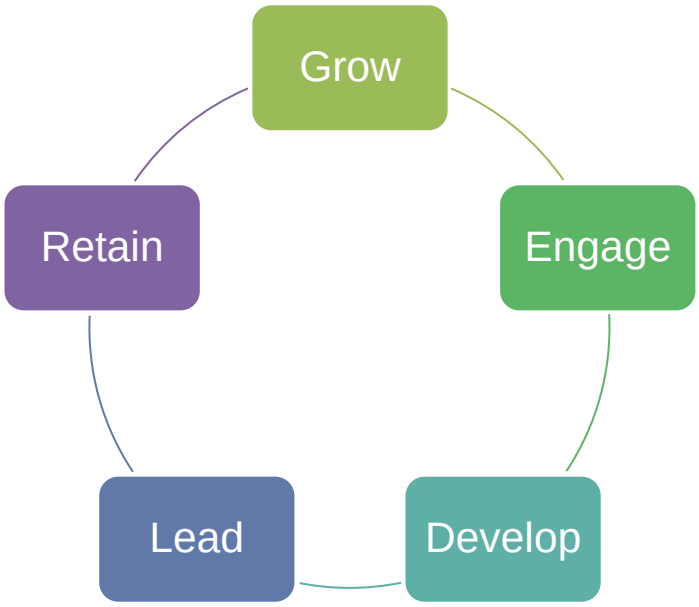
To ensure this strategy is reflective of the AHP workforce within Bridgewater we have consulted with a multi-professional group of AHP staff across the Trust in relation to the key themes.

The Vision

Our vision is to create an inclusive, diverse, and sustainable Allied Health Professionals workforce that delivers the highest quality, holistic, evidence-based care to meet the needs of the population served by Bridgewater Community Healthcare NHS Trust. The workforce will support and promote an improvement to health and wellbeing and enable people to live well with and beyond illness and disability in line with Bridgewater's Quality and Place Strategy (2022).

Our Priorities and Action Plan

Our objectives



Grow -Inspire the population we serve to embark on AHP careers, promoting diversity and stimulating growth of the AHP workforce.

Engage- Engage with our AHP workforce, ensuring they are connected to key programmes of work and are enabled to effectively contribute to service transformation.

Develop- Support the development and delivery of high-quality integrated care that is safe, responsive and close to home. Making sure our AHPs are equipped with the right knowledge and skills to continually improve the quality of care they deliver.

Lead- Promote the benefits AHP leadership can bring to the organisation and explore and develop leadership development opportunities.

Retain- Ensure AHPs are used effectively and to their maximum potential, optimising retention of AHPs within the organisation.

Our Priorities and Action Plan

			Timeframe	
Theme	Strategic Aims	Actions	Year 1	Year 2
Grow Inspire the population we serve to embark on AHP careers, promoting diversity and stimulating growth of the AHP workforce,	Motivate AHPS to remain with our organisation, promoting growth and sustainability within AHP workforce and building capacity and capability.	***Student allocation*** • Review and grow the student placement capacity, placement types, and the quality of placements. This also includes student AHPs having access to shared learning and peer support and those AHPs returning to practice. • Strengthen our links with universities delivering AHP programmes to help increase placement opportunities and build the future workforce. • Listen to our students, analyse their feedback , make change and support innovative approaces to student recruitment. • Support practice educator development and support. ***Work Experience*** • Provide In reach into local community schools, colleges, higher education institutions offering work experience opportunities to students interested in an AHP career.	✔ ✔ ✔ ✔ ✔	✔ ✔ ✔ ✔ ✔

		• Work with the Trusts Workforce Team and Talent for Care Team to develop AHP work experience and pre-registration shadowing for each profession.	✓	✓
		Communication		
		• Increase Bridgewater's AHP social media presence across a range of platforms to promote AHP careers, student placement and recruitment opportunities.	✓	✓
		• Create AHP external and internal webpages detailing key information including AHP careers information	✓	
		Support workforce		
		• Grow the support workforce in line with the development of registered AHP workforce ensuring the right skill mix to meet service demand.	✓	✓
		• Ensure the correct skill mix of AHP workforce in each team/service.	✓	✓
		• To explore the use of volunteers in AHP service provision ensuring the correct learning, training and development of this workforce.	✓	✓
		Return to practice		
		• Develop and implement a multi-professional approach to return to practice.	✓	

Engage Engage with our AHP workforce, ensuring they are connected to key programmes of work and are enabled to effectively contribute to service transformation.	Effectively contribute to service transformation and delivery, supporting transformation of the AHP workforce	***Communication*** • Create an AHP webpage available to all staff via the Trust intranet. This will highlight AHP activity, enable feedback on the workforce plan and enable sharing of case studies and best practice • To develop AHP Professional Forums for registered and non-registered staff as an opportunity to explore clinical and professional issues and share learning and best practice. • To use social media to promote opportunities for the AHP workforce e.g., return to practice, recruitment and apprenticeships. • Ensure the correct level of AHP involvement at key transformational and operational meetings within the organisation. • Listen and actively respond to what matters most to our AHP staff and communicate action effectively. ***Recruitment*** • Develop and implement a multi-disciplinary preceptorship policy to ensure we provide a consistent offer to all newly qualified staff and those returning to practice	✔ ✔ ✔ ✔ ✔ ✔	 ✔ ✔ ✔

		• Develop and promote innovative rotations with system partners in particular Band 5 rotations with opportunities for mixed rotations • Increase recruitment, and leadership opportunities for AHPs. AHP Lead to support individual workforce plans for AHP services. • Promote and support the use of apprenticeships across Bridgewater ensuring demand is captured as part of workforce planning and ensuring the equity of apprenticeships across teams. • Undertake a review of all AHP workforce job descriptions to ensure consistency and standardised elements across the Trust . • Involve service users in the recruitment of allied health professional staff	✔ ✔ ✔ ✔ ✔	✔ ✔ ✔ ✔ ✔
Develop Support the development and delivery of high-quality integrated care that is safe, responsive and close to home. Making sure our AHPs are equipped	Equip AHPs with the right knowledge and skills to continuously improve the quality of care for our patients and service users. Ensure AHPs can effectively contribute to	***Workforce Planning*** • To undertake a review of AHP structures as part of workforce planning identifying AHP champion roles that will function as a conduit between therapy staff and the Trust AHP Lead. • Undertake demand and capacity planning ensuring AHPs engage in job planning and benchmarking using the Model Hospital Tool and other workforce planning tools as appropriate.	✔ ✔	✔ ✔

with the right knowledge and skills to continually improve the quality of care they deliver.	service transformation	• Support providers in Bridgewater to ensure AHP ESR coding is correct. • To develop career pathways for newly employed support staff, • Maximise utilisation of the apprenticeship levy in line with the Talent for Care Team. ***Development*** • To explore and develop expansion of multi-professional advanced clinical practice initiatives to ensure AHP skills are fully utilised and to promote opportunities for AHPs to accelerate wider workforce transformation • Ensure a continued focus on upskilling – developing skills and expanding capabilities - to create more flexibility, boost morale and support career progression • Have employer support for continued professional development and engagement in research activities for AHPs and engage AHPs in the workforce planning process. • Ensure AHPs in Bridgewater understand leadership and talent development opportunities. In collaboration with Talent for care Team , Workforce Team and Learning and Development.	✔ ✔ ✔ ✔ ✔ ✔ ✔	✔ ✔ ✔ ✔ ✔ ✔ ✔

		• Support AHP leaders and aspiring leaders to effectively work at system, locality and neighbourhood level ensuring the right opportunities are put into place.	✓	✓
		• Empower practitioners to be able to reach their full potential with a rewarding career and work-life balance	✓	✓
		• Develop and implement a multi-disciplinary preceptorship policy to ensure we provide a consistent offer to all newly qualified staff and those returning to practice	✓	✓
		• Ensure staff utilise HEE's e-Learning for Healthcare (e-LfH) programme and online Learning Hub.	✓	✓
		• Develop a staff digital development passport which will include information about the training staff have undertaken and competencies achieved.		✓
		Maximise and grow partnerships		
		• Encourage AHPs to build on partnerships with social care, voluntary sector, and local community resources to develop a place-based partnership approach to supporting care across the community	✓	✓

		• Reduce the complexity of service pathways to ensure we meet the needs of people in our boroughs	✓	✓
		• Develop links and initiatives, such as social prescribing, with the primary care networks	✓	✓
		• To identify practitioner posts to facilitate AHP skill development and integrate best practice across localities, bridging transitions with primary care, acute hospitals, and community.	✓	✓
		• Ensure AHPs have access to the tools and support required to continue to develop their use of informatics and technology to continue to deliver quality and cost-effective care	✓	✓
		• Scope the digital readiness and staff upskilling required across allied health services	✓	✓
		• Identify how technology could enhance services for patients such as assistive technology.	✓	✓
		• Review and promote AHP's engagement with digital and health technology, ensuring they have access to the necessary digital tools.	✓	✓
		• To explore use of data to drive quality, productivity, efficiency and improvement in the AHP workforce teams.	✓	✓
		• Promote a culture were improving the population's health is a core component of the practice of all clinical and care staff	✓	✓

		• Ensure our responsiveness to local public health challenges and ill health prevention. ***Research*** • Promote and develop a research culture across the AHP workforce in Bridgewater • Embed a culture of quality improvement and culture change across AHP services. • Empower practitioners to deliver evidence -based care to contribute to positive patient outcomes. • Lead and drive research to evidence outcomes and the impact of AHP intervention.	✓ ✓ ✓ ✓ ✓	✓ ✓ ✓ ✓ ✓
Lead Promote the benefits AHP leadership can bring to the organisation and explore and develop leadership development opportunities.	Able to effectively contribute to service transformation and delivery	***Transformation*** • Support AHP services to evidence the quality and cost effectiveness of the care they deliver, • Support continuing improvement and innovation in service delivery focusing oneself-care and prevention of ill-health. • Ensure practitioners can access, understand data for their services/clinical area and how this impacts on their practice. • Ensure practitioners deliver care centred on the needs of the person and the populations they serve.	 ✓ ✓ ✓ ✓	 ✓ ✓ ✓ ✓

		Measuring meaningful outcomes and impact • Engage AHPs in capturing the key performance indicators required across the Trust • Engage AHPs in measuring and sharing both the clinical, social, environmental, and cost effectiveness of services provided to demonstrate the outcomes and impact of services delivered	✔ ✔	✔ ✔
Retain Ensure AHPs are used effectively and to their maximum potential, optimising retention of AHPs within the organisation.	Motivate the AHP workforce to remain with our organisation, promoting growth and sustainability within AHP workforce Effectively contribute to service transformation and delivery.	***Retention, career progression, role development, talent development.*** • Ensure time is made available to enable AHPs to access profession specific supervision either as an individual or in a peer group session. This should be additional to line management and clinical supervision depending on the line manager's profession. This should be in line with the Trusts Supervision Policy. • Ensure appraisal and peer supervision (My Plan) is embedded across the AHP workforce which promotes individual development and recognises knowledge, skills, and expertise both within and outside work roles • Develop AHP practice educator roles and learning development post within Bridgewater. • To explore hard-to-recruit posts and implement a plan for recruitment strategies.	✔ ✔ ✔ ✔	✔ ✔ ✔ ✔

		• The wellbeing of practitioners is supported, and a just and fair culture is evident, with equality, diversity, and inclusion.	✓	✓
		• Review and continue to develop models for pre-registration education of AHPs with key partners & stakeholders in collaboration with the Practice Education Facilitators within Bridgewater.	✓	✓
		• Strengthen relationships with pre-registration education providers where gaps exist in Bridgewater and explore development of career pathways to provide a stepping stone to AHP qualifications.	✓	✓
		• Develop an AHP careers promotion model for Bridgewater and develop further careers promotion activities.	✓	✓
		• Work with education providers to widen participation by ensuring a variety of routes into AHP careers are in place to increase applications and increase the diversity of the workforce.	✓	✓
		• To develop Band 5 peer support sessions to support preceptorship and maximise development of competencies.	✓	✓
		Health and wellbeing		
		• To take positive steps to improve representation of diverse groups in our AHP workforce and to ensure the barriers to progression for these groups are identified and removed.	✓	✓

		• To utilise workforce data to explore reasons for absence and plan targeted work to manage these absences. • To explore flexible and remote working opportunities for the AHP workforce. • Design and develop roles which make the greatest use of each individual's skills and experiences • Recognise and appreciate staff and celebrate successes.	✔ ✔ ✔ ✔	✔ ✔ ✔ ✔

How will we deliver our strategy?

Annual AHP programme planning A programme plan will be developed annually by the organisation which will detail the measurable objectives and outcomes for that year in line with the strategy themes. The AHP Lead will be responsible for delivery of the programme plan.

AHP Professional Forums- Our AHP Professional Forums, consisting of AHP staff across the Trust will be formed. The Trust AHP lead will engage with the AHP workforce through regular meetings, newsletters, and webinars. This will include updates on the work of the AHP strategy and workforce plan.

Reporting arrangements- The AHP Lead will report to Bridgewater's People Committee and will provide a regular review of progress against the strategic aims. It will support communication with other stakeholders and facilitate participation in national projects relevant to Bridgewater. Through this group and the professional forums, the AHP Lead will share the outputs of the work to promote engagement and ensure efficient and effective use of AHP resources within the organisation.

How will AHPs action the plan?

To achieve the plan, we will:

- ✓ Work co-productively with service users/carer, will provide an opportunity to capture the impact of the effective and efficient use of AHPs, to improve health and wellbeing and enable people to be as independent as possible.

- ✓ Fully realise the potential of the AHP workforce recognising their skills in maximising potential, rehabilitation, recovery, and self-management .

- ✓ Deliver flexible AHP provision which is responsive to the needs of users and families and delivered closer to home.

- ✓ Utilise the Health Education England Workforce planning tools e.g., Star Model to support workforce transformation, enabling us to explore workforce challenges in more detail, and develop bespoke action plans to address them.

- ✓ Maximise our workforce intelligence to fully understand our workforce profile to inform workforce planning utilising Population Centric Workforce Planning approaches.

- ✓ Work in collaboration with Bridgewaters Workforce and Learning and Development Teams to action identified workstreams.

Measuring our Success

AHPs have the capability and skills to lead change, develop their skills, better evaluate their impact, and use information and technology to meet the challenges of changing care needs. It is crucial for AHPs to be aware of and provide evidence based/informed best practice and to continually reflect on their skills and develop new capabilities. Delivering this plan will ensure more efficient and effective AHP and Trust services for our service users, carers, and the wider community.

Annual reporting of progress against this plan at locality and Trust levels, will enable its impact to be monitored and evaluated thereby facilitating informed discussion to address any shortfalls.

Performance monitoring and progress updates will be reported through our existing committee structure and reviewed and discussed at Board. Decisions will be made on the Trusts progress against the Strategy and any remedial actions needed. A key part of success will be to share our progress in relation to the Strategy on an on-going basis.

Our aim is to ensure our AHP workforce supply plans are integrated into routine organisational workforce planning activity.

Appendix 1


AHPs into Action
#AHPsintoAction
NHS England
Our collective commitments and priorities will deliver significant impacts for patients, their carers, communities and populations.
Impact
The Impact
of the effective and efficient use of AHPs for people and populations
1 Improve the health and well-being of individuals and populations.
2 Support and provide solutions to general practice and urgent and emergency services to address demand.
3 Support integration, addressing historical service boundaries to reduce duplication and fragmentation.
4 Deliver evidence based/informed practice to address unexplained variances in service quality and efficiency.
How?
Commitment
Plus
Priorities
Our Commitments
to the way services are delivered
1 Commitment to the individual.
2 Commitment to keep care closer to home.
3 Commitment to the health and well being of populations.
4 Commitment to care for those who care.
Our Priorities
to meet the challenges of changing care needs
1 AHPs can lead change.
2 AHPs skills can be further developed.
3 AHPs evaluate, improve and evidence the impact of their contribution.
4 AHPs can utilise information & technology.
A blueprint to support system leaders make decisions about AHPs, the services they offer, and how they can be most efficiently and effectively utilised.
16,128 contributions were submitted from services users, carers, citizens and health and care staff including AHPs, through a process of crowdsourcing. 'AHPs into Action' represents their collective voice.

Appendix 2

Workforce Development

Priorities:

- A culture of compassionate leadership is evident at all levels.
- Practitioner well-being is supported; a just and fair culture is evident, with equality, positive diversity and inclusion.
- Every practitioner has developmental opportunities identified and are enabled to fulfil them through discussions with their line manager.
- Clinical and professional teams recognise practitioner skill mix opportunities aligned to the needs of the population.

Aim:

Practitioners are empowered to be able to reach their full potential with a rewarding career and work-life balance (C&M NMAHP Workforce Charter – add hyperlink)

Professional Practice

Priorities:

- Every practitioner engages in regular supervision, mentorship and participates in reflective practice to enable them to thrive and develop.
- All practitioners can raise concerns and advocate for people in their care, recognising diversity and treating people as individuals.
- Practitioners can access, understand data for their clinical area and how this impacts on their practice.

Aim:

Practitioners are equipped to deliver the right care to the right patient at the right time and promote a culture of learning.

Cheshire and Merseyside Nursing, Midwifery and AHP Strategy (*Practitioners)

Aim:

Practitioners are empowered to deliver evidence -based care to contribute to positive patient outcomes.

Priorities:

- Practitioners have the capacity and capability to participate in and lead on research.
- Practitioners use quality improvement and methodologies to contribute to service development and innovation.
- A safety culture of learning is evident, and practitioners are skilled in interpreting data to support service developments, reduce inequalities and discrimination.
- Practitioners can access digital tools to deliver safe effective care that is more convenient and accessible for people.

Continuous Improvement

Aim:

Practitioners are advocates for those receiving our services to reduce health inequalities and promote positive experiences.

Priorities:

- Practitioners deliver care centred on the needs of the person and the populations they serve underpinned by values of equality and diversity.
- Practitioners are empowered to influence decisions about how they can deliver personalised care: Practitioner “voice” is valued.
- Practitioners engage and involve people to co-produce and develop services.
- Practitioners are enabled to implement a place based integrated approach to transform the quality and sustainability of care delivery.

Person and Family Centred Care

References

- **Cheshire and Merseyside Nursing and Midwifery AHP Strategy 2021-2024** (2021) Cheshire and Merseyside Healthcare Partnership
- **Clinical Placement Policy for Pre and Post Registration Learners (On NMC and HCPC Regulated Programmes)(**2021) Bridgewater Community Healthcare NHS Foundation Trust
- **Clinical supervision Policy (2022)** Bridgewater Community Healthcare NHS Foundation Trust
- **HCPC National Standards of Conduct, Performance and Ethics** (2016) Health and Care Professions Council
- **Our NHS People Promise** (2020) NHS England
- **Quality and Place Strategy** (2022) Bridgewater Community HealthCare NHS Foundation Trust
- **Research and Development Policy** (2019) Bridgewater Community Healthcare NHS Foundation Trust
- **The National Strategy. AHPs into Action. Using Allied Health Professionals to transform health, care and wellbeing. 2016/17 - 2020/21** (2017) NHS England
- **The NHS Long Term Plan** (2019) NHS England
- **We are the NHS: People Plan 2020/21 - Action for us all** (2020) NHS England

Abbreviations

AFC-Agenda for Change
AHP-Allied Health Professionals
FTE-Full time equivalent
HEE- Health Education England
HCPC -Healthcare Professionals Council
LTP- Long Term Plan
MSK-Musculoskeletal
NHS- National Health Servce
NMC- Nursing and Midwifery Council
OT -Occupational Therapist
SLT-Speech and Language Therapist
WTE- Whole time equivalent

Get in Touch

For further information about this strategy please contact:

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Email: jillian.wallis@nhs.net

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22i**		
Report Title	**CONSTITUTION**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Jan McCartney – Trust Secretary		
Presented by	Jan McCartney – Trust Secretary		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Purpose

To advise the Board of the amended and approved Constitution.

Executive Summary

The amended Constitution was approved by the majority of Council of Governor members on Friday 15 July via e-Governance.

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☒ 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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ Caring	☒ Effective	☐ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22i**		
Report Title	**CONSTITUTION**		
Report Author	Jan McCartney – Trust Secretary		
Purpose	To advise the Board of the amended and approved Constitution.		

1. INTRODUCTION

1.1 The amended Constitution was approved by the majority of Council of Governor members on Friday 15 July via e-Governance.

2. INFORMATION

2.1 The amendments are detailed as below:

Version	Date	Reviewed By	Comment
2.0	June 2022	Council of Governors	Reference to Monitor amended to NHS Improvement as the Regulator 11.3 Amendment to frequency of elections and reference to Annex 3 12.2. amended Department of Health to NHS Providers 14. Update of statutory provisions 22.3 & 22.4 definition of term of office and tenure of Chair and Non-Executive Directors 27. Update of statutory provisions 41.1.3. clarification of a casting vote 42.2. amendment: Governors are required to approve significant transactions **Annex 1:** The Public Constituencies: amendment to number of members **Annex 2:** The Staff Constituency: amendment to the number of members

			Annex 3: Frequency of Elections added **Annex 4:** Composition of Council of Governors: • amendment to composition • removal of paragraph 3 (duplicate of point 2) **Annex 5:** 2.3. Removed reference to Annex 4 3.2. Corrected reference to 3.1 5.1.7. Corrected reference to 5.2 3.3.2. Amendment to 5 clear days in advance 3.9. Amendment to 5 days prior to the meeting 3.11. Amendment to appointment of nominated chair in event of absence/conflict of interest 3.26.3. Removal of obsolete point 3.31. Amendment of quorum to reflect 50% of the Council being present where Public Governors outnumber Staff and Appointed Governors 3.33 Revision of Board quoracy to reflect the approved Terms of Reference **Annex 9:** 14.1 Amendment of quorum to reflect 6 Members present at the AMM **General** Chairman amended to Chair He/she and his/hers amended to they/theirs/them Addition of issue and review dates

3. CONCLUSION

3.1 The Board is asked to note the amended and approved Constitution.

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22ii**		
Report Title	**APPLICATION OF THE TRUST SEAL**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Jan McCartney – Trust Secretary		
Presented by	Jan McCartney – Trust Secretary		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Purpose

To record the use of the Trust Seal from 1 April 2022 to 22 July 2022.

Executive Summary

In the period from 1 April 2022 to 22 July 2022, there has been one application of the Trust Seal. Detail of this is provided within the attached report for the Board's information.

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?							
☒ 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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ Caring	☐ Effective	☐ Responsive	☐ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22ii**		
Report Title	**APPLICATION OF THE TRUST SEAL**		
Report Author	Jan McCartney – Trust Secretary		
Purpose	To record the use of the Trust Seal from 1 April 2022 to 22 July 2022		

1. INTRODUCTION

1.1 Documents signed on behalf of the Trust, which must be executed under deed, are sealed as set out within the Trust's Standing Orders at Section 9, 'Custody of the Seal and Sealing of Document', and Section 10, 'Signature of Documents'. This is normally confined to land deals, including purchases, transfers, tenancy agreements and acquisitions.

2. INFORMATION

2.1 In the period 1 April 2022 to 22 July 2022 there has been one application of the Trust Seal applied by the Board and Committee Administrator on behalf of the Trust Secretary.

Table 1. Application of the Trust Seal

Seal Number/ Reference	Application of the Trust Seal	Date	Signed (Authorised officers)
04/22	Lease between Peter Barry Brown of Mount Farm, 172 Orrell Road, Orrell, Wigan, WN5 9HQ and Bridgewater Community Healthcare NHS Foundation Trust	7 April 2022	Nick Gallagher, Director of Finance and Paula Woods, Director of People and Organisational Development.

3. CONCLUSION

3.1 The Board is asked to note the use of the Trust Seal as set out in Table 1 above.

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22iii**		
Report Title	**BOARD BUSINESS CYCLE 2022-23**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Jan McCartney – Trust Secretary		
Presented by	Jan McCartney – Trust Secretary		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Purpose

To apprise the Board of the revised Board of Directors business cycle.

Executive Summary

The Board is requested to approve the revised Board of Directors business cycle.

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Nominations & Remuneration Committee**
☐ **People Committee**	

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

How does the paper address the strategic risks identified in the BAF?

☒ BAF 1	☐ BAF 2	☐ BAF 3	☒ BAF 4	☐ BAF 5	☐ BAF 6	☐ BAF 7	☐ BAF 8
Failure to implement and maintain sound systems of	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of

corporate governance							the organisation

CQC Domains:	☒ Caring	☒ Effective	☒ Responsive	☒ Safe	☒ Well Led

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22iii**		
Report Title	**BOARD OF DIRECTORS BUSINESS CYCLE**		
Report Author	Jan McCartney – Trust Secretary		
Purpose	To apprise the Board of the Board of Directors business cycle		

1. SCOPE

1.1 The business cycle for the Board of Directors is a live document and should be fully reviewed annually, and as required, to ensure it remains fit for purpose and reflect all statutory, legislative and mandatory requirements.

2. RECOMMENDATION

2.1 The Board is asked to approve the current Board of Directors business cycle.

Appendix 1: Board of Directors Business Cycle

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BOARD OF DIRECTORS PUBLIC MEETING, PART I, 2022/23	CONSIDERED BY	07 Apr 2022	05 May 2022 Extraordinary	09 Jun 2022	20 Jun 2022 Extraordinary	04 Aug 2022	06 Oct 2022	08 Dec 2022	Feb 2023
Welcome, Apologies and Previous Meetings									
Apologies		✔	✔	✔	✔	✔	✔	✔	✔
Declarations of Interest in agenda items		✔	✔	✔	✔	✔	✔	✔	✔
Minutes from the Previous Public Meeting		✔		✔		✔	✔	✔	✔
Action Log		✔		✔		✔	✔	✔	✔
Urgent Items with the Agreement of the Chair		✔	✔	✔	✔	✔	✔	✔	✔
Patient Stories/Spotlight on Services		✔		✔		✔	✔	✔	✔
Key corporate messages		✔		✔		✔	✔	✔	✔
Equality, Diversity and Inclusion									
To actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive (BAF 5)									
Equality, Diversity and Inclusion Annual Report	People	✔							
Gender Pay Gap Annual Report	People								✔
WRES	People					✔			
WDES	People					✔			
Innovation and Collaboration									
To deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living (BAF 7)									
Organisational Strategy Review (Quality and Place)									
People									
To be a highly effective organisation with empowered, highly skilled and competent staff (BAF 1,3,5,6, and 8)									
Chair's Assurance Report from People Committee	People	✔		✔		✔	✔	✔	✔
Escalated People Risks (ad hoc)	People								
Freedom to Speak Up Annual Report	People	✔							
Medical Appraisal and Revalidation (annual)	People	✔							
People Plan	People	✔					✔		
Staff Survey Results and Action Plan	People	✔		✔					
Quality									
To deliver high quality, safe and effective care which meets both individual and community needs (BAF 2,3,5,6 and 8)									
Integrated Quality Performance Report	Q&S	✔		✔		✔	✔	✔	✔
Winter Plans (Annual)	Q&S						✔		
EPRR	Q&S						✔		
CQC Report, Compliance and Action Plan (ad hoc)	Q&S								
Learning from Deaths	Q&S	✔		✔		✔		✔	
Chair's Assurance Report from Quality & Safety Committee	Q&S	✔		✔		✔	✔	✔	✔
Escalated Quality & Safety Risks (ad hoc)	Q&S								
Safeguarding Annual Report	Q&S						✔		

DRAFT

Sustainability										
To deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability (BAF 1,4 6,7 and 8)										
Annual Accounts	Audit		✔		✔					
Annual Anti-Fraud/Bribery Report - check last years										
Annual Governance Statement	Audit		✔		✔					
Annual Report	Audit		✔		✔					
Chair's Assurance Report from Audit Committee	Audit	✔		✔		✔	✔	✔	✔	
Chair's Assurance Report from Finance and Performance Committee	F&P	✔		✔		✔	✔	✔	✔	
DIGITAL Strategy	F&P					✔				
Escalated Finance & Performance Risks (ad hoc)	F&P									
Escalated Audit Risks (ad hoc)	Audit									
Finance Report	F&P	✔		✔		✔	✔	✔	✔	
Financial Plan	F&P	✔		✔	✔	✔	✔	✔	✔	
Estates Strategy	F&P	✔								
H&S Strategy	F&P									
Integration and Collaboration Update	F&P	✔		✔		✔	✔	✔	✔	
Operational Plan	F&P	✔		✔	✔	✔	✔	✔	✔	
People										
To be a highly effective organisation with empowered, highly skilled and competent staff (BAF 1,3,5,6, and 8)										
Chair's Assurance Report from People Committee	People	✔		✔		✔	✔	✔	✔	
Escalated People Risks (ad hoc)	People									
Freedom to Speak Up Annual Report	People	✔								
Medical Appraisal and Revalidation (annual)	People	✔								
People Plan	People	✔					✔			
Staff Survey Results and Action Plan	People	✔		✔						

Corporate Governance									
Annual Audit Committee Report and Annual Audit Letter for Information	Audit		✔		✔				
Annual Report by the SIRO	F&P						✔		
BAF Review/ Risk Management Framework / Risk Appetite								✔	
Board Assurance Framework (BAF) - each meeting	All Committees	✔		✔	✔	✔	✔	✔	✔
Board Effectiveness Review - annual		✔							
Business Cycle - Board		✔				✔			
Business Cycles -Committees of the Board						✔			
Elections to Council of Governors (may also be ad-hoc reports following any unexpected vacancies)									
Fit and Proper Annual Review				✔					
Items to be added to the BAF		✔		✔		✔	✔	✔	✔
Items to be delegated or shared with Board Committees		✔		✔		✔	✔	✔	✔
Provider Licence Compliance				✔					
Questions from Members of the Public		✔		✔		✔	✔	✔	✔
Resolution to confirm the affixing of the common seal according to the Register of Seals						✔			✔
Review of Meeting		✔		✔		✔	✔	✔	✔
Sign off Corporate Objectives/Board Assurance Framework, and later half year review of progress		✔					✔		
Terms of Reference Review - Board	All Committees				✔				
Terms of Reference Review - Committees of the Board						✔			
Well Led Review	EMT/Audit			✔					

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22iv**		
Report Title	**REVIEW OF BOARD COMMITTEE TERMS OF REFERENCE**		
Executive Lead	Colin Scales – Chief Executive		
Report Author	Jan McCartney – Trust Secretary		
Presented by	Jan McCartney – Trust Secretary		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Purpose

To apprise the Board on the revised Terms of Reference of the Board's Committees.

Executive Summary

The Board is requested to approve the revised Terms of Reference for the Board and its Committees which have been reviewed by the relevant Committee.

- Audit Committee
- Finance & Performance Committee
- People Committee
- Quality & Safety Committee

The revised Nominations & Remuneration Committee ToR will be reviewed at the next meeting of the Committee.

Committee Business Cycles are included for information.

Previously considered by:

☒ **Audit Committee**	☒ **Quality & Safety Committee**
☒ **Finance & Performance Committee**	☐ **Nominations & Remuneration Committee**
☒ **People Committee**	

Strategic Objectives

☒ **Equality, Diversity and Inclusion** – to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive

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☒ **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

How does the paper address the strategic risks identified in the BAF?							
☒ **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 and morale	Staffing levels	Strategy & organisational sustainability	Digital services which do not meet the demands of the organisation

CQC Domains:	☐ **Caring**	☐ **Effective**	☒ **Responsive**	☐ **Safe**	☒ **Well Led**

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**04 August 2022**
Agenda Item	**61/22iv**		
Report Title	**REVIEW OF BOARD & COMMITTEE TERMS OF REFERENCE**		
Report Author	Jan McCartney – Trust Secretary		
Purpose	To apprise the Board on the revised Terms of Reference for the Board and its Committees		

1. SCOPE

1.1 The Terms of Reference (ToR) for Board and its Committees should be reviewed annually to ensure they remain fit for purpose and reflect all statutory and legislative requirements.

1.2 The revised format will be provided as a template for use by sub-committees and groups within the Trust.

2. SUMMARY

2.1 Amendments to each ToR are detailed within the Version Control of each document.

3. RECOMMENDATIONS

3.1 The Board is asked to approve the revised Terms of Reference

Appendix 1: Audit Committee Terms of Reference
Appendix 2: Finance & Performance Committee Terms of Reference
Appendix 3: People Committee Terms of Reference
Appendix 4: Quality & Safety Committee Terms of Reference
Appendix 5: Audit Committee Business Cycle
Appendix 6: Finance & Performance Committee Business Cycle
Appendix 7: People Committee Business Cycle
Appendix 8: Quality & Safety Committee Business Cycle

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Audit Committee
Terms of Reference

Name	Audit Committee
Purpose	The Board of Directors has established an Audit Committee for the purpose of providing the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Annual Governance Statement. The Board of Directors is responsible for ensuring effective internal control including: a) Management of the Trust's activities in accordance with statute and regulations. b) The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought. In addition, the Audit Committee shall: c) Provide assurance of independence for external and internal audit; d) Ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the Audit Committee; and e) Monitor corporate governance (e.g., compliance with codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).
Basis of Authority	The Board of Directors has provided delegated authority to the Audit Committee to seek assurance in accordance with these terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.
Reports to	Trust Board
Membership	**Members**

<table>
<tr><td rowspan="5"></td><td>Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Vice Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Members</td><td>All other Non-Executive Directors</td></tr>
<tr><td>Management Lead (but not a member of the Committee)</td><td>Director of Finance</td></tr>
<tr><td colspan="2">The Audit Committee members shall be afforded the opportunity to meet at least once per year with no others present.

Attendees

Only the members of the Committee have the right to attend meetings however, the following shall generally be invited to attend routine meetings:

• Deputy Chief Executive Officer / Chief Nurse
• Chief Operating Officer
• Deputy Director of Finance
• Trust Secretary
• Financial Controller
• Head of Internal Audit
• Anti-fraud Manager
• External Audit representative

Observers

Council of Governors' Representatives

Any other person with prior permission of the Chair

Invited as required

The Trust Chair may be invited to attend the Committee.

Medical Director (depending on agenda items)

Other staff will be invited as required by the Chair of the Committee, in particular to agenda items in relation to operations, contractual matters, estates or information technology.

The Chief Executive will attend at least once a year to provide assurance on the annual governance statement, or as required.

Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td>Connectivity</td><td colspan="2">Sub-committees reporting to this Committee

• None

The Chief Operating Officer or their Deputy attends all Committees of the Board and provides operational connectivity.</td></tr>
<tr><td></td><td colspan="2"></td></tr>
<tr><td>Frequency of Meetings and Location</td><td colspan="2">Meetings will take place quarterly.

No less than four meetings are to be held within a calendar year.</td></tr>
</table>

	An additional meeting may be held to consider the draft Financial Statements, Annual Governance Statement and Annual report if required. Each member is to attend at least 75% of the diarised meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The Audit Committee will be quorate when at least three Non-Executive Directors, including the Chair or Vice-Chair are present for a decision making meeting. 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	The duties and responsibilities of the Committee are: **Internal Control and Risk Management** a) To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements, ensuring the provision and maintenance of an effective system of financial and corporate risk identification and associated controls, reporting and governance. b) To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern. c) To review the adequacy by way of the Board Assurance Framework of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. d) To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. **Internal Audit** e) To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation. f) To oversee on an ongoing basis the effective operation of internal audit in respect of adequate resourcing, its co-ordination with external audit, meeting mandatory NHS Internal Audit Standards, providing adequate independence assurances, having appropriate standing within the Trust; and meeting the internal audit needs of the Trust. g) To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations. h) To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal. i) To conduct an annual review of the internal audit function. j) To oversee the conduct of a market testing exercise for the appointment of an internal auditor at least once every five years. **Anti-Fraud**

k) To review and approve the anti-fraud annual workplan, ensuring that it is consistent with the needs of the organisation.

l) To oversee on an ongoing basis the effective operation of the Trust's anti-fraud service in respect of adequate resourcing, its co-ordination with internal and external audit, meeting NHS Counter Fraud Authority Standards, having appropriate standing within the Trust; and meeting the anti-fraud needs of the Trust.

m) To consider the major findings of anti-fraud investigations and detection work, management's response and their implications and monitor progress on the implementation of any such recommendations.

n) To consider the provision of the anti-fraud service, the cost of the service and any questions of resignation and dismissal.

o) To conduct an annual review of the anti-fraud Service.

p) To oversee the conduct of a market testing exercise for the appointment of an anti-fraud service at least once every five years.

External Audit

q) To ensure that the Governors' Auditors Appointment Group are fully involved in the selection process for the appointment, reappointment or removal of the External Auditors.

r) To provide the Governor's Auditors Appointment Committee with the necessary information and to enable them to make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the Annual Report, along with the reasons that the recommendation was not adopted.

s) To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the Trust associated impact on the audit fee.

t) To assess the external auditor's work and fees on an annual basis and based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

u) To review external audit reports, including the annual audit letter, together with the management response, and to monitor progress on the implementation of recommendations.

v) To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

w) To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

Annual Reporting

x) To review and approve the annual statutory accounts for recommendation to the Board to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

	• the meaning and significance of the figures, notes and significant changes; • areas where judgment has been exercised; • adherence to accounting policies and practices; • explanation of estimates or provisions having material effect; • the schedule of losses and special payments; • any unadjusted statements; and • any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved. y) To review and approve the annual report and Annual Governance Statement for recommendation to the Board, to determine completeness, objectivity, integrity and accuracy. z) To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control. **Standing Orders, Standing Financial Instructions and Standards of Business Conduct** aa) To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of Business conduct, including maintenance of registers. bb) To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension. cc) To review the scheme of delegation. **Other** dd) To review performance indicators relevant to the remit of the Audit Committee. ee) To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee. ff) To develop and use an effective assurance framework to guide the audit committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference. gg) To review the work of all other Trust committees in connection with the Audit Committee's assurance function. In particular the respective roles and performance of the Audit Committee and the Quality and Safety Committee will be regularly reviewed to ensure that the Audit Committee primarily focuses in on the robustness of sources of assurance whereas the Quality and Safety Committee focuses in on the adequacy of the resulting assurances offered. hh) Review the process for any significant transaction.
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form 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 Committees work plan

	• Key policies and documents relevant to clinical quality, safety, effectiveness and patient experience • Exception reports • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and/or Board level Committees.
Outputs	• Minutes • Action log • Committee Chair's Assurance report to the Board • Annual report to the Board on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors
Closed Session	On specific occasions it may be necessary for the Audit Committee 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 are authorised to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. Deputies have no Voting rights. • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit. • 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) • Review of each meeting by Members and Governor Observers.
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	Month YEAR
Review Date	Month YEAR

Appendix A

<u>Monitoring Compliance with the Terms of Reference for Audit Committee</u>

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 Group	Review of agenda items	Trust Secretary	Annually	Board of Directors	Audit Committee
Reporting arrangements to the Trust Board	Review of Board agenda	Trust Secretary	Annually	Board of Directors	Audit Committee
Membership, including nominated Deputy	Annual report	Trust Secretary	Annually	Board of Directors	Audit Committee
Frequency of attendance by Members	Annual report	Trust Secretary	Annually	Board of Directors	Audit Committee
Reporting arrangements into the higher level committee	Review of Board minutes	Trust Secretary	Annually	Board of Directors	Audit Committee
Requirements for a quorum	Review of minutes	Trust Secretary	Annually	Board of Directors	Audit Committee
Frequency of meetings	Review of minutes	Trust Secretary	Annually	Board of Directors	Audit Committee

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

ISSUE DATE	Month YEAR
REVIEW DATE	Month YEAR

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Audit Committee	Full review of format **Membership**

			Medical Director moved from Attendees to Invited as Required **Connectivity** The addition of the Chief Operating Officer or their deputy as an operational link between Committees **Frequency of Meetings and Location** Members required to attend 75% of diarised meetings per year **Quoracy** Chairman replaced with Chair **Inputs** Provision of agenda and supporting papers **Outputs** Committee Chair's Assurance report to the Board, replaces Exception reports to the Board. **Other Matters** Review of each meeting by Members and Governor Observers

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Finance and Performance Committee
Terms of Reference

Name	Finance and Performance Committee	
Purpose	The Board of Directors has established a Finance and Performance Committee for the purpose of: a) Providing detailed scrutiny of financial, performance, estates and Digital matters, in order to provide assurance and raise concerns (if appropriate) to the Board of Directors b) Making recommendations as appropriate on financial, performance, estates and digital matters to the Board of Directors c) Assessing and identifying risks within the portfolio and escalating this as appropriate. The Committee's objectives are to: d) Advise the Board of Directors on all aspects of finance, performance, estates and Digital matters. e) Seek assurance in respect of financial business planning f) Ensure corrective action has been initiated and managed where gaps are identified in relation to risks within the portfolio of the Committee g) Scrutinise the Trust's financial and relevant plans, investment policy and proposed Digital business decisions and those relating to the Trust's estate which the policy defines and requires Board approval	
Basis of Authority	The Board of Directors has provided delegated authority to the Finance and Performance Committee to seek assurance in accordance with this terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.	
Reports to	Trust Board	
Membership	**Members:**	
	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director

	Management Lead	Director of Finance*
	In addition: • Two other Non-Executive Directors • Deputy Chief Executive Officer / Chief Nurse* • Chief Operating Officer* **Attendees:** Operational Leads as requested: • Deputy Director of Finance • Trust Secretary • Financial Controller *Individuals flagged with * are required to send a deputy in the event of non-attendance.* **Observers** The Committee is open to all Non-Executive Directors to attend as observers Council of Governors' Representatives Any other person with prior permission of the Chair **Invited as required** The Trust Chair may be invited to attend the Committee. Other staff will be invited as required by the Chair of the Committee, in particular for agenda items in relation to transformation, contractual matters estates or digital. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.	
Connectivity	Sub-committees reporting to this Committee: • Capital Council • CIP Council • DIGIT • Estates Sub Committee • Health & Safety Sub Committee • Performance Council There is an operational and governance link between this Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures. The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.	
Frequency of Meetings and Location	Meetings will take place bi-monthly, with additional meetings at year end and as required. No fewer than six meetings are to be held within a calendar year. Each member is to attend at least 75% of the diarised meetings within a calendar year.	

	Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The Finance and Performance Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. 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	The duties and responsibilities of the Finance and Performance Committee are: a) to undertake detailed scrutiny of monthly, quarterly and year to date financial and performance information against the cost improvement programme; and the capital Performance programme and cashflow b) to undertake detailed scrutiny of the financial forward projections; c) to consider proposals for financial plans and estimates; d) to consider the annual budget for the organisation in order to make a recommendation for approval at the Trust Board; e) to undertake capital planning and financial strategy formulation/review **Performance Management** f) to receive assurance from the Trust Directors in respect of performance, in relation to the Performance Management framework, against: • annual budgets, capital plans and the cost improvement programme, • innovation and productivity plans, • clinical activity by service • commissioning for quality and innovation plans (CQUIN) **Annual Planning Process** g) consider the draft Annual financial and activity plans which will be aligned to NHS Improvement's strategic planning requirements and make recommendations on appropriate KPIs as part of the annual planning process. h) recommend the Trust's Business Plan to the Trust Board. **Contract Negotiation and Performance** i) to oversee the negotiation of contracts with the organisation's commissioners; j) to receive assurance from the Trust Directors' and Executive Leads in respect of the organisation: • meeting the contractual requirements and expectations of commissioners; • meeting the legislative / regulatory requirements of regulators and other bodies; in so far as they relate to the finance portfolio **Risk Management and Internal Control** k) to receive the relevant elements of the Board Assurance Framework and Corporate Risk Register and take lead responsibility for identified risks in respect of non-clinical and financial matters and standards: • to receive reports and assurance from the Trust Directors in respect of risks, considering the recommendations as appropriate from Executive Directors as to those risks which are significant and need to be included in the Board's Assurance Framework and Corporate Risk Register,

	• to receive reports and assurance from Trust Directors in ensuring divisional action plans mitigate risks and gaps in controls and assurance are implemented, • to assess any risks within the finance and performance portfolio brought to the attention of the Committee and identify those that are significant for escalating as appropriate l) to work with the Trust Directors and assess and advise on the financial and operational aspects of the Risk Management Strategy; **Business Cases** m) in accordance with Standing Financial Instructions consider the recommendations of the Directors' Team when considering business cases in respect of: • major service and strategic developments • replacement and / or new consultant or clinical posts submitted by the Trust Management. **Commercial and Business Development** n) to consider proposals for Commercial and Business Development activities, including review and approval of commercial tenders for new business and appraisal of the impact of service exits. **Digital** o) to consider proposals and seek assurance on the delivery of the digital strategy **Estates and Assets** p) to consider proposals for Estates and Assets and seeking assurance on the delivery of the Trust's Estates Strategy. q) to receive assurance that, where appropriate, the Trust is compliant with guidance/legislation in respect of estate and health and safety matters. **Quality** r) to where a matter relating to finance has a significant quality implication the Committee will refer that matter to the Quality and Safety Committee
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form 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 Committee's work plan, in particular the monthly finance and operational report • IQPR report • Key policies and documents • Exception reports from designated sub-groups/committees • Performance reports from clinical services as required • Reports / formal correspondence from Regulators and key stakeholders • Delegated / transferred issues from Board and/or other Board level Committees
Outputs	• Minutes

	• Action log • Committee Chair's Assurance reports to the Board • Annual Report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors • Report to the Audit Committee on progress against Internal Audit recommendations
Closed Session	On specific occasions it may be necessary for the Finance and Performance Committee 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	• Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. Deputies have no voting rights. • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit. • 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	See monitoring table (Appendix A)
Issue Date	Month YEAR
Review Date	Month YEAR

Appendix A

Monitoring Compliance with the Terms of Reference for Finance and Performance Committee

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 Committee	Review of agenda items	Trust Secretary	Annually	Board of Directors	Finance and Performance Committee
Reporting arrangements to the Trust Board	Review of Board agenda	Trust Secretary	Annually	Board of Directors	Finance and Performance Committee
Membership, including nominated Deputy	Annual report	Trust Secretary	Annually	Board of Directors	Finance and Performance Committee
Frequency of attendance by Members	Annual report	Trust Secretary	Annually	Board of Directors	Finance and Performance Committee
Reporting arrangements into the higher level committee	Review of Board minutes	Trust Secretary	Annually	Board of Directors	Finance and Performance Committee
Requirements for a quorum	Review of minutes	Trust Secretary	Annually	Board of Directors	Finance and Performance Committee
Frequency of meetings	Review of minutes	Committee Chair	Annually	Board of Directors	Finance and Performance Committee

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

ISSUE DATE	Month YEAR
REVIEW DATE	Month YEAR

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Finance & Performance Committee	Full review of format **Frequency of Meetings** Members required to attend 75% of diarised meetings per year Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting **Connectivity** The addition of the Chief Operating Officer or their deputy as an operational link between Committees **Duties and Responsibilities** **Estates and Assets** Point 'p' split into two separate points **Quoracy** Amended to two Non-Executive Directors, and one Executive Director in line with all other Committees **Inputs** Provision of agenda and supporting papers **Outputs** Committee Chair's Assurance reports **Appendix A** Monitoring by the Trust Secretary

Bridgewater Community Healthcare NHS Foundation Trust

People Committee
Terms of Reference

Name	People Committee
Purpose	The Board of Directors has established a People Committee for the purpose of maintaining a strategic overview of the Trust's human resources and organisational development arrangements, along with arrangements for staff communication and engagement with a view to: a) ensuring these are designed to provide a positive working environment for colleagues and; b) that the Trust has in place at all levels the right people systems and processes to deliver, from a patient and service user perspective, safe high quality care. The People Committee will seek assurance on: c) Trust's approach, plans and processes for the delivery of the People Strategy, d) Efficient and effective use of resources, e) Controls and systems in place to support line managers to make effective decisions in the deployment of staff, f) Redesign of the workforce so that it remains fit for the future, and g) Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, h) Support and engagement with the 'unpaid volunteer' workforce so that their skills are safely and appropriately harnessed and i) Alignment of workforce transformation plans to deliver the NHS Long Term Plan, People Plan and People Promise, j) Plans for effective staff communication and engagement The Committee will oversee HR & OD and Communication and Engagement strategic actions to enable the Trust to deliver the Trust's Quality & Place Strategy and specifically the organisational objectives. In addition, the Committee will provide assurance to the Trust Board that the Organisational Objectives will support us to: • Deliver high quality, safe and effective care which meets both individual and community needs. • Deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living. • Deliver value for money, be financially and commercially successful.

<table>
<tr><td></td><td>
Be a highly effective organisation with empowered, highly skilled and competent staff.
The Committee will provide assurance to the Trust Board on the management of risks related to our people.
</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Basis of Authority</td><td>
The Board of Directors has provided delegated authority to the People Committee to seek assurance in accordance with this terms of reference.

It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust.

The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.
</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Reports to</td><td>Trust Board</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Membership</td><td>
Members:
<table>
<tr><td>Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Vice Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Management Lead</td><td>Director of People & Organisational Development*</td></tr>
</table>
In addition:

Two other Non-Executive Directors
Chief Operating Officer
Deputy Chief Executive/Chief Nurse*
Medical Director*

Attendees

Deputy Director of People & Organisational Development
Deputy Director of Communications & Engagement
Heads of: HR, OD and Education
Equality & Inclusion Manager
Library & Knowledge Services Manager (as per business cycle)
Trust Secretary
Staff-Side Chair

Individuals flagged with * are required to send a deputy in the event of non-attendance.

Observers

Council of Governors’ Representatives

Any other person with prior permission of the Chair

Invited as required

The Trust Chair may be invited to attend the Committee.
</td></tr>
</table>

	Other staff will be invited as required by the Chair of the Committee for specific agenda items. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.

Connectivity	**Groups reporting to this Committee**
	• People Hub
	• Medical & Dental Professional Governance
	• People Organisational Delivery Groups (PODs)
	  o Culture & Leadership
	  o Education & Professional Development
	  o Health & Wellbeing
	  o Recruitment & Retention
	• Flu Group
	• Freedom to Speak Up Guardian Group
	
	There is an operational and governance link between this Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures.
	
	The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.

Frequency of Meetings and Location	Meetings will take place bi-monthly No fewer than five meetings are to be held within a calendar year. Each member is to attend at least 75% of the diarised meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The People Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. 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	The duties and responsibilities of the People Committee are: **Duties – decision making:** a) To provide overview and scrutiny in areas of workforce performance referred to the People Committee by the Trust Board b) Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board c) To provide overview and scrutiny to the development and delivery of the People Strategy across all five priority areas – engage, attract, retain, develop and perform d) To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately and that it is in receipt of exception reports and updates

	e) To ensure that appropriate senior clinical leadership advice and involvement is provided on the impact of the delivery of the People Strategy f) To ratify employment policies and procedures on behalf of the Trust g) To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust h) To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience i) To ensure that all statutory and regulatory obligations are met in relation to Equality, Diversity & Inclusion agendas **Duties – advisory:** j) Consider any relevant 'people' risks within the Board Assurance Framework (BAF) and corporate level risk register as they relate to the remit of the People Committee, as part of the reporting requirements k) To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients, reported through the People Operational Delivery Plan (POD) **Duties – monitoring:** l) To monitor the Trust's performance against national standards so far as they relate to employment m) To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required n) To review the performance indicators relevant to the remit of People Committee o) To report any areas of significant concern to the Trust Board as appropriate via the Chair's Key Issues Report p) To receive a report on Employee Relations Cases in respect of numbers, workforce demographics, emerging themes, workforce issues addressed through the Freedom to Speak Up route, lessons learned and in particular those cases where suspension/exclusion is involved q) To monitor the progress with the Internal Audit recommendations within the 'HR and Workforce Aspects' r) To receive communication and staff engagement reports, including Staff Survey results and action plans
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form 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. • 'PEOPLE' Hub and People Operational Delivery Groups (PODs) • Reports and plans as per agreed Committee's work plan • Exception reports for designated sub-groups/Committees i.e. HR Policy Review Group • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and/or Board level Committees
Outputs	• Minutes

	• Action log • Committee Chair's Assurance report to the Board • Annual Report to the Board on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors (as requested) • Report to the Audit Committee on progress against Internal Audit recommendations • Annual Wellbeing Champion Report to Board • Annual Freedom to Speak Up Report to Board • Annual Occupational Health Service Report • Annual Payroll & Pensions Service Report • Bi-annual Doctors Disciplinary Report to Board
Closed Session	On specific occasions it may be necessary for the People Committee to meet in closed sessions (for example where there is a quality or safety issue relating to a specific individual or group). 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 are authorised and requested to appoint deputies or substitutes to act on their behalf when they are unable to attend meetings of the committee. Deputies or substitutes have no voting rights. • Other officers and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair sees fit. • 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). • The Committee will receive items from the Q&S and F&P Committees on matters within the Terms of Reference.
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	MONTH DATE
Review Date	MONTH DATE

Appendix A

Monitoring Compliance with the Terms of Reference for People Committee

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 Committee	Review of agenda items	Trust Secretary	Annually	Board of Directors	People Committee
Reporting arrangements to the Trust Board	Review of Board agenda	Trust Secretary	Annually	Board of Directors	People Committee
Membership, including nominated Deputy	Annual report	Trust Secretary	Annually	Board of Directors	People Committee
Frequency of attendance by Members	Annual report	Trust Secretary	Annually	Board of Directors	People Committee
Reporting arrangements into the higher level committee	Review of Board minutes	Trust Secretary	Annually	Board of Directors	People Committee
Requirements for a quorum	Review of minutes	Trust Secretary	Annually	Board of Directors	People Committee
Frequency of meetings	Review of minutes	Trust Secretary	Annually	Board of Directors	People Committee

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

ISSUE DATE	MONTH DATE
REVIEW DATE	MONTH DATE

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	People Committee	Full review of format **Purpose** Addition of staff communication and engagement **Membership** Additional Non-Executive Director, Chief Operating Officer, Equality & Inclusion Manager and Library & Knowledge Services Manager Amended Deputy Director of Communications & Engagement title Number of Governor Representatives removed **Connectivity** Addition of Medical & Dental Professional Governance Addition of Chief Operating Officer or their deputy providing operational connectivity **Frequency of Meetings** Members required to attend 75% of diarised meetings per year **Duties and Responsibilities** Ensuring statutory and regulatory obligations are met in relation to Equality, Diversity & Inclusion agendas Receive communication and staff engagement reports, including Staff Survey results and action plans Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting **Outputs** Committee Chair's Assurance report to the Board, replaces Exception reports to the Board Removal of Exception Report to Audit Committee Amendments and additions to reports

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Quality and Safety Committee
Terms of Reference

Name	Quality and Safety Committee	
Purpose	The Board of Directors has established a Quality and Safety Committee for the purpose of: a) Advocating an active role in keeping the Trust's services safe b) Seeking assurance on safe and effective clinical governance in the Trust c) Ensuring that the Trust is compliant with relevant national standards and statutory legislation. d) Ensuring continuous quality improvement in patient safety, clinical effectiveness and patient experience, including the wellbeing and safety of Trust employees e) Identifying risks and concerns to be escalated to the Board of Directors in accordance with the agreed assurance and escalation procedure referenced within the Board Assurance and Escalation Framework f) To oversee and scrutinise the implementation of the Trust's Quality Governance Framework	
Basis of Authority	The Board of Directors has provided delegated authority to the Quality and Safety Committee to seek assurance in accordance with this terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.	
Reports to	Trust Board	
Membership	**Members:**	
	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director
	Management Lead	Deputy Chief Executive/Chief Nurse*

	In addition: • Two other Non-Executive Directors • Medical Director* • Chief Operating Officer* **Attendees** Operational Leads as requested: • Deputy Chief Nurse • Director of Quality Governance • Trust Secretary • Workforce Representative *Individuals flagged with * are required to send a deputy in the event of non-attendance.* **Observers** The Committee is open to all Board members to attend as observers Council of Governors' Representatives Any other person with prior permission of the Chair **Invited as required** The Trust Chair may be invited to attend the Committee. Other staff will be invited as required by the Chair of the Committee, in particular for agenda items in relation to safeguarding, infection prevention and control, patient experience, risk management, medicines management, clinical audit. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.
Connectivity	**Group reporting to this Committee** • Quality Council • Risk Management Council **Groups reporting to the Quality Council** • Corporate & Clinical Policy Group • Education Governance • Infection Prevention & Control • Medical Devices • Medicines Management • Patient Safety • Research & Clinical Audit • Resus Council • Safeguarding & Risk Assurance Group – by exception and the Annual Report • Serious Incident Review Panel plus Learning from Deaths • Time to Shine There is an operational link between this Committee and the Finance and Performance Committee and an operational and governance link between this

	Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures. The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.
Frequency of Meetings and Location	Meetings will take place bi-monthly No fewer than five meetings are to be held within a calendar year. Each member is to attend at least 75% of the meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The Quality and Safety Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. 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	The duties and responsibilities of the Quality and Safety Committee are: a) To oversee and scrutinise the effectiveness of the risks escalated in relation to Quality & Safety b) To oversee and scrutinise the effectiveness of the Patient Safety Group via the Quality Council, specifically in relation to serious incidents, patient experience and learning lessons. c) To scrutinise the performance, adequacy and effectiveness of the Trust's clinical governance processes including patient safety, clinical effectiveness and patient experience and compliance with relevant national standards and statutory legislation, by way of receipt of the IQPR and quality indicators. To scrutinise and challenge the quality indications in the IQPR d) To ensure that the Trust scrutinise and benchmark in relation to information by way of available information on quality, safety and patient experience, or other indicators, outcomes of Board visits, serious untoward incidents, complaints, and reports from external bodies. e) Receive and approve clinical audit programme and maintain oversight of the programme. f) Where appropriate, to escalate to the Board themes, trends and risks from Serious Incidents and the Trust's capacity to learn lessons. g) To review and monitor the quality impact of cost improvement plans, via Quality Impact Assessments, to ensure that processes are robust and effective and that risks to quality and safety are understood, considered, mitigated and monitored. h) To refer activities and tasks to appropriate Board level Committees or Executive management as deemed appropriate by the Committee, having due consideration of the remit of those Committees and their work plans i) To receive and accept delegated activities and tasks from the Board or other Board Committees by agreement j) To hold executive directors to account for the quality and safety of the Trust's clinical services and clinical risk management outcomes k) To have oversight and again assurance on the delivery of the Trust's Improvement Plan

	l) Ensure delivery and management of the agreed Committee work plan, building in at least an annual review giving consideration to the work plans of other Board level Committees m) To make recommendations and escalate identified risks to the Board as considered appropriate by the Committee n) To approve and monitor the delivery of strategies in relation to Quality & Safety o) To receive assurance on compliance with NICE guidance p) Have oversight on the delivery in relation to quality and safety related MIAA audits q) To have oversight and be the responsible committee on the Board Assurance Framework for BAFs, 2, 3 and 6. r) To review and monitor Learning from Deaths. s) Receive an annual report on safeguarding for assurance t) Receive Infection Prevention Control assurance reports
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form 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 Committee's work plan • IQPR report • Key policies and documents relevant to clinical quality, safety, effectiveness and patient experience • Quality impact assessments of Cost Improvement Programmes. • Exception reports from designated sub-groups • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and/or Board level Committees
Outputs	• Minutes • Action log • Committee Chair's Assurance reports to the Board • Annual Report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors • Report to the Audit Committee on progress against Internal Audit recommendations
Closed Session	On specific occasions it may be necessary for the Quality and Safety Committee to meet in closed sessions (for example where there is a quality or safety issue relating to a specific individual or group). 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	• Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. Deputies have no voting rights. • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit. • 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	See monitoring table (Appendix A)
Issue Date	Month YEAR
Review Date	Month YEAR

Appendix A

Monitoring Compliance with the Terms of Reference for Quality and Safety Committee

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 Committee	Review of agenda items	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee
Reporting arrangements to the Trust Board	Review of Board agenda	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee
Membership, including nominated Deputy	Annual report	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee
Frequency of attendance by Members	Annual report	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee
Reporting arrangements into the higher level committee	Review of Board minutes	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee
Requirements for a quorum	Review of minutes	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee
Frequency of meetings	Review of minutes	Trust Secretary	Annually	Board of Directors	Quality & Safety Committee

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

ISSUE DATE	Month YEAR
REVIEW DATE	Month YEAR

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Quality & Safety Committee	Full review of format **Connectivity** Operational link between this Committee and the Finance & Performance Committee Addition of the Chief Operating Officer or their deputy as an operational link between Committees **Duties and Responsibilities** Removal of oversight of quality aspects of the safer staffing reports **Frequency of Meetings and Location** Frequency of members attendance specified including reference to 75% of diarised meetings. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting **Inputs** Provision of agenda and supporting papers **Outputs** Addition of assurance in relation to Committee Chair's report to the Board **Appendix A** Monitoring by the Trust Secretary

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

AUDIT COMMITTEE BUSINESS CYCLE 2022/23	ToR Clause	Lead	Action	27 Apr 2022	May 2022 Extraordinary (Draft Annual Report & Accounts review)	Jun 2022 Extraordinary (Final Annual Report & Accounts review)	7 July 2022	27 Oct 2022	Jan 2023
Welcome, Apologies and Previous Meetings									
Apologies	Membership	Chair	Information	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	Membership	Chair	Information	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting	Membership & Inputs	Chair	Information	✔	✔	✔	✔	✔	✔
Action Log	Outputs	Chair	Information	✔			✔	✔	✔
Urgent Items with the agreement of the Chair	Outputs	Chair	Approve	✔			✔	✔	✔
Items for escalation to Board / other Committees	All	Chair	Information	✔	✔	✔	✔	✔	✔
Review of meeting	Other Matters	Committee		✔	✔	✔	✔	✔	✔
Governance									
Review of Committee Terms of Reference	Appendix A	Trust Secretary	Recommend to Board				✔		
Review Committee Business Cycle	Appendix A	Committee	Approve	✔			✔		
Review Board Assurance Framework and Corporate Risk Register	Duties & Responsilbities (D&R) a-d	Trust Secretary	Assurance	✔			✔	✔	✔
Produce Annual Audit Committee report	Outputs	Chair	Approve	✔					
Review of audited annual accounts and financial statements to include the Annual Governance Report	D&R x-z	DOF	Recommend to Board for approval		✔	✔			
Review process for significant transactions (as identified by the Board)	D&R hh	Trust Secretary	Assurance						
Review of Freedom to Speak Up / Raising Concerns (Whistleblowing) policy	D&R b		Assurance						✔
Self-assessment of Committee's effectiveness	D&R ff, gg & Outputs	Trust Secretary	Information						✔
Well-led – monitoring of the Action Plan as requested by the Board		Chair					✔	✔	✔
Annual Report from each Committee to be received by April AC (governance, how many times met, quorate, TOR reviewed, workplan on track etc.)	D&R gg			✔					
Oversight of conducting a market testing exercise for the appointment of internal audit and anti fraud services * *Required every 5 years, Q2 or Q3 - last review in 2021	D&R j, p								
External Audit									
Agreement of External Audit plans and fees (recommendation to Council of Governors) *April - only if needed e.g., for additional fees	D&R q-w	External Audit	Approve	✔ *					✔
External Audit Progress report and sector update	D&R q-w	External Audit	Information	✔			✔	✔	✔
External Auditors Findings Report / ISA260	D&R q-w	External Audit	Recommend to Board		✔	✔			
VFM Risk Assessment		External Audit		✔					
External Auditors Letter of Representation	D&R q-w	External Audit	Recommend to Board			✔			
Annual Review of Effectiveness of External Audit	D&R q-w	Trust Secretary	Information					✔	
Private discussions with External Audit (takes place as required but as a minimum once per year)	D&R q-w	Chair		✔		✔			

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AUDIT COMMITTEE BUSINESS CYCLE 2022/23	ToR Clause	Lead	Action	27 Apr 2022	May 2022 *Extraodinary (Draft Annual Report & Accounts review)*	Jun 2022 *Extraodinary (Final Annual Report & Accounts review)*	7 July 2022	27 Oct 2022	Jan 2023
Internal Audit									
Annual Internal Audit Plan	D&R e	Internal Audit	Approve	✔					✔
Review of Audits with limited or no assurance	D&R f,g	Internal Audit	Approve	✔		✔	✔	✔	✔
Internal Audit Progress Reports and Sector Updates	D&R f,g	Internal Audit	Information	✔			✔	✔	✔
Annual Internal Audit Report and Director of Audit Opinion	D&R e-j	Internal Audit	Approve	✔		✔			
Internal Audit Charter	D&R e-j	Internal Audit	Assurance	✔					
Annual Review of Effectiveness of Internal Audit	D&R i	Trust Secretary	Information						✔
Private discussions with Internal Audit (held as a pre meet as required but a minimum of once per year)	D&R e-j	Chair							✔
Anti-Fraud									
Anti-Fraud Annual Plan	D&R k	Anti-Fraud	Approval	✔					✔
Anti-Fraud Progress Update	D&R l, m	Anti-Fraud	Information	✔			✔	✔	✔
Anti-Fraud Annual Report	D&R l, m	Anti-Fraud	Information	✔					
Annual Review of Effectiveness of Anti-Fraud services	D&R o	Committee	Information					✔	
Private discussions with Anti-Fraud Services (held as required but as a minimum once per year)	D&R k-p	Chair							✔
Registers									
Register of Declarations of Interests for reporting period	D&R q	Trust Secretary	Assurance	✔			✔	✔	✔
Hospitality Register for reporting period	D&R q	Trust Secretary	Assurance	✔			✔	✔	✔
Annual Review of Register of Interests	D&R q	Trust Secretary	Assurance	✔					
Review of losses, write offs and special payments	D&R bb	DOF	Information	✔			✔	✔	✔
Financial Reporting									
Review of annual accounts progress	D&R x	DOF	Information	✔	✔	✔			✔
Review of other reports and policies as appropriate e.g. changes to Standing Orders and Standing Financial Instructions, changes to accounting policies, Standing Order Waiver Reports.	D&R aa-cc	DOF	Information	✔			✔	✔	✔

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FINANCE & PERFORMANCE COMMITTEE BUSINESS CYCLE 2022/23	28 Apr 22 (extra meeting)	19 May 22	21 Jul 22	22 Sep 22	24 Nov 22	Jan 2023	Mar 2023
Welcome, Apologies and Previous Meetings							
Apologies	✔	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	✔	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting		✔	✔	✔	✔	✔	✔
Action Log		✔	✔	✔	✔	✔	✔
Urgent Items with the agreement of the Chair	✔	✔	✔	✔	✔	✔	✔
Finance Report		✔	✔	✔	✔	✔	✔
Contracts Report		✔					
Annual Report and Accounts	✔	✔					
Internal Audit Action Plans		✔	✔	✔	✔	✔	✔
Digital/Information							
Business Continuity Arrangements				✔			
Chair report from DIGIT		✔	✔	✔	✔	✔	✔
Information update report		✔		✔		✔	
National Cost Collection (reference costs)				✔			
Service line reporting (SLR)		✔		✔		✔	
Other items							
Annual budget setting				✔			✔
Board Assurance Framework		✔	✔	✔	✔	✔	✔
Charitable Funds Report				✔			✔
Estates and H&S Report			✔		✔		✔
Estates and H&S Strategy							✔
Green Plan							✔
Green Plan Update (quarterly)			✔		✔		✔
New Business and Divestment Report				✔		✔	
Planning and financial arrangements	✔	✔			✔	✔	✔
Procurement report		✔				✔	

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FINANCE & PERFORMANCE COMMITTEE BUSINESS CYCLE 2022/23	28 Apr 22 (extra meeting)	19 May 22	21 Jul 22	22 Sep 22	24 Nov 22	Jan 2023	Mar 2023
Performance							
Operational Risk Report - finance, IT, procurement, information, estates		✔	✔	✔	✔	✔	✔
Performance Report IQPR		✔	✔	✔	✔	✔	✔
Report from Performance Council		✔	✔	✔	✔	✔	✔
Other Matters							
Annual Review of Terms of Reference and Assessment of Committee Effectiveness			✔				
BAF workplan items not covered elsewhere - as required							
Business cycle			✔				✔
Deep Dives							
Grip and Control Checklist			✔				
Items for escalation to Board and/or Committees	✔	✔	✔	✔	✔	✔	✔
Review of meeting	✔	✔	✔	✔	✔	✔	✔
Strategies							
Digital Strategy							✔

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PEOPLE COMMITTEE BUSINESS CYCLE 2022/23	Lead	11 May 2022	13 Jul 2022	14 Sep 2022	16 Nov 2022	Jan 2023	Mar 2023
Welcome, Apologies and Previous Meetings							
Apologies	Chair	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	Chair	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting	Chair	✔	✔	✔	✔	✔	✔
Action Log	Chair	✔	✔	✔	✔	✔	✔
Urgent Items with the agreement of the Chair	Chair	✔	✔	✔	✔	✔	✔
Delegated matters from Trust Board	Chair	✔	✔	✔	✔	✔	✔
Review of Committee Terms of Reference	Chair		✔				
Review of Committee Business Cycle (with May review)	Chair		✔				✔
Committee Annual Activity Report	DoP&OD						✔
Committee Effectiveness Survey	Chair						✔
Director of People and Organisational Development Report	DoP&OD	✔	✔	✔	✔	✔	✔
Review Board Assurance Framework BAF 5 & 6	DoP&OD/CN	✔	✔	✔	✔	✔	✔
Risk Register: Leadership, Organisational Development and Education	EPDL	✔	✔	✔	✔	✔	✔
Risk Register: HR	HHR	✔	✔	✔	✔	✔	✔
Risk Register: Communications	DDoCE	✔	✔	✔	✔	✔	✔
IQPR: PEOPLE Indicators	DoP&OD/ DDoP&OD/ HoW	✔	✔	✔	✔	✔	✔
Review of the People Strategy: endorsement as per NHS People Plan	DoP&OD	✔	✔	✔	✔	✔	✔
People Strategy and People Plan - People Operational Delivery Plan Report - for assurance	DDoP&OD/ DDoCE	✔		✔			
Medical Appraisal and GMC Revalidation Report *(twice a year)*	MD				✔		
Responsible Officer Annual Report	MD						✔
Chair's Report: Medical & Dental Professional Governance Meeting	MD			✔			
Policies and Procedures Report - as required	HHR	✔	✔	✔	✔	✔	✔
Employee Relations including triangulation with Freedom to Speak Up Report	HHR	✔	✔	✔	✔	✔	✔
National Staff Opinion Survey - Launch Report	DDoCE			✔			
National Staff Opinion Survey - Results Report and Action Plan	DDoCE	✔					✔
Equality, Diversity & Inclusion Strategy: Refresh - for approval	E&IM						✔
Equality, Diversity & Inclusion Objectives and Action Plans Updates	E&IM		✔	✔		✔	✔

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PEOPLE COMMITTEE BUSINESS CYCLE 2022/23	Lead	11 May 2022	13 Jul 2022	14 Sep 2022	16 Nov 2022	Jan 2023	Mar 2023
Equality, Diversity & Inclusion - Regulated reports (as required):							
• Public Sector Equality Duty (PSED) for Workforce and Services Annual Report (for sign off)	E&IM						✔
• Gender Pay Report	E&IM					✔	
• Equality Delivery System 2 - within People Committee Chair's report to Board	E&IM						✔
• Workforce Race Equality Standards (WRES) - within People Committee Chair's report to Board	E&IM		✔				✔
• Workforce Disability Equality Standards (WDES) - within People Committee Chair's report to Board	E&IM		✔				
• Staff Networks Governance Assurance	E&IM					✔	
Facilities Time Off Annual Report	HHR				✔		
Leadership, OD, L&D and Staff Engagment Programmes - updates (as required)	DDoP&OD/ DDoCE						
Knowledge & Library Service Annual Report *(moved to May from March as covers March as well)*	K&LSM	✔					
PDR and Statutory & Mandatory Training Compliance	EPDL	✔	✔	✔	✔	✔	✔
Apprenticeship Scheme and Levy	HoW	✔		✔		✔	
Talent Management & Succession Planning	HoOD		✔		✔		✔
Staff Engagement & Recognition Annual Report - March (with updates)	DDoCE		✔		✔		✔
Communication Update	DDoCE	✔		✔		✔	
Review of Staff Sickness Against Trust Target	HoW	✔	✔	✔	✔	✔	✔
Staffing System Implementation Update	CN/HoW	✔	✔	✔	✔	✔	✔
Delivery of OH Services (annual update, including progress on procurement)	HHR	✔					
Payroll Provider Performance Review (annual update)	DDoP&OD				✔		
Review of SLA Performance for Transactional Training Services	DDoP&OD				✔		
Vaccination Campaign and Numbers - Staff	CN			✔	✔	✔	✔
Freedom to Speak Up Annual Report	CN						✔
Internal Audit Action Plans (Review of MIAA Audits within the remit of People Committee)	DDoP&OD/ DDoCE	✔	✔	✔	✔	✔	✔
Review of Meeting	Chair	✔	✔	✔	✔	✔	✔
Any items for escalation to Board or sharing with other Committees	Chair	✔	✔	✔	✔	✔	✔

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PEOPLE COMMITTEE BUSINESS CYCLE 2022/23	Lead	11 May 2022	13 Jul 2022	14 Sep 2022	16 Nov 2022	Jan 2023	Mar 2023

Key:

CN - Chief Nurse
DDoCE - Deputy Director of Communication & Engagement
DoP&OD - Director of People & Organisational Development
DDoP&OD -Deputy Director of People & Organisational Development
EPDL - EPD Lead
E&IM - Equality & Inclusion Manager
HoOD - Head of Organisational Development
HoW - Head of Workforce
K&LSM - Knowledge & Library Services Manager
MD - Medical Director

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QUALITY & SAFETY COMMITTEE BUSINESS CYCLE 2022/23	21 Apr 2022	23 Jun 2022	18 Aug 2022	19 Oct 2022	21 Dec 2022	Feb 2023
Welcome, Apologies and Previous Meetings						
Apologies	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting	✔	✔	✔	✔	✔	✔
Action Log	✔	✔	✔	✔	✔	✔
Urgent Items with the agreement of the Chair	✔	✔	✔	✔	✔	✔
Duties and Responsibilities						
BAF 2, 3 & 6	✔	✔	✔	✔	✔	✔
Clinical Audit Plan Assurance		✔			✔	
Infection Prevention & Control Assurance	✔		✔		✔	
IQPR	✔	✔	✔	✔	✔	✔
Learning from Deaths Monitoring	✔	✔		✔		✔
Improvement Plans: Paediatric, Dermatology, Dental, Children's Transformation	✔	✔	✔	✔	✔	✔
QIA Report		✔		✔		✔
Quality Accounts - draft and final	✔	✔				
Quality Council Report, including Effectiveness of Patient Safety Group and NICE Guidance Compliance	✔	✔	✔	✔	✔	✔
Quality Priorities			✔			✔
Quality, Safety and Patient Experience	✔		✔		✔	
Review of MIAA Audits within the remit of Q&S Committee	✔	✔	✔	✔	✔	✔
Risk Management Council Report	✔	✔	✔	✔	✔	✔
Safeguarding Annual Report			✔			
Serious Incidents Oversight	✔	✔	✔	✔	✔	✔
Terms of Reference Review		✔				
Trust Improvement Plan		✔		✔		✔
Deep Dive Programme						
Pressure Ulcers		✔				
TBC						

Strategy Approval and Review Programme						
Carers Strategy		✔			✔	
Children's Strategy						✔
End of Life Strategy				✔		
Infection Prevention & Control Strategy	✔		✔			
Research & Development Strategy	✔					
Risk Management Strategy			✔			✔
Safeguarding Strategy						✔
Corporate Governance						
Assessment of Committee Effectiveness	✔	✔	✔	✔	✔	✔
Committee Effectiveness Review - annual						✔
Committee Business Cycle Review - six monthly		✔			✔	✔
Items for Escalation to other Committees or Board	✔	✔	✔	✔	✔	✔

Items referred from other Commitees

Item
Date
Details