Bridgewater Community Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING

Thursday 8 December 2022, 10am

Lancashire County Cricket Club, Emirates Old Trafford, Talbot Road, Manchester, M16 0PX

AGENDA

Ref	Time	Item Title	BAF Ref	Action
79/22	10.00	Apologies for Absence Declarations of Interest in items on the agenda		Information Assurance
80/22 Page 3	10.00	Minutes of the last meeting: (i) Board meeting held 6 October 2022		Assurance/ Approval
81/22 Page 11	10.05	Matters Arising from the Action Log		Assurance
82/22	10.10	Any urgent items to be taken at the discretion of the Chair		
83/22	10.10	Patient Story – Special Care Dental GA Service		Information
84/22 Page 19	10.30	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs		Assurance/ Approval
85/22 Page 35	10.45	Key Corporate Messages		Information
QUALITY: to deliver high quality, safe and effective care which meets both individual and community needs				
86/22 (ii) Page 40	11.00	(i) IQPR – presented by Executive Leads *(please see separate document)* (ii) Report from the Quality and Safety Committee held on 19 October 2022 – presented by the Committee Chair	ALL 2,3,6	Assurance Assurance
BREAK				
SUSTAINABILITY: to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability				
87/22 (i) Page 51 (ii) Page 57	11.40	(i) Finance Report – presented by the Director of Finance (ii) Report from the Finance and Performance Committee held on 24 November 2022 – presented by the Committee Chair	4 4,7,8	Assurance Assurance

(ii) Page 64		(iii) Report from the Audit Committee held on 21 October 2022 – presented by the Deputy Committee Chair	1, 4	Assurance
INNOVATION AND COLLABORATION: to deliver innovative and integrated care closer to home which supports and improves health, well-being and independent living				
88/22 (i) Page 68 (ii) Page 74	12.15	(i) Integration and Collaboration Update including Children's Services Transformation – presented by the Programme Director of Integration and Collaboration (ii) Update on Provider Collaboratives – presented by the Programme Director of Integration and Collaboration	3-8 7	Information Information
EQUALITY, DIVERSITY AND INCLUSION: to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive				
89/22 Page 84	12.40	(i) Anti-discrimination report – presented by the Director of People and Organisational Development	2,5,6	Assurance
PEOPLE: to be a highly effective organisation with empowered, highly skilled and competent staff				
90/22 Page 115	12.55	(i) Report from the People Committee held on 16 November 2022 - presented by the Committee Chair	5,6	Assurance
OVERARCHING CORPORATE GOVERNANCE ITEMS				
91/22 (i) Page 146 (ii) Page 156	1.10	(i) Accountability Framework (part II) – presented by the Trust Secretary (ii) Covid-19 Public Inquiry – presented by the Trust Secretary	1 1	Approval Assurance
92/22	1.30	Review of meeting and Items to be added to the Board Assurance Framework		Information
93/22	1.35	Opportunity for questions to the Board from Staff, Media or Members of the Public at the discretion of the Chair		Information

DATE & TIME OF NEXT MEETING

Thursday 2 February 2023, 10am in person meeting. Venue details to be provided

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 6 October 2022, 10am
Veep Lounge, Halliwell Jones Stadium, Warrington

Present
Karen Bliss, Chair
Colin Scales, Chief Executive
Gail Briers, Non-Executive Director
Sarah Brennan, Chief Operating Officer
Nick Gallagher, Director of Finance
Abdul Siddique, Non-Executive Director (from item 70/22)
Martyn Taylor, Non-Executive Director
Tina Wilkins, Non-Executive Director
Sally Yeoman, Non-Executive Director
Lynne Carter, Chief Nurse

In Attendance
Rob Foster, Programme Director of Integration and Collaboration
Mike Baker, Deputy Director of Communications and Engagement
Andi Sizer, Principal Lead for Public Health (from item 75/22)
Rebecca Emery, Clinical Specialist for Paediatric Physiotherapy and Team Lead, Warrington Paediatric Occupational Therapy and Physiotherapy Service (for item 70/22 only)
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

Observers/members of the Public
Christine Stankus, Lead Governor

66/22 (i) APOLOGIES FOR ABSENCE
Aruna Hodgson, Medical Director
Ted Adams, Medical Director
Linda Chivers, Non-Executive Director
Paula Woods, Director of People and Organisational Development

ii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made.

67/22 MINUTES OF THE LAST MEETING HELD ON 4 AUGUST 2022

Typographical error on page five to be corrected.
The remainder of the minutes were approved as an accurate record.

68/22 MATTERS ARISING FROM THE ACTION LOG

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

55/22 Board Assurance Framework (action one)

The Board agreed that a session to review the Board Assurance Framework with external support would be scheduled following the completion of strategy work in April 2023.

58/22i Finance Report (outstanding debt)

The Director of Finance confirmed that this matter was being progressed and an update was provided within the finance report which was included on the agenda.

58/22iv Financial Impact of Pay Award

The Director of Finance advised that further information was awaited from the ICS concerning non-NHS funding streams for local authority staff. **The Finance and Performance Committee would monitor this matter going forwards and the Board agreed that this action could be transferred to the Finance and Performance Committee action log.**

The following green rated items were completed and would be rated as blue:
61/22iii Board and Committee Business Cycles
61/22iv Board and Committee Terms of Reference
62/22 Review of meeting/items to be added to the Board Assurance Framework

It was agreed that the following items were completed and could be removed from the action log:
25/22iii Board Effectiveness Review
34/22 Board Assurance Framework
36/22ii IQPR
55/22 Board Assurance Framework (action two)
56/22 Key Corporate Messages

69/22 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.

70/22 SPOTLIGHT ON SERVICES – WARRINGTON PAEDIATRIC PHYSIOTHERAPY SERVICE

The Board welcomed Rebecca Emery, Clinical Specialist for Paediatric Physiotherapy and Team Lead, Warrington Paediatric Occupational Therapy and Physiotherapy Service along with Elspeth, a patient of the service and her mother. The patient had a diagnosis of Spinal Muscular Atrophy, a degenerative neuromuscular condition. She was initially assessed by the Paediatric Physiotherapy service in May 2015. Elspeth and her mum shared what they had found positive about their experiences with the service: this included the attitude of staff who they had found to be nice and kind, professional and knowledgeable, working at the right pace with an understanding of what was working for Elspeth and working with her as an individual. In terms of what they would like to improve, Elspeth explained that there could be too long a time between reviews for Elspeth as she could sometimes experience some changes between those reviews, such as sore hips, and she would also like to have regular

reviews for her equipment. Her mum commented that the frequency of reviews and availability of staff could vary and that there was some disparity across the other Trusts that helped to look after Elspeth where they were structured in different ways. She highlighted that Elspeth was still growing and so there was a need for her equipment to be reviewed regularly as she grew. She also highlighted that having one regular member of staff to see Elspeth was beneficial and highlighted that support from one Occupational Therapist on a regular basis provided good consistency. She also advised that increased communication between the different services, including Elspeth's school could be beneficial, as there had been some disparity in the past between them.

They explained the different ways that Elspeth was involved in the decisions about her care and treatment: this included Elspeth being actively involved in her treatment decisions, programmes including sleep and physiotherapy and ensuring that Elspeth was informed about clinical matters that affected her, such as some recent surgery that she had undergone. She was then able to be involved in decision making, understand the reasons behind her treatment and what to expect which helped to allay anxieties. She described her experiences of attending appointments where staff would talk to her mum rather than to herself about her care. Elspeth felt that it was important for staff to talk to children at their appointments to help them understand what is happening with their treatment and for them to be involved in the decision making. She also suggested that letters from services could be addressed to the child to detail what will happen at the next appointment and information such as who will be there.

Elspeth and her mum shared improvements that they would like the Trust to consider: including a patient handbook, explanation of services and the patient journey, and a co-ordinator of patient care. In addition, they suggested that patients be kept up to date on any service changes and impacts upon families i.e., where teams were renamed or a change in contact details.

The Board agreed that the Chief Nurse would progress the suggested improvements by Elspeth: Improving communications to support children as patients to help them understand what would happen at appointments and to help them be involved in decision making/consent with their care. It was suggested that letters could also be addressed to the child. Consistency in terms of the members of staff supporting patients to be considered. A suggestion was made that videos could be produced to inform patients on different aspects of their care such as what would happen at appointments and those could be uploaded on to platforms such as YouTube. Consideration to be given around timing/frequency of reviews i.e., for changes in conditions between set review times/where children were outgrowing equipment/experiencing changes in their conditions.

The Deputy Director of Communications invited Non-Executive Director, Tina Wilkins to attend an upcoming meeting regarding the Voice of the Child following her expressing her interest in this work.

The Board thanked Rebecca Emery, Elspeth and her mum for their attendance and valuable insights and input at the Board today and would write to Elspeth following today's meeting to invite her to continue to provide important input in the future.

71/22 BOARD ASSURANCE FRAMEWORK

The Trust Secretary presented a report which set out the recommended updates from the Committees of the Board to update the Board Assurance Framework.

She particularly highlighted a recommended change to BAF5: As the People Committee had not met since the last Board there had not been any opportunity for it to review this section of the Board Assurance Framework. Therefore the Executive Management Team recommend the following additions to be made: 'Principal risk: Trade Union Ballots and strike action on the 2022/23 pay deal', and 'Assurances, legislative strike framework, legal timeframes and business continuity plans'.

The Board noted the recommended updates and agreed to the above additions to be made to BAF5.

72/22 KEY CORPORATE MESSAGES

The Chief Executive presented the report which detailed Non-Executive and Executive Director activity since the last Board meeting, Board sessions and events that had taken place, director's feedback from time to talk sessions and links and information related to external publications and reports. The Board received the report for note.

73/22 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 across operations, quality, people and finance.

The Chief Operating Officer reported that there were eight red rated indicators and 11 green rated indicators for month four. The Board noted that significant work had been undertaken to reduce very long waiting times (104 weeks) across the Trust, however there was still further work in train, recognising the operational team efforts and work, 30 weeks was still a considerably long time for patients to wait for an appointment and a focus must be retained on reducing waits further post-Covid. It was recognised that the 18 weeks target should be the absolute maximum wait time, rather than being a target in itself, and that patients should be seen by services within this time recognising clinical consequences of conditions worsening where patients were not being seen within an appropriate time frame.

The Board received the report for assurance. It was noted that work was being undertaken to further develop the IQPR indicators by the Chief Operating Officer with an update report to be presented to the November meeting of the Finance and Performance Committee.

Following a suggestion from the Chair **it was agreed that a proposal would be made for People indicators to be reconsidered/broadened out within the IQPR to include measurement of key areas such as the Trust's Just and Learning Culture journey and the key work and impacts of the People Operational Delivery (PODs) groups.**

(ii) Report from the Quality and Safety Committee held on 18 August 2022

The Board received a report for assurance from Non-Executive Director and Committee Chair, Gail Briers.

Concerning a number of policies that remained out of date, the Chief Executive asked when this would be addressed. The Chief Nurse confirmed that a trajectory was in place to address this by the end of the calendar year. The Quality and Safety Committee would be kept updated on progress via the Quality Council.

A discussion took place concerning Learning from Deaths reporting requirements into the Board which had been raised at the Quality and Safety Committee. Non-Executive Director, Gail Briers advised that whilst reports could be taken through the Quality and Safety Committee, there was a requirement for reports to be presented to the Board. **It was agreed that Learning from Deaths reporting would be added to the Board business cycle to be presented to the public Board meeting on a quarterly basis.**

(iii) Emergency Preparedness, Resilience and Response (EPRR) Annual Report

The Chief Operating Officer presented the report and confirmed that following a self-assessment exercise, the Trust was compliant against 46 of 55 standards across 10 domains.

She reported that there were nine areas of partial compliance and work was ongoing to resolve those elements. The Trust was therefore declaring a current 84% compliance rate. She advised that work would continue to address outstanding elements. The EPRR Plan would be submitted at the end of October. The Board noted that the current position was in line with that of many other NHS organisations and that this was an honest but positive reflection.

The Board agreed that if compliance could be declared against any of the partially compliant nine areas following further work that was in train, that the EPRR and compliance level would be updated. **The document would be reviewed again by the Audit Committee later in October and would subsequently be recommended to the Board via e-governance.**

(iv) Winter Plan 2022/23

The Board received and welcomed the winter plan, acknowledging that this winter would be a significantly challenged period for the Trust and the wider NHS nationally. The Chief Operating Officer advised that the plan in place was robust and that she was confident that the Trust would be able to manage challenges via the arrangements in place.

Non-Executive Director, Sally Yeoman asked whether the Trust would be exploring work with the voluntary sector and any existing schemes recognising that those agencies and the Trust would be working with same people. The Chief Operating Officer advised that this was being explored with work underway to connect resources in Warrington and similar work would take place in Halton. Non-Executive Director, Gail Briers commented that the plan was well-written, but that the confidence in place around the plan should be balanced with the staff who had been recruited/were available as she recognised that there would be challenges. The Chief Operating Officer advised that transformation work was being undertaken within to review key elements such as skill mix. She commented that the Trust was reviewing how it could connect services effectively internally, utilising skill mixing and ensuring it was maximising the knowledge and benefits from its more experienced senior nursing staff.

The Chief Executive asked that staff health and wellbeing be a prominent aspect of the final plan, recognising the pressures that the winter would present alongside other contributing factors such as vacancies and the current cost of living crisis.

(v) Delivery of the Staff Vaccination Programme 2022/23

The Chief Nurse reported that the Trust staff flu and Covid-19 booster programme would be taking place over one week in October 2022, with a further programme over one week in November 2022. The Board received this update for note.

(vi) Safeguarding Annual Reports 2021/22

The Board received the safeguarding reports for information only and noted that the reports had been taken to the August 2022 meeting of the Quality and Safety Committee.

74/22 SUSTAINABILITY -– to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability

(i) Finance Report – month five

The Board received the report for month five presented by the Director of Finance. A discussion took place concerning the use of agency staffing across the Trust. Formal approval was awaited of an agency cap which was expected to be in line with original plans. Work was being undertaken by the Finance Team to understand granular information concerning the exact number of vacancies in the organisation, where agency staff were in place and where there were plans to recruit to those posts. It was noted that the Trust's

recovery and restoration work had a reliance on agency support, some of which had been agreed with commissioners, to reduce waiting times. It would therefore be important to have an accurate picture of the Trust's position to present in the future if this was required.

The Trust was forecasting a break-even position, with the Cost Improvement Programmes (CIP) on track and work continuing to reduce aged debts.

(ii) Report from the Finance and Performance Committee held on 22 September 2022

The Board received a report for assurance from the November meeting of the Finance and Performance Committee from Non-Executive Director and Committee Chair, Tina Wilkins.

75/22 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 Board received an update on integration and collaboration development and opportunities across the Trust. This included an ICS update, work on renewing the Trust strategy; the Quality and Place Strategy for 2023, an update on BOOST (Building on our Strengths Together): a service-led transformation programme, designed to deliver real change and improve patient care and staff morale and transformation governance and engagement. From October 2022, a new Transformation Group would be established, and input would be required as part of this including from the Trust's Governors.

It was agreed that the Chief Nurse would liaise with the Programme Director of Integration and Collaboration to review information being shared with staff concerning transformation; ensuring that this is clear and demonstrating links to existing processes and resources with information being provided in a schematic. The Principal Lead for Public Health would also provide input concerning public health and health inequalities. The Council of Governors would also be invited to select a volunteer to input into the transformation group.

(ii) Update on Community Health and Wellbeing Workers Project

The Board received a report for information from the Programme Director for Innovation and Collaboration providing an update on the Community Health and Well-Being Worker (CHWs) Project. He reported that the pilot was being trialled in three locations across the UK: Birchwood, Warrington, Westminster, London, and Calderdale, West Yorkshire. The Trust had established an operational group and two Community Health and Well-Being Workers had been recruited. A Project Lead had also been recruited and would commence in post on 3 October 2022 and this appointment would ensure traction with the pilot in the community in Birchwood. The pilot would report into the Cheshire and Merseyside People Board (CMPB).

(iii) Cheshire and Merseyside Prevention Pledge

The Board agreed to adopt the Cheshire and Merseyside Prevention Pledge as a cohort three member. The adoption of the Pledge was a requirement of the Cheshire and Merseyside Anchor Institution Charter and this would enable the Trust to collate and present its actions and commitments on prevention, inequalities, and social value. **It was agreed that a named Non-Executive Director would be agreed as part of Board level sponsorship/support for the Pledge. The Chair would discuss this with Non-Executive Directors at their next meeting.**

76/22 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) People and Organisational Development Committee Arrangements for September 2022

Non-Executive Director and Committee Chair, Abdul Siddique informed the Board that the People Committee meeting had not taken place during September 2022 as planned: the planned meeting had been stood down on 14 September as this was during the period of national mourning and was then rescheduled to 26 September, however that meeting was then unable to take place as it was not quorate.

The business of the Committee would be brought forward to the next meeting in November 2022 and a copy of the September agenda and the business that would have been transacted was appended to the circulated report.

Non-Executive Director, Abdul Siddique highlighted that due to the standing down of the meeting on 26 September, the Medical Appraisal and General Medical Council Revalidation Report was approved by the Committee members via e-governance and a copy of this was also appended to the circulated report for the Board's final review and approval. The Board approved this report.

(ii) People Plan Update

The Board received a high-level update concerning the progress of the People Operational Delivery (POD) Groups, underpinned by the NHS People Plan, People Promises and Trust People Strategy.

77/22 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Annual Report from the Senior Risk Information Officer

The Board received the annual report and noted that the Trust was compliant against all required standards and there were no areas of concern to be raised.

(ii) Accountability Framework/Devolved Autonomy

The Trust Secretary presented the first part of the accountability framework and explained that this described the Board's responsibilities. The personal objectives for each of the directors had been included which they would be held to account for. The Trust Secretary advised that a second part of the framework would be presented to the Board and this would set out responsibilities and accountabilities for the senior leadership team and directorate leadership teams and governance arrangements. The Board approved the first part of the framework. This would also be taken to the Council of Governors in October for information and oversight.

(iii) Corporate Calendar 2023/24

The Board approved the corporate calendar for 2023/24. It was clarified that the date for the Finance and Performance Committee's January 2023 meeting would be Thursday 19 January.

78/22 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

Non-Executive Director, Martyn Taylor commented that the focus on dental services could be increased within reports across the Board agenda. The Chief Operating Officer advised that this was being reviewed and that a spotlight on services would be scheduled to take place with dental services at a future Board. The Board would also be updated on the dental strategy at a future session with a presentation that would take place from the dental staff. The Lead Governor added that some of the Trust Governors would be visiting dental services based in Middleton during November 2022.

79/22 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.

DATE AND TIME OF NEXT MEETING

Thursday 8 December 2022, 10am. Meeting to take place in person with venue details to be confirmed.

MOTION TO EXCLUDE

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

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

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
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 October 2022**	Item considered by the Quality and Safety Committee in October 2022: The Committee agreed that the Trust had all the necessary policies and procedures in place around Ockenden requirements and it could provide this assurance to the Board. Further detail included within the Committee Chair's report to the Board on the agenda.
04.08.22	55/22	Board Assurance Framework	**Board session to review the BAF to be scheduled with support from GGI. Any further work following the development of an ICS BAF would be considered subsequently.**	Jan McCartney	**GREEN April 2023**	Now part of the Board Development programme
04.08.22	58/22i	Finance Report	**Deputy Director of Finance to ensure that the outstanding debt owed to the Trust by Oldham Council was being successfully progressed via internal process and whether it was appropriate for a CEO to CEO conversation to take place.**	Rachel Hurst	**BLUE**	October 2022: The Director of Finance confirmed that this matter was being progressed and would be taken through the Finance and Performance Committee.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
04.08.22	58/22iv	Financial Impact of Pay Award	**Board to be kept sighted on this matter via the Finance and Performance Committee Chair reports to the Board – a section would be included within the finance report to the Committee concerning the pay award. Discussions would need to take place with the local authorities concerning health staff who also undertook work commissioned by local government.**	Rachel Hurst /Nick Gallagher	**BLUE**	October 2022: The Board agreed that this action would be transferred to the Finance and Performance Committee action log and would be removed from the Board action log – the Board would be kept updated via the Finance and Performance Committee Chair's report.
04.08.22	61/22iii	Board Committee Business Cycles	**Series of amendments to be made as agreed. Committees to review the amendments as required.**	Jan McCartney	**BLUE**	Complete
04.08.22	61/22iv	Board Committee Terms of Reference	**Amendment to be made as agreed.**	Jan McCartney	**BLUE**	Complete

ACTION LOG

Key

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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
04.08.22	62/22	Review of meeting/items to be added to the Board Assurance Framework	**Scoring to be reduced as recommended for BAF1.**	Jan McCartney	**BLUE**	Complete
06.10.22	70/22	Patient Story	**The Chief Nurse to take forward suggested improvements: Improving communications so that could be understood by children as patients to help them understand what would happen at appointments and to help them be involved in decision making/consent with their care. Consistency in terms of staff supporting patients to be considered Videos to inform patients on different aspects of the care/what would happen at appointments Consideration around timing of reviews i.e. for changes in conditions between set review times/where children were outgrowing equipment**	Lynne Carter	**GREEN**	Actions being addressed via Children's Service Transformation delivery. Includes patient feedback and Voice of the Child.

ACTION LOG

Key

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Amber	**Slightly Delayed and / or of Low Risk**
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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
06.10.22	70/22	Patient Story	**Letter to be sent to patient and family to thank them for their attendance at Board and valuable input and feedback**	Jan McCartney	**BLUE**	Letter has been sent to patient and her family.

ACTION LOG

Key

Red	**Significantly Delayed and / or of High Risk**
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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
06.10.22	73/22i	IQPR	**Proposal made for People indicators to be reconsidered/broadened out to include aspects/measure key people areas such as the Trust's Just and Learning Culture journey and the key work and impacts of the People Operational Delivery (PODs) groups.**	Sarah Brennan/Paula Woods	**GREEN**	**18th October 2022:** A meeting took place with Tina Wilkins to discuss JC metrics (Paula Woods, Lynne Carter, Jo Waldron and Ros Connolly). These will be included in the ER/FTSU report that is a standing item at the People Committee. Turnover rates were discussed at the meeting, along with the further analysis being done with regards to staff reasons for leaving the Trust. The PODs are looking at the People Indicators as per the IQPR to benchmark the targets in operation at other Trusts. The work will be fed into the People Committee with recommendations to proceed to Board etc. IQPR continues to be a dynamic process and will be considered at Board Development session 1 December

ACTION LOG

Key

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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
06.10.22	73/22ii	Quality and Safety Committee Chair report	**Learning from Deaths report to be added to the Board business cycle to be presented to the public Board meeting on a quarterly basis.**	Jan McCartney	**BLUE**	Item has been added to the Board business cycle.
06.10.22	73/22iii	EPRR	**It was agreed that if compliance could be declared against any of the partially compliant nine areas following further work that was in train prior to submission of the EPRR, the compliance level would be updated. The document would be reviewed by the Audit Committee later in October and would subsequently be recommended to the Board via e-governance.**	Sarah Brennan	**BLUE**	October 2022: The Audit Committee received an update on compliance: the Trust was now fully compliant with 49 of 55 standards, demonstrating an improvement since it was considered by the Board. There was a good level of confidence around being able to meet the outstanding six areas of partial compliance in relation to business continuity which would be addressed in the coming months, The Audit Committee agreed that the EPRR could now be circulated to the Board for final approval via e-governance – this has now been completed.

ACTION LOG

Key

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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
06.10.22	73/22iv	Winter Plan 2022/23	**It was agreed that staff health and wellbeing should be a prominent aspect of the final plan, recognising the pressures that the winter would present alongside other contributing factors such as vacancies and the current cost of living crisis.**	Sarah Brennan	**BLUE**	Information now included in the winter plan.
06.10.22	75/22i	Integration and Collaboration report	**Chief Nurse to liaise with the Programme Director of Integration and Collaboration to review information being shared with staff concerning transformation; ensuring that this is clear and demonstrating links to existing processes and resources with information being provided in a schematic. Principal Lead for Public Health to also provide input concerning public health and health inequalities.**	Rob Foster/Lynne Carter	**BLUE**	Update in Integrated Care paper on agenda, including reference to Boost as part of the transformation plan
06.10.22	75/22i	Integration and Collaboration report	**Council of Governors to be asked to nominate a volunteer to input into the transformation group**	Jan McCartney	**BLUE**	Volunteer Governor has been selected.

ACTION LOG

Key

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Amber	**Slightly Delayed and / or of Low Risk**
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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
06.10.22	75/22iii	Cheshire and Merseyside Prevention Pledge	**Named Non-Executive Director to be identified**	Karen Bliss/Jan McCartney	**GREEN**	Verbal update to be provided by the Chair.

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08/12/2022**
Agenda Item	**84/22**		
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	08/12/2022
Agenda Item	84/22		
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 the 21 October 2022 and asked for the following effectiveness reviews be added under assurance;

a. Annual Review of Effectiveness of Anti-Fraud Service, and

b. Annual Review of Effectiveness of External Audit Service

No further changes were recommended, the risk remains at target.

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

The Quality & Safety Committee met on 19 October 2022. It is recommended that;

a) Winter Plans be added to prevent controls, and

b) The Ockenden Report received at Committee be added for assurance.

No further changes were recommended, the risk remains the same.

2.3 BAF3 – Managing demand and capacity

The Quality & Safety Committee met on the 19 October 2022. It is recommended that;

a) The Winter Plan is added to the Prevent Controls, and

b) Emergency Preparedness Resilience and Response (EPRR) plans and Quality Summits are added to the Assurance section.

No further changes were recommended, the risk remains the same.

2.4 BAF4 – Financial sustainability

The Finance & Performance Committee met on 24 November 2022 where the Committee did not make any changes to the document but after a lengthy discussion decided to keep the current risk rating which is 12, high.

The Committee reflected on the fact that the Trust is about to enter a challenging winter period with sickness rising alongside the potential threat of industrial action and power outages. They also recognised the current pressures on services throughout the NHS and the financial impact thereof, along with the potential restrictions and controls if the ICS submits a revised forecast outturn for the system.

2.5 BAF5 - Staff engagement and morale

The People Committee met on 16 November where the following updates where recommended:

a) Principle Risk – updated to reflect the reality of industrial action,
b) Prevent Controls – updated to include the industrial action working groups and national negotiations
c) Gaps in Controls – add Cap on agency costs

Due to the above changes, specifically in relation to industrial action, the Committee recommended an increase in likelihood which would bring the current risk rating to 4 x 4=16, significant.

2.6 BAF6 – Staffing levels

The Quality & Safety Committee met on the 19 October 2022, when it recommended that workforce review is added to the assurance section.

The People Committee met on 16 November when the following changes were recommended:

a) Rationale for current score – updated to show consideration of competing with local employers
b) Prevent Controls – updated to remove command and control structure and redeployment plans
c) Assurances – workforce plans added
d) Gaps in control – Sickness absence, exit interviews, BAME representation and impact of covid removed. Winter plans being refreshed was added

Neither Committee recommended a change in the current risk rating.

2.6 BAF7 – Strategy and organisational sustainability

The Finance & Performance Committee met on 24 November 2022 and asked for the work the CEO conducts within Cheshire & Mersey be reflected as an Assurance.

2.7 BAF8 – Digital Services

The Finance & Performance Committee met on 24 November 2022 and recommended that the Gaps in Control section is updated to reflect that there is a risk to delivery of the digital strategy due to the digital team working at capacity and as such work is required to ensure delivery of the strategy.

3. RECOMMENDATION

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

Board Assurance Framework (BAF) December 2022 – V0.1 – for 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 ASSURANCE FRAMEWORK

LAST UPDATED 24 November 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 4 (L) = 16, **significant** 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 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 2 (L) = 8, **medium**

Board Assurance Framework (BAF) December 2022 – V0.1 – for Board

BAF 1: **Failure to implement and maintain sound systems of Corporate Governance**	**TRUST OBJECTIVES:** • People • Sustainability	**RISK RATING:** 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**	**RISK APPETITE:** **CAUTIOUS**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Chief Executive Officer Deputy CEO / Chief Nurse Last reviewed: October 2022 Audit Committee Last reviewed: October 2022 Risk Ratings reviewed: October 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 Ops leads, these are reported to the Board • Staff engagement • Performance Council established • Senior Leadership Team meeting monthly • Risk Management Council • 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 • Declarations of Interests Register • MIAA governance checklists • Annual Review of Effectiveness of Anti-Fraud Service • Annual Review of Effectiveness of External Audit Service • 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) December 2022 – V0.1 – for 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: October 2022 Quality & Safety Committee Last reviewed: October 2022 Risk Ratings reviewed: October 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** 3031 : Dermatology – delays in results	Quality & safety governance structure in place. Robust QIA process for all services Number of ongoing high risks	**Prevent Controls** • 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 • Winter Plan **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 • Deep Dives at Committee • Ockenden Report to Committee **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) December 2022 – V0.1 – for 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: October 2022 Quality & Safety Committee last reviewed: October 2022 Risk Ratings reviewed: October 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** 3031 : Dermatology – delays in results	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 • Contract meetings with commissioners & 1:1 meeting with commissioners • Daily system pressure calls • Workforce Strategy in place / Workforce POD **Assurances** • Audits monitored at each relevant Board Committee, exception reports to Audit Committee • Performance Council • Deep dives at Committee • Winter Plans • Emergency Preparedness, Resilience and Response Plans (EPPR) • Quality Summits 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) December 2022 – V0.1 – for Board

BAF 4: Financial sustainability	**TRUST OBJECTIVES:** • Sustainability	**RISK RATING:** Inherent risk rating: 4 (C) x 4(L) = 16, **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: November 2022 Finance & Performance Committee last reviewed: November 2022 Risk Ratings reviewed: November 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 may result in a deficit for 2022/23 and the potential loss of public and stakeholder confidence. **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 breakeven 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) December 2022 – V0.1 – for 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 4(L) = 16, **significant** 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: November 2022 People Committee Last reviewed: November 2022 Risk Ratings reviewed: November 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, system incentives and the certainty of union strike ballots in relation to 22/23 pay deal. 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 • Industrial Action working group, national negotiations **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 • The Employee Relations Activity Report • Staff Survey – sustained score for staff engagement • Temporary increase in milage payments • Assurances: Legislative strike frameworks, legal timeframes, and Trust business continuity plans. **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 and mandatory training (to remain until processes embedded)
Staff morale and resilience (inc. cost of living crisis) – ongoing monitoring, communication, engagement and health and wellbeing services and programmes
Cap on agency costs

Board Assurance Framework (BAF) December 2022 – V0.1 – for Board

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

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Chief Operating Officer Last review: October 2022 Quality & Safety Committee Last review: October 2022 People Committee: November 2022 Risk Ratings reviewed: October 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. With consideration to local employment opportunities and competing with local employers.	**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 • People Strategy & People Delivery Plan • HR Policies and working groups • 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 • Daily Ops Huddles x 3 per week • 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 • Workforce plans developed by service to support recruitment **Audits – Substantial Assurance** Induction audit (2020/21) Attendance Management (2019/20
Gaps in controls and assurance: (and mitigating actions) Winter plan being refreshed – awaiting National Guidance			

Board Assurance Framework (BAF) December 2022 – V0.1 – for 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: November 2022 Executive Team July 2022 F&P Committee Last reviewed: November 2022 Risk Ratings reviewed: November 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** • Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, 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 • CEO is SRO for Workforce and Chair of the Cheshire & Mersey People Board • CEO is SRO for virtual wards and the Chair of the Virtual Ward Programme Board
Gaps in controls and assurance: (and mitigating actions) Implementation of revised system governance arrangements, to be finalised			

Board Assurance Framework (BAF) December 2022 – V0.1 – for Board

BAF 8: **Digital services which do not meet demands of the organisation**	**TRUST OBJECTIVES:** • Innovation and collaboration • People • Quality • Sustainability • Equality, diversity & inclusion	**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 2 (L) = 8, **medium**	**RISK APPETITE:** **SEEK**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Director of Finance Last reviewed: November 2022 F&P Committee Last reviewed: November 2022 Risk Ratings reviewed: November 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 – work ongoing to review current structures to ensure timely delivery. Teams working at capacity, and the delivery of strategy may require additional resource.
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

Board Assurance Framework (BAF) December 2022 – V0.1 – for Board

Appendix I: Risk grading criteria

	Consequence score & descriptor with examples				
Risk type	**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. +

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 December 2022**
Agenda Item	**85/22**		
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**

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**	☐ **EMT**

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

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 December 2022**
Agenda Item	**85/22**		
Report Title	**KEY CORPORATE MESSAGES**		
Report Author	Jan McCartney		
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 visited the North West Driving Assessment Centre on 10 October.

Karen attended a number of meetings, as follows:

- Cheshire & Merseyside Chairs' meeting on 18 October.
- North West Chairs & CEO call on 25 October and 22 November.
- 1-1 meeting with the Chair of Warrington & Halton Hospitals NHS Trust on 22 November.
- Race Inclusion Network meeting on 22 November.
- NED shortlisting meeting on 22 November.

On 19 October, Karen met with the ICB Chair and the ICB Transformation Director to discuss Public Engagement.

Karen accompanied the Chief Executive on the Time to Talk session with the OPAT team based at Bath Street Health & Wellbeing Centre, Warrington and the Exec Engagement session with the Dental team based at Seymour Grove.

On 15 November, Karen attended Day 1 of the NHS Providers' Annual Conference and on 18 November attended a webinar hosted by the Good Governance Institute "Realising untapped value from Community Trusts".

1.2 Non-Executive Director, Linda Chivers attended the Rest of England Governors meeting and the monthly MIAA meeting in September.

1.3 Non-Executive Director, Tina Wilkins attended the Voice of a Child meeting on 11 October and the Just Culture – metrics meeting on 18 October. Tina also joined the Good Governance Institute on-line discussion with Sir Ciarán Devane, Chair of the Health Service Executive, Ireland on 11 November 2022. As part of the buddying arrangements, Tina met with the Chief Nurse on 14 November.

1.4 Non-Executive Director, Gail Briers attended the Warrington and Halton Governors meeting on 28 September. Gail met with the Freedom to Speak Up Guardian on 28

September and also attended the Freedom to Speak Up meeting on 7 October. On 10 October Gail joined a meeting with members of The Voice of the Child initiative and on the 12 October attended the Council of Governors meeting. A Dental Symposium meeting took place on 3 November, which Gail attended. Since the last Board meeting, Gail met with the Chief Operating Officer as part of the buddying arrangement.

1.5 Non-Executive Director, Martyn Taylor attended a number of meetings - Warrington & Halton Governors/NEDs; Time to Shine; STAG; Risk Management Council; CIP Council.

On 26 October Martyn visited the Rapid Response Community Team based in Warrington. As part of the buddying arrangement, he also had a 1-1 meeting with the Medical Director, Aruna Hodgson. On 21 November, Martyn met with Steve Connor, Non-Executive Director of Wirral Community NHS Foundation Trust.

As part of the Non-Executive Director recruitment process, Martyn held informal discussions with potential candidates for the role.

2. EXECUTIVE UPDATES

2.1 The Chief Executive, along with a number of directors and senior management team, met with Sue Rogers and Tom McCaskill-Baxter from the Department of Transport who visited the North West Driving Assessment Service on 10 October.

2.2 On 5 October, the Chief Executive attended the Staff Engagement Champions Event. Presentations were provided on Digital, Equality, Diversity and Inclusion, Health & Wellbeing, Just Culture and Freedom to Speak Up.

2.3 A number of the executive team members accompanied the Chief Executive at the Dental Symposium held on 3 November at the AJ Bell Stadium in Salford.

2.4 The Inaugural meeting of the Transformation Group took place on Monday, 21 November. The Executive Management Team has given this group the authority to act and deliver the transformation agenda to underpin delivery of elements of the Trust's Strategy. It will be responsible for the development and oversight of the delivery of the Trust's transformation agenda.

2.5 Executive and Senior Team Engagement

2.5.1 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:

2.5.2 The Chief Executive met with the Warrington OPAT Team based at Bath Street Health & Wellbeing Centre, Warrington on 28 October.

2.5.3 On 22 November, the Director of Finance met with the Halton Safeguarding Team at Lister Road. He also met with the OT/Physio Team on 25 November at the Child Development Centre, Warrington.

2.5.4 The Chief Operating Officer met with the 0-19 team based in Birchwood on 10 November.

2.5.5 On 15 November, Medical Director, Aruna Hodgson met with the community nursing team based at The Bridges Learning Centre, Widnes.

2.5.6 The Trust Secretary met with the Community Equipment Store at Europa Point on 18 October.

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 Brennan	Gail Briers
Paula Woods	Linda Chivers
Nick Gallagher	Abdul Siddique
Ted Adams	Sally Yeoman
Aruna Hodgson	Martyn Taylor

The 2021 NHS Staff Survey results highlighted areas of improvement across three directorates: dental; Warrington Adults; Halton Children. As part of the ongoing engagement programmes across the Trust, members of the executive team have been aligned to a service/team within these three areas, to enable open discussions to take place with team members to ensure their basic wellbeing needs and our people promises are being met.

The following teams were visited by the executive team:

- Dental team based at Seymour Grove and Nye Bevan House
- 0-19 service based at Widnes Health Care Resource Centre
- District Nurses and Adult Community Matrons based at Spencer House

2.7 Board Sessions/Events

2.7.1 Two Board Time-Out sessions have taken place. The 29 September session focused on Anti-Racism and Unconscious Bias and a presentation took place on the Race Inclusion Staff Network. The session held on 24 October focused on system risks, risk appetite and BAFs.

3. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

3.1 Monthly feedback from the Executive Team is collated. An example of feedback from an October session is provided below:

"The team really impressed me with their work ethic and how seriously they take their jobs. They recognised that providing equipment to patients at home can be life changing. I was made to feel welcome and listened to."

4. EXTERNAL PUBLICATIONS AND REPORTS

4.1 On the day briefing: NHS England's new operating framework

On 12 October, NHS England (NHSE) published its new operating framework. The document sets out how the NHS will operate in the new statutory framework created by the Health and Care Act 2022 and reflects the formal establishment of integrated care systems (ICSs) and NHSE's expanding remit. The framework defines NHSE's purpose, its areas of added value, and sets out the roles and accountabilities of providers, integrated care board and NHSE's national and regional teams. This briefing summarises the content of the guidance and includes NHS Providers view. On the day briefing: NHS England's new operating framework - NHS Providers

5. RECOMMENDATIONS

5.1 The Board is asked to note the report.

Committee Chair's Report

Name of Committee/Group:	Quality and Safety Committee		**Report to:**	Board of Directors
Date of Meeting:	19 October 2022		Date of next meeting:	21 December 2022
Chair:	Gail Briers		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Gail Briers, Non-Executive Director and Committee Chair Martyn Taylor, Non-Executive Director Sally Yeoman, Non-Executive Director Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer	**In Attendance & Observers:** **In attendance** Kristine Brayford-West, Director for Safeguarding Services Susan Burton, Deputy Chief Nurse Mark Charman, Assistant Director of Transformation Jilly Wallis, Associate Director of Halton Adult Community Services/Allied Health Professional Lead, Katherine Summers, Adult Immunisation and Infection, Prevention and Control Nurse Jan McCartney, Trust Secretary Lynda Richardson, Board and Committee Administrator **Observer**: Christine Stankus, Public Governor, Rest of England	**Key Members not present**:	**Apologies received from:** Abdul Siddique, Non-Executive Director Ted Adams, Medical Director Sue Mackie, Director of Quality Governance Tania Strong, Head of HR

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
Urgent item of business taken at the discretion of the Committee Chair: Freedom to Speak Up	2, 3		The Committee noted that Freedom to Speak Up month was taking place during October 2022. It also received an update on recruitment to the Freedom to Speak Up Guardian role; the Chief Nurse had added some	A discussion took place concerning the reporting to the Board and Committees around Freedom to Speak Up. Whilst

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			further hours to the post to encourage interest and the post would now be re-advertised.	it was noted that the Board had delegated Freedom to Speak Up to the People Committee, the Trust Secretary agreed to clarify the reporting requirements for this Committee, People Committee and the Board.
Deep Dive – Learning Disability Group	2,3,6		The Committee welcomed a detailed report from Jilly Wallis, Associate Director of Halton Adult Community Services/Allied Health Professional Lead on the work and achievements of the Learning Disability Group. This was requested by the Committee to increase its awareness of the work of this important group. The group marked events such as the annual national learning disabilities day, awareness events, considerable work with service users and groups to discuss how improvements could be made to areas such as appointment letters and the friends and family test. This also included work linking in more widely with community groups to look to drive forwards changes. A digital solution was also being piloted to establish if the work within the Trust was making a difference to people. The Committee was pleased to note that health equity and addressing health inequalities were featuring as part of this work.	The Committee recognised the important work of the group and its potential to improve the lives of people within the communities that the Trust serves. The importance of ensuring that learning disabilities support was embedded into the organisation and roles going forwards was recognised.
Serious Incidents Compliance Report	2, 3		The Deputy Chief Nurse presented a report detailing the serious incidents within the Trust from August to September 2022. During this period, the Trust reported 13 serious incidents, as required by the NHS England Serious Incident Framework with all of those being recorded on the Strategic Executive Information Service (StEIS) within the required time frame of 48 hours following identification of the incident. The Trust	The Committee noted an increase in the number of pressure ulcer related incidents that had been reported over the period. Whilst those would be picked

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			submitted 15 completed serious incident investigation reports to the Integrated Commissioning Board (ICB) during this time period and that all of those were submitted within the required timescales. Two cases had been closed without any requests for further information, and eight cases remained open after the submission requesting further information. The Committee also noted that a new process had been introduced to review completed action plans, together with supporting evidence. This was to provide assurance to the Trust that actions had been completed, prior to the action plans and evidence being submitted to the ICB. This work was carried out in the weekly Patient Safety Group (PSG) and was overseen by the Serious Incident Review Panel (SIRP). It was confirmed that the Trust did not submit any action plans to the ICB during the reporting period.	up via the pressure ulcer steering group, and an upcoming Quality Summit for Warrington would review actions from previous serious incident plans to ensure that they had been embedded and the impact they had, the Committee requested that an update paper be presented to the December Committee (as an appendix to the serious incidents compliance report) to highlight the work undertaken and to help the Committee understand how this was having an impact The Committee received the report and acknowledged that there was a sense of creeping pressure generally at the current time, however this was being taken into consideration and there were alternative actions being put into place. The Committee was therefore assured that the Trust was continuing to manage serious incidents across the organisation, recognising pressure points.

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Committee Chair's Report

Summary report for risks relating to quality and safety	2, 3		The Committee received a report that provided oversight of risks from the corporate risk register in relation to quality and safety of the Trust's services for September 2022. There had been a reduction in the number of risks scoring 12 and above related to quality and safety, with 16 risks reduced from 17 within the time period. However, there had been a small number of risks that had passed the review dates (an increase of one to four overdue risks), which had subsequently been updated by the risk owners. There had been one new reported risk concerning capacity within dental services during the period. The Chief Nurse confirmed that this had been fully reviewed, the reasons clarified and that this was now resolved. There were three risks that had been closed by the Risk Management Council in September: one of those was concerning dental services waiting times at one particular base and two were related to district nursing risks and this was in view of the establishment of one joint risk for district nursing services across both Warrington and Halton. The Risk Management Council had agreed the assurance level for current risks: four had significant assurance, 10 had moderate assurance and two were limited assurance. Those risks included paediatric continence, which was due for a full service review at the QIA panel, as well as the risk related to access to staff e-rostering for district nursing staff in Halton which had now been resolved. Discussion took place concerning a risk that had been closed for dental services which was related to theatre capacity. Whilst there had been work to reduce waiters from 104 weeks to 78 weeks, it was noted that due to winter pressures, this could remain a fluid risk over the coming months. This position would be continually assessed with work in place to mitigate where possible against dental long waits.	The Committee received the report and agreed that it was assured that risks scoring 12 plus were managed effectively within the organisation.
IQPR	2, 3, 6		The Committee noted that training indicators were demonstrating an improvement in relation to safeguarding, however some challenges were	The Committee acknowledged that the IQPR was a

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			continuing around compliance: as staff were becoming compliant the turnover of staff meant that there were staff who were still then non-compliant. It was confirmed that a continued focus was being maintained with staff and managers around ensuring compliance. There had been a decline in the number of incidents in month and Information Governance training compliance was now reporting as red in month. In terms of the quality and safety related indicators, there were no significant changes to report to the Committee Work around the quality indicators was still ongoing to ensure that they were accurate from a quality and safety perspective. There was one new red rated target: Duty of Candour 10 day compliance: this was reporting as red in month and this would be reviewed as it had previously and consistently reported as green rated.	developing report. The Committee also noted that Duty of Candour was reporting at less than 100% during the period for the first time and the Committee would review the compliance level at the next meeting to ensure that this was returning to 100% compliance.
Report from the Quality Council	2, 3		The Deputy Chief Nurse presented the key considerations of the Quality Council that took place on 26 September 2022. This included: Research and Audit: There were 34 clinical audits planned for the year with three CQUINs which were progressing well and six medicines management audits. One audit had been completed on the community paediatrics pathway with an action for the outputs to be shared across Warrington and Halton. There would be an audit across both of those boroughs going forwards and work to share learning across both similar pathways. District Nursing: A third District Nursing workshop for Halton was to take place at the end of October 2022 which would include sharing information on an emerging model and discussion on an action plan. This action plan was to be shared with an update on actions at the November meeting of the Quality Council.	The Committee welcomed the report acknowledging that this provided a good summary of the key considerations of the Quality Council which provided good assurance. The Committee was satisfied that all issues in relation to quality and safety were being managed effectively by the Quality Council. The Committee Chair requested that future reports included the key points considered by the Quality Summits to provide an

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			The Warrington District Nursing Service would be returning to a Quality Impact Assessment (QIA) panel during October with outputs to go to the Quality Council. Delayed policies: The Committee noted that a number of policies still required exception report templates completing and there had been discussions that had taken place with the policy authors on the impact of the policies being delayed. Meetings were taking place with policy authors to ensure that the templates were being completed and some had now been completed and received. A significant improvement was expected within the next reporting period. It was noted that a commitment to achieve compliance by 31 December had been agreed. Dermatology: A dermatology quality summit had taken place and this had acknowledged good progress on the improvement plan, however it was noted that there were still some challenges being faced by the service. A quality improvement action plan would be taken to the November meeting of the Quality Council. Community Paediatrics: Warrington community paediatrics had seen an increase in referrals and waiting times. One further area of concern related to the paediatric continence service which had now moved across to children's services to provide support with resilience and to also attract new members of staff to work within this service. There had been a slight increase in the number of complaints received for that service, and a full service review was being undertaken and would be presented to the Quality Council at its next meeting. Dental Services: There had been no harms reported via the clinical harms review and shared learning had been presented to a recent Senior Leadership Team meeting concerning experiences and learning including around long waits.	overview to the Committee of what was being considered at those forums. The Committee must also be kept sighted on the record keeping audit outputs via a dedicated report or via clinical audit. Concerning the delayed/out of date policies, a report would be presented to the December 2022 Committee to explain the actions being taken to achieve full compliance.

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			Celebratory event: A celebratory event had taken place for professional nurse advocates who had qualified in the last six months. There had been a reduction in medication incidents at Padgate House as a result of harm free care work which had been a focus of the medication incidents group work.	
CQC update report	2, 3		The Committee received a verbal update report from the Chief Nurse. A CQC relationship meeting that was due to take place had been rescheduled due to staff absences. The Trust would commence well led review work with external support from January 2023 and work would continue to look across the Trust on a service by service basis with a programme across all services and risks which would be reviewed with latest information from the CQC following inspections and the available evidence. This would be prioritised based on the Trust's highest areas of risk. Information from Quality Summits would also link into the work as this would provide action plans around any areas of issue.	The Committee received the update and would be kept informed at future meetings on any further developments.
Trust Improvement Plan update	2, 3		There were currently nine service improvement plans that were being monitored and RAG rated on their progress within the quality improvement programme. There were seven plans that had demonstrated positive progress with an increased number of blue and or green RAG rated actions. There had been one plan demonstrating a marked increase in red and amber actions in relation to the Northwest Driving Assessment Centre. It was noted that there were no quality or safety concerns regarding the service but that the areas of issue related to performance and the delivery of activity.	The Committee agreed that it was assured that the Trust Improvement Plan was being reviewed and reported on a two monthly basis and that progress with the individual action plans was being routinely monitored with exceptions being reported to the Quality Council. The Committee agreed that the North West Driving

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Committee Chair's Report

				Assessment Improvement Plan would be deferred to the Finance and Performance Committee to consider at its November meeting, recognising the issues related to performance and activity.
Update on Paediatric Service Improvements	2,3		The Chief Nurse provided an update to the Committee concerning the Royal College of Paediatricians plan: the plan had now been superseded by the work of the Quality Summits which picked up the outstanding actions around the community paediatrics service. It was also acknowledged that a number of elements of the plan were outside of the Trust's control. Therefore the plan would be closed, and the remaining outstanding elements taken forward by the Quality Summits reporting into the Quality Council. An ask from this Committee remained outstanding: to receive direct feedback from service users and their families to check if improvements had been made. This element of work would be followed up; whilst there had been some feedback, further work was required to explore how this was undertaken and gathered in the future including how feedback could be utilised to help to make improvements. This had also been discussed at the Quality Summits.	The Committee noted that the Royal College of Paediatricians plan would be closed down with outstanding elements being taken forwards by the Quality Summits and acknowledged that work was ongoing to check that improvements had been made via service user and families feedback.
Ockenden II Report			The Committee received a detailed report from the Chief Nurse which provided information and evidence to demonstrate that the Trust had fully reviewed the requirements/recommendations against the Ockenden II report. A retrospective review had been taken following a request by the Board in June 2022 to ascertain if there may have been issues related to the recommendations across maternity services pre-transfer and any wider implications for other services across the Trust.	The Committee received the report and agreed to inform the Board that it was assured that the organisation had fully considered the Ockenden II report and its

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				recommendations and any impacts across the Trust.
Update on Clinical and Professional Leadership	2,3		The Committee received an update from the Chief Nurse. A workplan would now be developed, along with a framework, following consultations with groups of staff, including managerial and administrative staff on their views. This workplan would commence in December 2022, although some elements such as Quality Summits for each service were already in place.	The Committee recognised that the development of the workplan and framework would be positive for individual staff with complete career structures being put in place, in terms of career aspirations and the organisation to demonstrate itself as a good employer. The Committee agreed however that there were workforce and financial aspects to be considered, to ensure that proposals were costed and to consider any impacts upon performance. It requested that the Finance and Performance Committee and People Committee received an update in this regard.
Quality Impact Assessment Report – quarter two			There was a total of 13 QIAs that had been completed. Nine QIAs had assured the panel that the risks posed had been reduced/mitigated and that the plans could continue through governance processes. Three of the QIAs were scheduled to return to the panel during October and November (in relation to Warrington District Nursing, Halton Treatment Rooms and Warrington Paediatric Continence Service) and one QIA	The Committee agreed that it was assured of the actions undertaken to ensure the quality and safety of patient care and that where a QIA

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			(Warrington Adults Complex Discharge) had been rejected and recommended to return to the CIP Council for further discussion.	was required, the process in place appeared to be robust.
Review of MIAA and Clinical Audits with limited or moderate assurance	2, 3		The Committee noted that there were no current audits to be reviewed.	This item will remain as a standing item on every agenda.
Infection, Prevention and Control (IPC) Strategy	2, 3		The Committee received the draft 2022-25 IPC Strategy: the vision for the strategy was zero tolerance to avoidable healthcare associated infections and to influence all IPC practice across the Trust by informing and promoting evidence based infection prevention policy and practice and avoiding harms from any preventable infections. The strategy was aligned with the Trust's values and included aims relating to quality and safety, antimicrobial stewardship and ensuring that the correct policies and procedures were in place, as well as empowering staff and ensuring they had access to policies and training.	The Committee approved the strategy and also took the opportunity to recognise the significant work that was continuing to be undertaken by the IPC team.
End of Life Strategy	2, 3		The Committee agreed to a one-year extension (to October 2023) of the current strategy as proposed by the Trust's End of Life Steering Group. By extending the strategy, this would allow the findings and proposals from the place-based review to be included where relevant to Bridgewater services.	The Committee approved the one-year extension to the strategy, agreeing that this was a sensible approach.
Board Assurance Framework	2, 3, 6		The Committee considered BAF2, 3 and 6: Updates to be made to BAF2 needed to be reviewed by the Executive Management Team. The People Committee was also yet to review and update BAF6 as its September meeting was stood down due to the period of national mourning. The Trust Secretary had agreed a number of changes to be made with the Chief Operating Officer. Those elements would now be carried forward	BAF2 to reflect positive assurances taken from the report on Ockenden II presented to the Committee. A review of BAF3 would take place outside of the

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			into the November People Committee meeting. The Chief Operating Officer would review the changes again beforehand to ensure that they remained up to date. The Committee agreed that the risk ratings for BAF2, 3, and 6 would remain unchanged.	Committee. This should also include winter planning and the updated EPRR plan. Quality Summits would also be included within the controls section. BAF6 to include the approval by the Committee of the proposal for the development of the clinical professional leadership structure.
Items for Deep Dive	2, 3		The Committee was supportive of a proposal made by the Committee Chair for a deep dive to be presented on the Voice of the Child.	It was agreed that this would take place at the December Committee, with the deep dive for clinical harms taking place in February 2023.
Review of meeting			**Items to be shared with the Board or other Committees**: As agreed earlier in the meeting, the clinical and professional leadership paper would be shared with the People Committee and the Finance and Performance Committee. Freedom to Speak Up reporting requirements to the Board and Committees must also be clarified. The Finance and Performance Committee would be asked to consider the Driving Assessment Service Improvement Plan.	
Risks Escalated: None from this meeting				

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Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 December 2022**
Agenda Item	**87/22i**		
Report Title	**FINANCE REPORT – OCTOBER 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 on the financial position as at Month Seven

Executive Summary

To brief the Board on:

- Financial position as at Month Seven
  - The Trust is reporting a year-to-date financial position slightly ahead of plan, a deficit of £0.14m (plan £0.15m).
  - The Trust year to date savings plan to month seven is £2.22m, the Trust is reporting savings in line with plan.
  - Year to date income is £54.49m - £1.88m above plan, predominantly due to additional income for services to other NHS Trusts, together with additional funding for the pay award.
  - Total expenditure is £54.63m for the year-to-date – £1.87m above plan.
  - Financing costs are £0.17m favourable to plan.
  - Capital expenditure is £0.59m for the year, £1.02m behind plan
  - Cash is £24.33m

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**	**08 December 2022**
Agenda Item	**87/22i**		
Report Title	**FINANCE REPORT – OCTOBER 2022 – MONTH SEVEN**		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the Financial Position as at Month Seven		

1. SCOPE

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

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

2. FINANCIAL POSITION AS AT MONTH 7

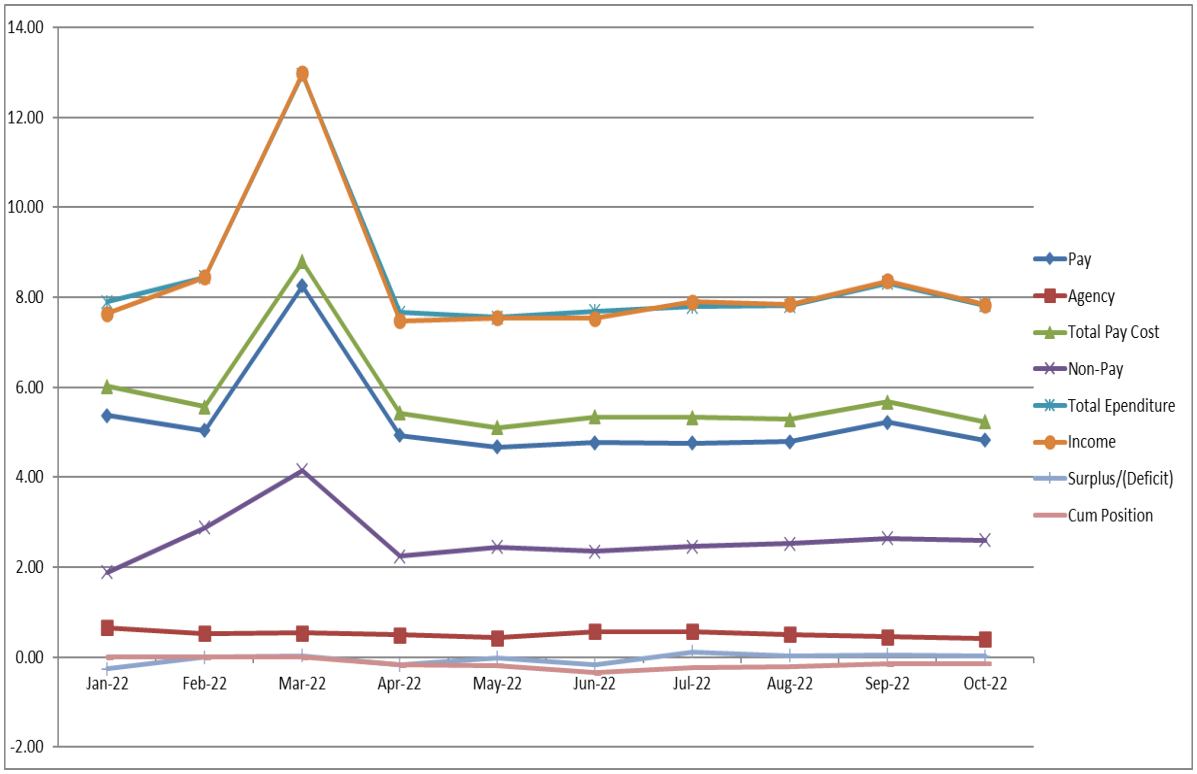
2.1 The key headlines for Month Seven are shown in the table below.

Table 1 – Summary of financial performance

Summary Performance Month 07 2022-23	Month 7 Plan (£M)	Month 7 Actual (£M)	Month 7 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.47)	(7.84)	0.37	(52.61)	(54.49)	1.88	(89.96)	(93.18)
Expenditure - Pay	4.80	4.82	(0.02)	33.60	33.96	(0.36)	57.60	58.62
Expenditure - Agency	0.41	0.41	0.00	2.89	3.43	(0.54)	4.95	5.68
Expenditure - Non Pay	2.20	2.59	(0.39)	16.05	17.19	(1.14)	27.03	28.79
EBITDA	(0.06)	(0.01)	(0.05)	(0.07)	0.09	(0.16)	(0.37)	(0.09)
Financing	0.03	(0.02)	0.05	0.22	0.05	0.17	0.37	0.09
Normalised (Surplus)/Deficit	(0.03)	(0.03)	0.00	0.15	0.14	0.01	(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	(0.03)	(0.03)	0.00	0.15	0.14	0.01	(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	(0.03)	(0.03)	0.00	0.15	0.14	0.01	(0.00)	0.00
CIP	0.40	0.41	0.01	2.22	2.23	0.01	4.20	4.20
Capital	0.09	0.40	(0.31)	1.61	0.59	1.02	2.10	2.10
Cash	26.00	24.33	(1.66)	26.00	24.33	(1.66)	25.20	26.64
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

Favourable Variance Adverse Variance

Table 2 - Rolling Run Rates 2021/22 to 2022/23



2.2 The Trust is reporting a year-to-date financial position slightly ahead of plan, a deficit of £0.14m (plan £0.15m deficit).

Income

- The £1.88m favourable variance from plan is predominantly due to additional recharges to other NHS Trusts for services provided and the recognition of additional income relating to Dental Epidemiology surveys. There has also been additional funding for the pay award above the plan amount of 3%.

Pay

- The overspend on pay is primarily driven by the additional cost of the pay award above the plan amount of 3%.

Agency

- Although month on month agency expenditure continues to decrease, cumulative expenditure of £3.43m, remains above the year-to-date planned expenditure of £2.89m. £0.78m of the cumulative expenditure is COVID related.

- NHSE/I are implementing an ICS agency cap and reintroducing agency control measures from the end of September. The Trust is awaiting information on how the cap will be split by provider.

- Agency costs incurred in month seven equated to 67.96 whole time equivalent staff.

Non Pay

- Cumulative non pay expenditure is £1.14m adverse to plan, primarily due to increased expenditure on drugs and equipment plus additional estates related costs.

Financing Costs

- Additional interest received and an improved statement of financial position have contributed to reduced financing costs and a £0.17m variance favourable to plan

2.3 Adjusting for year-end national accounting adjustments, all month seven run rates are consistent with expectations and previous year comparators (see table 2 above).

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. The additional cost reductions are primarily driven by the requirement to reduce Covid expenditure in line with the 53% Covid funding reduction.

3.2 This results in total savings for 2022/23 of £4.197m (4.5%), split between £1.865m recurrent CIP (required by the original planning guidance) and £2.332m non-recurrent savings.

3.3 The Trust year to date savings plan to month seven is £2.22m, the Trust is reporting savings in line plan.

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 October, expenditure is above budget, although information continues to be collated from budget managers to ensure all Covid related expenditure is complete and accurate.

4. SYSTEM IMPACT ON FINANCIAL OUT TURN & RISK

4.1 NHSE/I guidance expects systems to deliver a cumulative breakeven position at the end of the financial year. The Cheshire and Merseyside ICS currently has an underlying planned deficit.

4.2 System performance is monitored monthly, with specific focus on organisations with performance adverse to plan. As reported in 2.3 above, the Trust is currently reporting a financial position in line with plan and forecasting a breakeven 2022/23 outturn, in line with the submitted plan.

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

5.1 Total capital expenditure as at 31st October is £0.59m against a plan of £1.619m. The underspend relates to expected delays in the delivery of a couple of high value schemes, i.e., the Strategic Estates and Altrincham dental schemes.

5.2 Of the remaining schemes, £0.08m have orders raised and are committed for expenditure and dental equipment schemes are either in the process of raising requisitions or awaiting specification sign off by the service.

5.3 Capital spend is monitored in detail on a monthly basis by the Capital Committee and reported to the Finance and Performance Committee. At this time, the Trust is expecting the 2022/23 capital spend to be in line with the plan.

5.4 In October there was a net cash inflow of £0.17m with a closing cash balance of £24.33m.

5.5 Total debt as at 31st October is £11.86m excluding bad debt and credit note provisions, of which £9.52m relates to invoiced debt. Overall debt has decreased by £0.16m from September, overdue debt has decreased by £0.22m.

5.6 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
Jul-22	95	99.7	99.9
Aug-22	95	99.4	99.3
Sep-22	95	99.4	99.9
Oct-22	95	99.0	99.8
Year to date performance	95	99.4	99.6

5.7 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

Name of Committee/Group:	Finance and Performance Committee		**Report to:**	Board of Directors
Date of Meeting:	24 November 2022		Date of next meeting:	19 January 2023
Chair:	Tina Wilkins		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Tina Wilkins, Non-Executive Director Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Nick Gallagher, Director of Finance Sarah Brennan, Chief Operating Officer Lynne Carter, Chief Nurse	**In Attendance & Observers:** Rachel Hurst, Deputy Director of Finance Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Dave Smith, Assistant Director of IT Anita Buckley, Information Team Jan McCartney, Trust Secretary	**Key Members not present**:	**Apologies received from:** Linda Chivers, Non-Executive Director Eugene Lavan, Deputy Chief Operating Officer

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Finance	4		Month 7 finance report received and provided assurance. The Committee noted that: • Month 7 22/23 deficit on plan • CIP on plan • Maintenance of improvement in BPPC performance • Healthy cash position Increased capital spend to date	The Committee noted the financial position of £0.14m deficit slightly ahead of plan of £0.15m, with a forecast outturn of breakeven. The Committee noted the additional detail regarding agency and that the cap had yet to be confirmed for the Trust. The Committee raised some concerns about the profile of capital spend. Further

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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

				assurances to be provided in terms of timescales for the next meeting.
Finance	4		Chair's report from CIP Council was received. This provided an update to the programme.	The Committee noted the report and the progress reported to date including the potential pipeline for 2023/24 schemes. Martyn Taylor attended the meeting in November and reflected that good assurance was provided both in terms of process and review.
Finance	4		Clinical and Professional Structure	The Committee noted the paper which had been previously received at Quality and Safety Committee. Assurance was received that all proposals would be fully costed and would be within existing budgets. The overarching aim of the proposal is to maximise the amount of time clinicians devote to clinical work.
Performance	4,8		IQPR update	The Committee noted the report and the next steps in terms of updating the IQPR to include: 4 new indicators to be added in January 2023.

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Committee Chair's Report

			IQPR for month 6 was received by the Committee	The performance framework to be brought back to March F&P committee with the new IQPR in place for reporting from April 2023. The Committee noted that there is one new red indicator relating to Warrington Audiology three indicators have moved from red to green. The cancer 28 day faster diagnosis has been achieved for the first time which the Committee were pleased to note. Of the six indicators remaining red, five had shown a deterioration.
Performance	4,8		The Chair's report from Performance Council for month six was received.	The Committee noted the report and was pleased to note the improvements which provided significant assurance.
Performance	4,8		Dermatology Update	The Committee were assured by the report and noted the delay in the implementation of the Advice and Guidance service which when in place will aim to support more appropriate referrals and

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Committee Chair's Report

				provide feedback to GPs within 48 hours.
Performance	4,8		North West Driving Assessment Service.	The Committee received the report which included an improvement plan developed as a result of the Department of Transport and Driving Mobility raising concerns regarding: reach, management capacity, adherence to processes and the provision of cognitive assessments in all reports. The Committee noted the rebrand to Drive Ability North West. A marketing programme has now commenced however the importance of achieving accreditation as highlighted and an update to be brought to March 2023 F&P. The Committee also asked that consideration be given to the long term financial sustainability of the service.

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Committee Chair's Report

Digital	8		The Committee received the Chair's report from DIGIT	The Committee noted the report for assurance. The Committee noted the capacity issues facing Digital both within digital and operational services. Structures are being reviewed to include clinical and operational input to facilitate the delivery of the Digital Strategy.
Estates	4		Estates update report Green plan update report	The Committee received the report and noted the timescales regarding Europa Point and Spencer House. The Committee received the report and noted the LED lighting project.
Audit	4		The paper was received and noted.	
Risks	4		The paper was received and noted.	
BAF	4,7,8		BAF 4	No change given ICS system pressures. Rationale to be updated to include:

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				The current pressures on services throughout the NHS and the financial impact thereof, along with the potential increased restrictions and controls if the ICS submits a revised forecast outturn for the system
			BAF 7	No change
			BAF 8	Risk unchanged due to continued pressures on digital services capacity and demand. Rationale to be updated to include : **Teams are working at capacity, and the delivery of the Digital Strategy may require additional resource and changes to some team structures to support delivery. Work is ongoing to review current structures to enable timely delivery**

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Governance	4,7,8		Review of meeting	Feedback regarding the meeting was very good and members were assured by the content and triangulation between the papers and the interrelated discussions. **The Committee reflected that in the light of the significant demands across the Trust and the system that this was the time to review our risk appetite and identify and focus on our priorities.**

Risks Escalated: **None from the meeting**

Actions delegated to other Committees:

1. **The committee would like the Board to consider the Trust's risk appetite in identifying key priorities where support would be focussed.**

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	Audit Committee		**Report to:**	Board of Directors
Date of Meeting:	21 October 2022		Date of next meeting:	12 January 2023
Chair:	Tina Wilkins (acting chair)		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Tina Wilkins, Non-Executive Director (Chairing) Gail Briers, Non-Executive Director Sally Yeoman, Non-Executive Director Martyn Taylor, Non-Executive Director	**In Attendance & Observers:** Nick Gallagher, Director of Finance Sarah Brennan, Chief Operating Officer Jan McCartney, Trust Secretary Rachel Hurst, Deputy Director of Finance Debbie Weir, Financial Controller Gary Baines, Regional Assurance Manager, MIAA Adrian Poll, Senior Audit Manager, MIAA Phillip Leong, Anti-Fraud Specialist, MIAA John Blewett, Audit Manager, KPMG Public Sector North Lynda Richardson, Board and Committee Administrator, taking minutes **Observers** Andrew Mortimer, Governor Observer Sarah Ball, Apprentice Business Accountant	**Key Members not present**:	**Apologies received from:** Linda Chivers, Committee Chair Abdul Siddique, Non-Executive Director Lynne Carter, Chief Nurse/Deputy Chief Executive James Boyle, Director, Public Sector Audit, KPMG Bill Harrison, Governor Observer

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

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Committee Chair's Report

E Governance External Audit Contract Extension	1		Confirmation that the extension had been approved and recommended to Council of Governors for final approval.	Assurance received
Audit Committee Terms of Reference	1		Amendments and updates noted by the Committee and approved.	Assurance received
Well Led – Monitoring of Action Plan	1		The Committee noted the good progress made to date and agreed the remaining actions could be closed. The Committee also noted that a new well led review would be started in January and would be carried out through Board development sessions.	Assurance received Review to take place through Board development sessions
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. The Committee considered the comprehensive assurance paper covering the Corporate Risk Register processes including an update on the proposed move from the Ulysses system to Datix.	Assurance received
Register of Interests	1		The Committee received updates on new declarations of interest from staff and new governors including staff governors.	Assurance received
Review of Losses, Special Payments and Waivers	1,4		Proposed bad debt write offs totalling £2,171.93 were noted and assurance received that all possible recovery options had been exhausted. It was noted there had been 1 Special Payment, linked to 1 case. The Committee were assured that due process had been followed for all 10 waivers, which were documented.	Assurance received
Salary Overpayment Trends	1,4		The Committee noted the paper showing an overall reduction in salary overpayments over time. There were some older overpayments to be approved for write off by EMT which would then be included in the next losses report to the Committee.	Assurance received

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Committee Chair's Report

IR35	1,4		The Committee noted the report and the recent government changes which have the potential to make changes to the IR35 legislation. Given the likelihood of change the Committee agreed that an update would go to Finance and Performance Committee in January and Audit Committee thereafter.	Assurance received Finance and Performance Committee to oversee prior to being brought back to Audit Committee
Emergency Preparedness, Resilience and Response (EPRR) plan	1,4		The Committee received the paper and noted the recommendation of substantial compliance against the EPRR self-assessment framework. The Committee noted that standards 19,21 and 50 have been amended from partial compliance to full compliance, leaving 6 partially compliant out of a total of 55 standards. This would then go to the Board for approval.	Assurance received To go to Board via e governance for approval
Mersey Internal Audit Agency Progress Report	1,4,8		The Committee noted the following reports were now finalised: • E-Rostering – Moderate Assurance • Data Quality and Performance Targets – Substantial Assurance • Conflicts of Interest – High Assurance	Assurance received
Update of Fit and Proper Person Audit Recommendations	1		The Committee noted the update which now confirms that all recommendations have been fully implemented and validated by Mersey Internal Audit Agency.	Assurance received
Review of the mandated HFMA NHS Financial Sustainability checklist	1,4		The Committee received the paper which had previously been to EMT and Finance and Performance Committee. The Committee noted the deadlines for completion and review by Mersey Internal Audit Agency with a report to come back to the Committee following the review.	Assurance received
Anti-Fraud report	1,4		The Committee received the regular progress report. It was noted that work is ongoing on the updated fraud risk assessment by the Trust to assess and score the 40 key fraud risks which form part of the fraud risk assessment in line with the Trust's own risk scoring	Assurance received

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Committee Chair's Report

			mechanism, with a view to relevant risks being added to the Trust's risk management system.	
Annual Review of Effectiveness of Anti-Fraud service	1,4		The Committee received the positive responses received from the survey. The effectiveness review to be added to the BAF.	Assurance received The effectiveness review to be added to the BAF.
External Audit Health Sector Update	1,4,8		The Committee received the update including updated guidance and revised accounting standards.	Assurance received
Annual Review of Effectiveness of External Audit service	1,4		The Committee received the generally positive responses received from the survey. The effectiveness review to be added to the BAF.	Assurance received The effectiveness review to be added to the BAF.
Risks Escalated: **None from the meeting**				

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Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 December 2022**
Agenda Item	**88/22i**		
Report Title	**INTEGRATION & COLLABORATION**		
Executive Lead	Colin Scales – Chief Executive Officer		
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**

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**	☐ **EMT**

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	08 December 2022
Agenda Item	88/22i		
Report Title	INTERGRATION & COLLABORATION		
Report Author	Rob Foster – Programme Director Collaboration and Integration Sarah Brennan – Chief Operating Officer		
Purpose	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.		

1. ICS UPDATE

1.1 Following the launch of 42 Integrated Care Systems (ICSs) as statutory bodies on 1st July 2022, the various elements of the new systems continue to evolve and embed.

1.2 Over the last month, quarterly review meetings between members of the ICB Executive Team and the place-based teams have commenced. Bridgewater were involved and contributed in the review meetings that took place in Warrington and Halton.

1.3 Since the previous Board report, we have continued to meet as place-based teams, with partners to drive the agenda forward.

1.4 **Warrington Together update**

- Work has continued establishing the governance around the workstreams and the key workstreams have been agreed as Starting Well, Living Well and Ageing Well and the enabling groups are now in place and the majority have now had their first meeting.
- Under each workstream, the projects are being identified and a delivery plan is being developed so that progress around the actions can be monitored and reviewed.
- Dr Sangeetha Steevart has been appointed as the Clinical Director for Warrington Place.
- A Clinical and Care Priorities Leadership Forum (CCPLF) has been established and has representation from Bridgewater on this group which is attended by the Primary Care Clinical Directors.
- The ICB Board Meeting took place in Warrington on 28th November and the Place Director Carl Marsh presented an update in relation to the Warrington partnership and place and this was accompanied by a patient story delivered by the Clinical Lead for Paediatric Physiotherapy for the Trust.

1.5 **One Halton update**

Whilst not exhaustive, the following activities have been taking place:

- Update of the One Halton Health & Wellbeing Strategy, with a clear focus on developing schemes and initiatives based on the following framework:
    - Wider determinants of health
    - Starting Well
    - Living Well
    - Ageing Well
- The introduction of a Children's specific Operations & Delivery Group – to date, one group has met to drive the delivery of all One Halton partner projects. The purpose of creating specific adult and children's groups is to ensure each is allocated dedicated focus.
- Planning for an Integrated Neighbourhood Delivery workshop in December 22, to develop and agree principles, plans and actions for our collaborative approach
- Development of the One Halton Voices approach and meetings, to drive public and patient communications and engagement
- Development of the One Halton digital and data strategy, with workshops planned to start to consider a place-based approach to Digital Inclusion, for local people and local staff
- An initial planning session to develop a place-based workforce plan has taken place, with plans to facilitate a partnership workshop in the near future
- We continue to engage with both Primary Care Networks in Halton, developing relationships and defining and delivering projects to support our joint work.

1.6 **Dental update**

Members of the Dental Network team continue to work and engage with partners and the respective commissioning teams across Greater Manchester and Cheshire & Merseyside

Action plans have been developed to implement and drive the delivery of our Dental Strategy, with regular review meetings with commissioners taking place.

A Board Development session with our Dental Network is taking place early in the new year.

2. RENEWING OUR QUALITY AND PLACE STRATEGY

2.1 Work is continuing on renewing our Quality & Place strategy for April 2023 (Q&P23)

2.2 Engagement work is underway to ensure our approach is one of co-production, as we engage with our staff, our patients, our partners and local people.

2.3 We have commissioned support from the Good Governance Institute (GGI) to support elements of our Q&P23 development work.

2.4 As part of this work, we held a Board Development session in October 22 with GGI and invited colleagues from the Halton ICB place-based leadership team. The purpose was to collectively discuss 'system risk' within the context of the ICS infrastructure, with all parties acknowledging the benefit of coming together to discuss such matters,

helping to shape our thinking for Q&P23 and the opportunities presented by the new ICS arrangements.

2.5 Ensuring our vision and transformation aspirations are driven and influenced by our own teams and services will be fundamental. As such, we have launched a new Transformation Programme within the organisation called Boost, which is led by our Transformation Team.

3. BOOST

3.1 Boost forms a key strand of our overarching Transformation service and offer.

3.2 Bridgewater has a well-established Transformation Team in place and is investing in growing the capacity of the team. The Transformation Team have historically supported services in different ways. Quality Summits are an example where a service identifies a need for improvement, and the Transformation Team support the teams to centre on addressing defined areas of concern. It is needs driven.

3.3 The concept of Boost is more for 'blue sky thinking' across services, directorates and/or internal/external partnerships. Its purpose is to improve patient care and staff morale and as such, it's vital that any Boost workshops are driven by our staff and services (clinical and corporate)

3.4 Boost has been established to help support and encourage services, teams and our staff to identify and drive innovation.

3.5 Workshops have already started across a number of services. An example is given below of the approach being taken by our Children's services

4. CHILDREN'S SERVICE TRANSFORMATION

4.1 The Children's Directorate have launched a Boost service transformation programme, supported by the Bridgewater Transformation Team.

4.2 The overarching aim of the transformation programme is to create an Improvement Plan for Children's Services, based on outputs of workshops involving staff at all levels within the Directorate.

Through early workshops, the themes and ideas being explored include:

- **Training** - developing a training programme that can be undertaken by jointly by staff from all (or as many as possible) children's services.
- **Co-location of services** - exploring the options for colocation of children's services.
- **Digital** –
    - To explore the possibilities for increasing the digital offer of children's services.
    - To review and revise the setup of SystmOne to allow all children's services to use a single unit within the system.
    - To explore the options for improving the Wi-Fi signal in the areas where children's services are delivered.

- **Improve understanding** of roles, responsibilities, service offers and pathways - developing a framework for better communication and joined up working, to enable staff to fully understand each service within the children's directorate and how they interoperate.
- **Experience** – improving the child and family experience, including the experience of visiting the centres where children's services are delivered – particular, the experience prior to their appointment (e.g., information received, first impressions of buildings, videos etc.)
- **Communication –** ensuring children and families are involved in decision making with their care.
- **Access** –
    - Exploring the possibility of delivering mobile clinical services, via ambulatory care, such as a "clinic bus".
    - Access to appropriate clinical rooms - ensuring children's services have access to appropriate clinical rooms, such as a baby room, toddler room and adolescent room.
- **Review of administrative support** for the service, which links to the current organisation-wide administration review.
- **Improve transition arrangements** from Children's to Adult services - reviewing and improving the transition arrangements and patient experience of transition from Children's services to Adult services;
- **Review of Multi-Disciplinary Team meeting arrangements** – considering the membership and function of the MDT

4.3 Workshops are scheduled to take place throughout 2022-23, involving a wide range of staff – clinical, administrative and management – to develop and drive actions forward across the breath of the programme.

4.4 Public engagement is also key in taking this forward and feedback received at the October Board from the patient story is being taken forward to shape the delivery of our children's services.

4.5 Progress will be monitored within the Children's Directorate Leadership Team, with oversight and support provided by the newly formed Transformation Group.

5. TRANSFORMATION GOVERNANCE

5.1 In November 22, a new Bridgewater Transformation Group was launched. Initially chaired by the CEO/Deputy CEO, the aspiration is to develop the group in line with our approach to Devolved Autonomy.

5.2 The purpose of the group is to oversee, co-ordinate and lead the delivery of the organisation's transformation ambitions. The focus will be on transformation, not 'Business as Usual'/operational matters.

5.3 Membership includes representatives from the Directorate leadership teams, EMT, the Transformation Lead, a communications lead, HR, OD and Education leads, a digital lead and a governor. Expanding the number of clinicians on the group was an agreed action.

5.4 The Transformation Group will report into EMT initially, with the output from the meeting being shared with all relevant committee's and councils.

6. RECOMMENDATIONS

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

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**08 December 2022**
Agenda Item	**88/22ii**		
Report Title	Update on the Provider Collaborative		
Executive Lead	Colin Scales – Chief Executive Officer		
Report Author	Rob Foster – Programme Director Collaboration and Integration		
Presented by	Rob Foster – Programme Director Collaboration and Integration		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Executive Summary

This report aims to update the nine Trust Boards, that currently make up the Mental Health Learning Disability & Community Provider Collaborative (MHLDC PC) membership, on how the collaborative has been working since its inception.

The MHLDC PC is at a critical stage of its development and the report sets out the context, current workstreams and governance.

As part of the engagement phase described in the report, further reports will be developed for the Trust Boards to update on relevant matters.

Previously considered by:

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

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	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

systems of corporate governance							

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

Cheshire & Merseyside
Mental Health, Learning Disability and Community Provider Collaborative

Information and Update for Membership Trust Boards

21st November 2022

Executive Summary

The Cheshire & Mersey Mental Health, Learning Disabilities and Community Services Provider Collaborative (MHLDC) was established in October 2021 with an aspiration to bring providers of services closer together and to find opportunity through Collaboration at scale and capitalising on the benefits of linking physical and mental health services.

The provider collaborative helped to deliver a number of beneficial schemes during the Covid-19 pandemic through the Out of Hospital Cell, Specific achievements included the development of the nMABs service, Oximetry at Home, Telehealth/remote monitoring services and prioritisation of services to support the wider system.

The collaborative has recently taken on responsibility for the delivery of some of the schemes linked to the Ageing well agenda and as of November 2022 is now responsible for the delivery of the Cheshire and Mersey wide Mental health programme.

As the collaborative develops there are an increasing number of opportunities being identified and this document aims to inform the Boards of the Membership Trusts of the recent successes and the future ambition of the Collaborative.

During December 2022 and January 2023 an engagement exercise with stakeholders will be rolled out to gain views on the potential next steps for the collaborative and will seek to ensure that the final model proposed to the ICB Board takes these views into account.

Introduction

Over the past decade health Policy has increasingly advocated for NHS organisations and Local Authorities to work together to deliver improved outcomes for the people they serve.

The most recent legislation taken through the Parliamentary course seeks to eradicate that old style of working and formalise collaboration between all providers of health and care services. The legislation required NHS Trusts to be part of at least one collaborative arrangement with at least one other NHS provider organisation, and the creation of a formal partnership that must include Local Authorities.

This document aims to update the 9 Trust Boards, that make up the MHLDC membership, on how the collaborative have been working together since it's inception and is produced in response to a direct request asking the collaborative to set out its purpose, achievements and future ambition

The national Policy context:

The requirement for all NHS trusts providing acute or mental health services to become part of one or more provider collaboratives, by July 2022 is part of national policy with a shared ambition to:

- ❑ reduce unwarranted variation and inequality in health outcomes, access to services and experience

- ❑ improve resilience by, for example, providing mutual aid
- ❑ ensure that specialisation and consolidation occur where this will provide better outcomes and value

The NHS *Working together at scale: guidance on provider collaboratives*, sets out expectations for provider collaboratives to:

- ❑ identify the shared purpose of each collaborative and the specific opportunities to deliver benefits of scale and mutual aid
- ❑ develop and implement appropriate membership, governance arrangements and programmes (or reflect on these where collaboratives are already in place)
- ❑ ensure purpose, benefits and activities are well aligned with ICS priorities

For mental health and community providers, the provider collaborative model provides the opportunity for joined up working in the delivery of mental health, learning disability and community services by integrating community physical and mental health provision, standardising approaches, and developing best practice.

The MHLDC Provider Collaborative

The Mental Health, Learning Disability and Community Services Collaborative (MHLDCPC) relates to the NHS Trusts or NHS Foundation Trusts that provide community, mental health and learning disability services across Cheshire and Mersey. The member organisations are:

Community / Mental Health Trusts	Acute / Community / Mental Health Trusts
Bridgewater Community Health Care NHS FT	Alder Hey Children's NHS FT
Cheshire & Wirral Partnership NHS FT	Countess of Chester Hospital NHS FT
Mersey Care NHS FT	East Cheshire NHS Trust
Wirral Community Health and Care NHS FT	Mid Cheshire Hospitals NHS FT
	St Helens & Knowsley Teaching Hospitals NHS Trust

Members are signatories to a formal Memorandum of Understanding that established the Collaborative on 1 October 2021. The scale and strength of the Collaborative is significant – current budgets are estimated at around £1.5bn. Staff employed in the Collaborative's services number c.20,000.

Founded upon the principles of subsidiarity, inclusivity, engagement, co-operation, and a belief in best intent the MHLDCPC purpose, vision and mission is set out below.

"Collaboration at scale to enable better care at Place"

PURPOSE: We are a collaborative of NHS providers pursuing equitable, sustainable, connected physical and mental health services that deliver improved health and wellbeing for people in their communities. Founded upon a principle of subsidiarity we do this at Place level across the whole of Cheshire and Merseyside, in partnership with local communities and a wide range of agencies .

MISSION We will work together with the people we serve, and all partners to commission and provide a population health focused approach to delivering connected MH, LD and Community Services. We will use our scale, breadth and diversity of expertise to offer high quality levels of service across Places, to improve outcomes and equity of care. Our alliance will provide a sound platform to retain, engage and motivate our workforce, improve our employment offer and ensure the best possible value for investment across the system.

Achievements to Date:

In the context of the Covid pandemic, the members of MHLDC PC strengthened their already positive working relationships and established a good foundation of closer collaboration through initiatives with demonstrable benefits to partnership working. Examples of the Covid response and post Covid developments that have been enabled by the MHLDC collaborative include:

- ❑ Improved data flows enabled better management of capacity and provision of mutual aid, both within community services and to acute and social care
- ❑ Creation of a mental health bed hub led to fewer out of area mental health placements
- ❑ Establishment of a system-wide intelligence system (CIPHA)
- ❑ Creation of a single mental health resilience hub to support staff across Cheshire and Merseyside
- ❑ Establishment of a telehealth enabled Covid Oximetry @ Home service that can expand to support other long-term conditions
- ❑ Delivery of a joint Covid Medicines delivery unit for IV and oral administration of covid medicines (nMABS) with a shared assessment and prescription service
- ❑ Remote monitoring services for patients with specific disease types
- ❑ Development of the Urgent Community response service across Cheshire and Mersey.
- ❑ Review of waiting times for community services across Cheshire and Mersey to understand inequity in access to service for populations.

- ❑ Development of best practice pathways for administration of Home Intravenous therapy utilising experience from each provider organisation
- ❑ Support of the development of 3 Lead provider collaboratives for mental health services.

Current MHLDC Workstreams:

The Collaborative continues to develop workstreams to further enhance delivery of care based on the requirements identified at Place and by individual providers. The adoption of workstreams being based on the principle of being limited to "schemes that can benefit from consideration at a multi organisational level". The MHLDC is currently actively taking forward the following:

- ❑ Development of a consistent offer for the population of C&M to meet the national requirements of the Ageing Well agenda for delivery of Virtual wards
- ❑ Sharing the learning and experience of organisations providing the Urgent Community Response and maximising the benefits through sharing of best practice
- ❑ Expanding the work across C&M that was initiated within Cheshire to compare the access and availability of community services against population health outcomes
- ❑ Working with Local authorities to capitalise on a number of best practice schemes that's have reduced reliance on hospital and community beds and to develop a robust monitoring tool for intermediate care provision
- ❑ To understand the benefits and appetite for changes to the commissioning arrangements for community and mental health services providers.
- ❑ Development of the Community Services Winter planning including delivery of services/ mutual aid between providers and monitoring of community activity
- ❑ Supporting small and/or fragile services that are difficult to deliver for smaller organisations
- ❑ Working with partners to develop a mental health and Community services Workforce plan
- ❑ Support the Mental Health programme of work following formal adoption of this transformation Programme in November 22
- ❑ Utilise the data from the review of waiting times for community services to deliver better equity of access to patients across the ICS
- ❑ Development of the Covid Medicines Support unit to deliver access in treatment for specific cohorts of patients across C&M

MHLDC Provider Collaborative Ambition

The membership of the MHLDC Provider collaborative forum believes that by working together, in a more formalised way, with strong, two-way connections with local communities, primary care, Local Authorities and Place based partnerships, Health and Well Being Boards, the ICB and ICP, the Prevention Board, the clinical networks and the acute care collaborative (CMAST), the organisations within it will be better equipped to withstand and rise to the widely recognised challenges faced in Cheshire and Mersey. It will support the delivery of the triple aim of the ICS through a focus on population health using the benefits driven through implementation of System P, driving up standards and spreading

best practice and delivering economies of scale, reducing unwarranted variation, and removing duplication.

The Collaborative is actively working on a proposal related to the commissioning of Mental health and Community services and how a new approach could maximise the efficiency and efficacy of delivery whilst maintaining the importance of the Place based approach and the sovereignty of the membership Trusts. During December 2022 and January 2023 an engagement exercise with all stakeholders will be taking place to understand better the views of stakeholders to the potential changes and to ensure that the business case due to go to ICB Board in February 2023 is reflective of these views and is deliverable and beneficial to the system as a whole based on the principles outlined below:

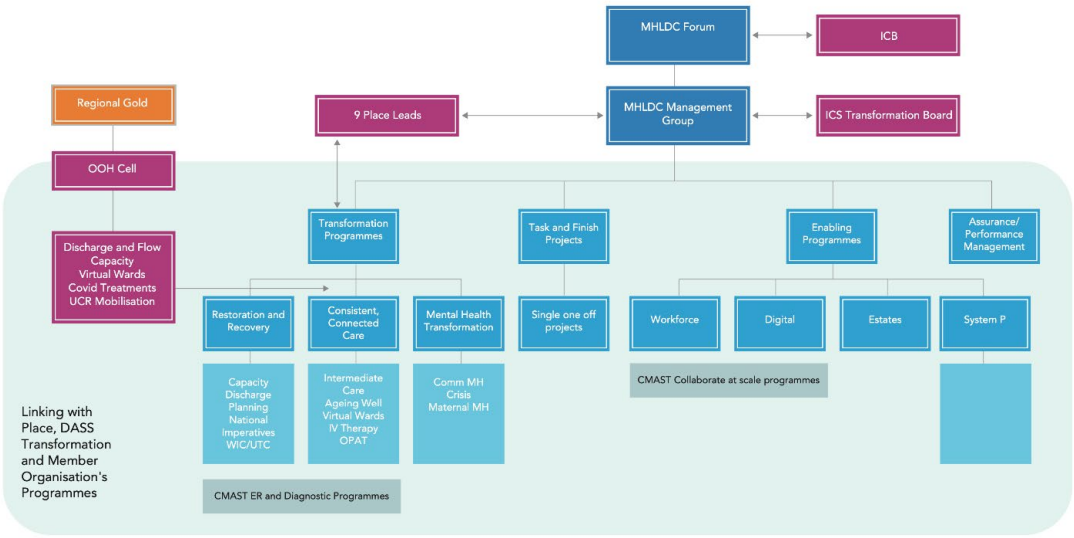
- **Advocacy** – there is significant focus on the acute sector given the issues of demand and capacity that have already been discussed, this can lead to the services represented by the MHLDCPC to be seen as an adjunct to other services. The MHLDCPC will mitigate this by being entirely focused on improving its services for local communities.
- **Sustainability** – whilst each member has a set of core services that are of sufficient scale to stand alone, each also have small, fragile services that are highly susceptible to the impact of the key drivers for change. The cross member mutual aid, and single, coherent commissioning plan for such services will offer greater resilience than the fragmented approach that could arise from a more disparate commissioning structure.
- **Consistency** - there is variation in the scale, scope, range, and level of investment in these services across the ICS that has arisen from the complexity of commissioning arrangements within previous structures. The extent of MHLDCC services in any one community is highly dependent upon the presence of other provision that may come from Local Authorities, the voluntary or independent sector. The MHLDCPC is uniquely placed to understand the nuance in each community and understand if it needs to be addressed.
- **Co-production and engagement** – traditionally these services have a long history of working with local communities and those with lived experience to build, improve and transform services that is fundamental to their culture. The MHLDCPC members all do this within their local communities, Places, with their staff, and with their partners so ensuring that services are developed that are accessible and acceptable to those who they serve.
- **Integrated Services** – all members of the MHLDCPC already have services that they provide jointly with another partner, or partners. Each is experienced in working, sharing risk, and benefit with each other, and with non-NHS partners. This expertise will support future partnership arrangements.
- **Community competence** – most of the care provided by the MHLDCPC is delivered in an individual's own home, or somewhere local to their home. This often requires flexibility, innovation, and ingenuity in the means of care delivery and a clinical maturity that supports staff to work in isolated settings managing high levels of clinical risk. Community competence is essential within all services that seek to reduce acute hospital (including mental health acute beds) admissions and facilitate early discharge.
- **Workforce** – there are significant workforce challenges in all members. Working together will drive initiatives that will include developing an employment passport to enable people to flex their careers through all members, having a single and focused approach to recruitment, offering flexible contracts across member organisations and pooling training and development opportunities.

These opportunities translate into benefits that help address the key drivers for change for the population at Place and system level:

Benefit	Place	ICS
Resilience	service continuity	Mutual Aid across system
Health Inequalities	targeted Interventions	Standardise core offer
Improved service & clinical outcomes	Reduced clinical risk, improved user experience	Consistent service standards
Improved access	local service provision	Reduce service transfers (exports)
Research and Innovation	new and improved evidenced based services	opportunity for external funds to support innovation and transformation
Expert partner	access to wide body of expertise for service planning	access to a wide body of expertise for strategy development
Workforce	reduced capacity constraints, more stable workforce	reduced clinical risk, less cost of temporary staffing, improved productivity
Economies of Scale	improved use of resources, less risk of service reductions	opportunities for reduced costs in infrastructure & investment in new technologies

The MHLDC Provider Collaborative delivery structures

The current structure of the MHLDC Collaborative is set out below. It should be noted that the collaborative is awaiting a view from the ICS regarding resourcing and that this structure does not include any element of a commissioning structure.



Development Roadmap

The collaborative is committed to listening and learning from all stakeholders in support of their efforts and to inform the future strategy and service models. Members of the collaborative are embedded within each of the 9 Places and are therefore well positioned to ensure that the priorities of each Place are reflected and acted upon within the commissioning strategy.

Communication and engagement that takes place routinely helps to develop trust and fosters mutual understanding will be developed over coming weeks / months, making it easier to identify sustainable service improvements.

The collaborative is therefore developing a Communications and Engagement Strategy, underpinned by its members organisation's strategies, and co-produced with the 9 Places. This document is a step towards that process of engagement and any comment or suggestions are willingly received by the Collaborative.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 December 2022**
Agenda Item	**89/22**		
Report Title	**ANTI-DISCRIMINATION REPORT**		
Executive Lead	Paula Woods (Director of People and Organisational Development)		
Report Authors	Ruth Besford (Equality & Inclusion Manager) Tania Strong (Head of HR) Kathryn Sharkey (Head of Workforce) Paula Woods (Director of People and Organisational Development)		
Presented by	Paula Woods (Director of People and Organisational Development)		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

As an employer and public sector organisation we have legal duties under the Equality Act 2010 in employment and service delivery to show due regard to the three aims of the General Equality Duty.

This report, which is provided for assurance, sets out Trust approaches in relation to the first of these three aims to eliminate:

1. Discrimination
2. Harassment
3. Victimisation, and other prohibited conduct

Outlined in the report is a description of our legal equality duties, a section detailing overarching processes and governance and a table detailing risks and assurances by protected characteristic group.

The report confirms that we have strong assurance that we are meeting our legal duties in relation to discrimination. There is and will always be more work to do, and this reflects in part the ongoing learning all organisations are undertaking in partnership with staff to understand all of the associated issues.

Overall, we would like the Board to be fully assured that in relation to employment, we are meeting our legal duties. We appreciate that this requires ongoing commitment and further programmes of work. In that respect and as per this report focusing on anti-discrimination in employment, it includes links to the Trust's policies, procedures, protocols, systems, processes and programmes of work. We have presented this in the form of a table for ease of reference given the magnitude of the legislative frameworks and public sector duties.

Appendix 1 of the report provides an overview of a very complex area of law, but one with which key members of the People Directorate are well versed in.

The Trust's four PODs (People Operational Delivery Groups) have equality, diversity and inclusion running through them as a golden thread. Our POD progress is reported to the Trust's People Committee.

Previously considered by:	
☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Remuneration & Nominations Committee**
☐ **People Committee**	☐ **EMT**

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	8 December 2022
Agenda Item	89/22		
Report Title	ANTI-DISCRIMINATION REPORT		
Report Author	Ruth Besford (Equality & Inclusion Manager) Tania Strong (Head of HR) Kathryn Sharkey (Head of Workforce) Paula Woods (Director of People and Organisational Development)		
Purpose	To detail current policies, procedures, processes, programmes of work, governance, and control in relation to our legal duty to eliminate discrimination in employment.		

1. SCOPE

1.1 This report regarding equality relates to all aspects of employment.

1.2 This report relates primarily to the Equality Act 2010 and its Public Sector Equality Duty. However, it must be highlighted that the Trust also has a more general duty under Article 14 of the Human Rights Act 1998 to ensure we protect people from discrimination.

1.3 This report relates specifically to our legal duty to show due regard to the three aims of the General Equality Duty, specifically aim one – to eliminate discrimination, harassment, victimisation, and other prohibited conduct.

1.4 The report aligns to the systems, processes, policies, procedures, programmes of work and frameworks that we have in place and are planning.

2. INTRODUCTION

2.1 As an employer and provider of NHS healthcare services we have a legal duty under the Public Sector Equality Duty of the Equality Act 2010 to show due regard to the elimination of discrimination, harassment, victimisation, and other prohibited conduct. Appendix 1 sets out a brief description of that due regard.

2.2 The duty relates to the nine protected characteristic groups; these are age, disability, gender reassignment, marriage and civil partnership (in employment only), pregnancy and maternity, race/ethnicity, religion/belief, sex (gender), and sexual orientation. In Appendix 1 basic descriptions of each protected characteristic group are provided for information.

2.3 Discrimination, harassment, and victimisation all have specific definitions, and they all relate to protected characteristic groups. For a legal claim to be valid the act must relate to one of the nine groups listed above.

2.4 As stated earlier, full details are given in Appendix 1, but briefly there are four main types of discrimination:

a. Direct discrimination – there are three types of direct discrimination:

i. Straightforward direct discrimination

ii. Discrimination by association

iii. Discrimination by perception

b. Indirect discrimination

2.5 Harassment is also a form of discrimination and has a quite specific definition.

2.6 Victimisation is a specific form of discrimination where someone is treated unfavourably for making, or helping someone else to make, a protected disclosure in relation to equality.

2.7 There is also discrimination arising because of disability, which differs from direct and indirect discrimination, and again Appendix 1 provides more details.

2.8 In relation to disability, we have a legal duty to make 'reasonable adjustments' that meet individual need for people with a disability; failure to do so, and in a timely manner, is both a failing in our duty and can also be discrimination.

2.9 Awards in relation to discrimination in employment are uncapped unlike in most unfair dismissal claims and they can cover any or all of the following:

a) Loss of earnings

b) Future loss of earnings

c) Injury to feelings

d) Personal injury

e) Interest and/or uplifts in some tribunal cases

f) Other awards where there have been breaches of law

2.10 There are specific rules for dismissal under pregnancy and maternity, unlike in other unfair dismissal cases there is no compensation cap.

2.11 The cases that generally make the headlines are the ones that attach very high compensation awards, generally involving future loss of earnings. A case against Kellogs in 2021 totalled £2.5 million.

2.12 An award for compensation in the NHS, back in 2011, was made against Manchester University Hospitals NHS Trust for £933,000 for race discrimination and unfair dismissal.

Compensation of £4.5 million was awarded against Mid Yorkshire Hospitals NHS Trust for sex and race discrimination, and unfair dismissal.

2.13 Awards are more likely to be in the tens of thousands, but there is also potential cost in terms of loss of reputation. Furthermore, there could be a loss of business as we know we have to declare tribunal complaints and findings against us when tending for new services. At the time of writing, this is not an issue for the Trust.

2.14 The law protects individuals who are not employed by us and an example of that is the recruitment process. There are numerous cases of where applicants have been successful in lodging discrimination claims in relation to protected characteristics when applying for jobs with organisations. Recruiting within the law is paramount and we have training programmes in place.

3. GOVERNANCE

3.1 The Director for People and Organisational Development has Board responsibility for equality in employment.

3.2 Within Bridgewater equality in employment is reported, generally, through the Trust's People Committee to Board, with most detail being provided as assurance, and just specifics going to the Board for sign off. For example, our Gender Pay Gap Report, Workforce Race and Disability Equality Standards, Equality Delivery System (now EDS2022), and the annual equality report.

3.3 Updates are also provided through the Joint Negotiating and Consultation Committee (JNCC) which is a formal meeting of Management and Trade Unions. Fortnightly meetings also take place with our Staff-side Chairs and their Deputies and HR. This gives us an opportunity to discuss our employee relations climate and cases in more detail.

3.4 We take an Employee Relations Report to every People Committee meeting. It outlines activity in relation cases such as Dignity at Work, Grievances and Disciplinaries. This also illustrates our Freedom to Speak Up cases (FTSU). It is really pleasing that our cases are showing a positive trend in number and in the duration of time it is taking to investigate and conclude them. Our Just Culture programme has now started to impact with incidents being looked at by way of a 4 Step Process that we have agreed with our Staff-side Colleagues. Staff are reporting a much better experience when things do not go as planned or as expected for them.

3.5 Periodically, the Director of People & Organisational Development will receive incident reports, and should there be any staff related incidents, these are triangulated with current caseloads in the HR Department. Such cases are extremely rare, but we do have staff who are subject to inappropriate conduct and behaviour from patients and public. Reviewing these ensure that staff receive the appropriate support.

3.6 The Trust has action plans for equality, and these are developed from staff feedback, including the annual survey and networks, through national mandate, such as the

WRES and WDES, and through review undertaken for accreditation such as Disability Confident, Navajo, and Veterans Aware.

3.7 The day-to-day equality work through action plans and task and finish groups are overseen by the Trust's four People Operational Delivery Groups (PODs), all of which have equality within their terms or reference – it's a golden thread:

1. Culture and Leadership POD – main assurance group for equality which includes our Just Culture, Kindness and Civility Programmes of work
2. Health and Wellbeing POD – menopause and support when adjustments are required during employment
3. Recruitment and Retention POD – military veterans, disability confident etc
4. Education and Professional Development – competency frameworks and other specific action, including EDI training and modules

3.8 We have recently (September) had a Board Development session take place that focused on race equality and unconscious bias.

3.9 Our 'Leader in Me' event on the 13th of December 2022 will build on the Board Development session referred to above and link to protected characteristics.

Equality, diversity, and inclusion matters to us all. Keeping this on our agenda has never been as important as it is right now. We are really pleased to welcome back Real and Authentic Representations of Africans and Caribbeans (RARA) Education Project as our keynote speaker. RARA believe that it is through anti-racism education and training (in various aspects of equality, diversity and inclusion), that we can each take a step towards growing and creating more inclusive environments where all individuals can equally, thrive and flourish.

Having recently presented at a Bridgewater Trust Board Development Day, feedback from the event was overwhelming. We are now excited to provide the RARA experience to our wider teams and colleagues throughout Bridgewater.

By taking part in this event, colleagues will join a wider beyond.

3.10 As referenced earlier, we actively seek external accreditation through schemes such as Disability Confident as they both allow us to demonstrate publicly the work we are doing in relation to equity and anti-discrimination, and they importantly give us scrutiny and support through independent bodies with lived experience in protected characteristic groups.

3.11 Finally, our systems, process and programmes of work are listed below. These are areas of employment that we need to ensure are compliant with the law and free from bias.

3.12 The recommendations of this report and reference to appendices are after the table.

Systems, Processes and Programmes of Work	
Policies	All HR policies undergo equality analysis as part of policy governance. This includes recommendation of actions in identified areas of potential discrimination, and also recommendations to enhance identified positive impacts. Equality analysis forms also identify areas where there is a potential negative effect. Though this is rare – our legal duty for due regard is to make decisions based on knowledge of legal duties and knowledge of impact. This reflects that sometimes, for example the pandemic step down of services, that we must do something that will disadvantage but we are doing so with a conscious mind on impact and an understanding that all steps have been taken to eliminate or mitigate disadvantage. A workforce example of potential negative affect would be our Uniform Policy and bare below the elbow requirements.
Terms and conditions of employment	Starting Salaries Guidance to ensure pay parity. Agenda for Change Job Matching and Evaluation Policy as per the assessing and banding of job roles, including applications for regrade. The matching and evaluation processes have been nationally impact assessed. An equality analysis of AfC pay step progression has been completed. National T&Cs contain protocols on equal opportunity, dignity and respect at work which are incorporated into our HR policies and practices.
Governance	Equality governance for employment is through the People Operational Delivery Groups (PODs) and People Committee to Board. Main governance is through the Culture and Leadership POD, though there are streams running through all four as per equality action plans. Our JNCC also supports engagement with our Staff-side colleagues.
Board	Fit & Proper Persons Policy, the VSM Contract and the terms within set standards of probity, conduct and behaviour.
Staff Networks	Six staff networks currently allow engagement with diverse staffing groups. More is needed to embed and mature each, but all networks have brought value in terms of the feedback, support, and insight provided by members on employment matters. Staff network assurance is provided through JNCC and People Committee. Each has an Executive Sponsor.
Freedom to Speak Up / Raising Concerns	Our Freedom to Speak Up Guardians and Champions provide a safe space for staff to speak up regarding any issues that concern them in the workplace, this includes when they have witnessed or experienced discrimination. While other pathways, processes and procedures for reporting and accessing support are available, it is important that this group are also available for all staff. We are working to increase diversity in champions through actively promoting in the staff networks. Our staff survey results indicate that staff are fully aware as to how to raise concerns.

Systems, Processes and Programmes of Work	
PODs (People Operational Delivery Groups)	Each POD has equality representation and actions to work on. All ensure equality compliance for the Trust in their own area – culture and leadership, recruitment and retention, education and professional development, and health and wellbeing. Task and Finish Groups sit under each POD and for equality this include disability confident, and Armed Forces Friendly. As stated earlier, the PODs outputs are routed through the People Committee in the form of a POD Group Action Plan. This work is delivering our People Strategy which is underpinned by the NHS People Plan and seven People Promises.
Our Just Culture Journey	Our Just Culture journey is an ongoing programme of work. It supports the NHS People Plan action plan, and the WRES: A Model Employer mandate. It also supports elimination of discrimination in employee relations cases, particularly in relation to ethnicity, identified at national level, as reported in WRES.
Kindness, Civility and Respect	An ongoing programme of work to build on work started with BABAH (Bridgewater's Anti-Bullying & Harassment). It supports due regard to General Equality Duty, and elimination of discrimination, including harassment, in the workplace. We have recently engaged staff in the national programme and are inviting staff to enter a competition to brand this work. Anti-bullying and harassment week took place in November with staff posting their 'odd sock' wearing pictures.
Violence, Prevention and Reduction Standard	Led by Michaler Kan, a programme of work is underway to minimise violence and aggression, including non-physical assaults on staff by patients and their families etc. It supports due regard to General Equality Duty, and minimisation of harassment – it must be noted here that as a provider of healthcare services we recognise that we cannot totally eliminate these instances as they can occur without prior warning or knowledge, and we need to balance the individual circumstances in every instance.
Action Plans – Our 6 Priority areas for equality	Six Priority Areas for Equality are outlined in our Trust action plans: Armed Forces Friendly, Cheshire and Merseyside d/Deaf action plan, Navajo action plan, Disability Confident action plan, Anti-racism Framework and WRES action plans. These all support our legal due regard duties, and the continued identification and elimination of potential discrimination in employment and service delivery.
National reporting	Our WRES, WDES, Gender Pay Gap Report, EDS2, and the Equality Annual Report have all been submitted on time as per legal and contractual mandates. All with their own focus, they support due regard to the General Equality Duty, and identification of best practice or action for elimination of discrimination in employment, and for EDS2 and the annual report for service delivery. EDS2022 is a refresh to EDS2 and we are working collaboratively with partners in Cheshire and Merseyside on domain 1 which relates to patients, and with Staff-side and our Staff Networks on domains 2 and 3 which relate to workforce and leadership. EDS2022 is designed to support us evidence due regard and identify areas for improvement or enhancement.

Systems, Processes and Programmes of Work	
Local reporting	Quarterly equality reports are submitted to Halton and Warrington CQPG on the equality indicators of the NHS Standard Contract. Assurance is provided by the Midlands and Lancashire ICB Equality Lead.

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
Age – younger and older age groups *Starting salaries, experience required, unconscious bias and stereotyping based on age, protections for under 18s, retirement, caring responsibilities, ill health, and disability*	Recruitment	**Equal Opportunities Policy** * *Details Trust policy on equality of opportunity, discrimination, and harassment for all protected characteristic groups.* **Recruitment Policy including NHS Employment checks and anonymised shortlisting** * *Details Trust policy on fair employment practices, safe recruitment, equality and employment law.* **Recruiting Managers Training** * *Includes recruiting within the Equality Act 2010.* **Mandatory Training and Induction Policy** * *Induction includes modules on equality, values, HR, and other topics relevant to equality in employment. Mandatory training includes equality module.*	Direct age discrimination Indirect age discrimination Disability discrimination could also be relevant Harassment	ET cases

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
		Induction and Onboarding Process * *Supports safe induction, and inclusion into the workplace. Our People Values, standards of behaviour, FTSU, raising concerns, risk/incident reporting and Just Culture are featured.* **Apprenticeships Policy and SOP** * *Supports new opportunities for careers, with different options to suit different abilities, career pathways, young staff, staff returning following career breaks, and others.* **Traineeship Pre-Employment SOP** * *Details Trust processes to support traineeships for those who may be new to the workplace or have struggled to access or maintain work in the past.* **Work Experience Policy** * *See also Traineeship above.* **Flexible Working Policy** * *Open to all staff from the start of their employment. This has links to employment law and the NHS national terms and conditions of service. Working flexibly is one of the seven NHS People Promises. We are placing emphasis on flexible working to attract and retain*		

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
		our workforce and help them balance their home and work lives. **Career Break Policy** * *Particularly supportive for staff looking to take a break for family support needs/commitments, travel, other training etc.* **Age Positive Employer** *illustrates our commitment to all ages.* **Anonymised Shortlisting as per NHS Jobs** * *See recruitment policy above (removes potential bias in the recruitment and selection process).* **Starting Salary Guidance and Recognition of Previous Experience (ROPE Form)** * *Provides guidance on fair recruitment / equal consideration in relation to previous experience, recognising that some roles will require specific previous experience but others can be more flexible. Previous experience may be recognised as per starting salary.*		
	Employment	**Dignity and Respect at Work Policy** * *Details Trust policy on harassment, bullying, and abuse*		NHS Staff Survey

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
		from staff. Includes informal and formal processes. **Just culture** * *Programme implemented and being further developed and embedded to look at understanding human factors and learning from when things don't go as planned. A move away from formal processes for every incident, though it is recognised that some incidents, including those relating to equality will require a formal process. Disciplinary and dignity at work are just two policies being reviewed as part of this ongoing just culture journey/programme.* **Civility and Respect Programme** * *Aligned to and alongside Just Culture, this cross cuts across all protected characteristic groups through harassment and discrimination definitions. We have added 'Kindness' to this agenda.* **Freedom To Speak Up** * *A formal network of Guardians and Champions for all staff to access if they are concerned about something in the workplace, including discrimination.*		EDS2022 ER data

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
		Annual Leave Policy *Entitlement relates to length of service which could detriment younger staff, but it is a recognised practice based on rewarding loyalty of service to NHS.* **Working Time Policy** *Makes specific reference to younger staff who legislation requires different break periods and length of working day/week.* **Special Leave Policy** * *Allows for additional paid and unpaid time off to support staff with unexpected family emergencies etc. Will have relevance for different groups of staff.* **Menopause Policy *** *Supports staff going through menopause transition, whether natural, early, premature, medical, or surgical. Cross cuts of course with gender, gender reassignment, and race.* **Flexible Retirement Options** *Supports older staff to make a choice as to how and when they retire from the Trust. It can also support those older staff who may wish to remain in the workplace for family, financial, and other personal reasons (retire and return).*		

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
	Other – students, work placements	**Placement Risk Assessments** * *Particular reference and support for younger people attending the Trust on placements.*		
Disability *Reasonable adjustments, experience required, unconscious bias, harassment, progression, capability, data limitations, health conditions, health questions*	Recruitment	**Disability Confident - guaranteed interview** *As per the Disability Confident scheme we offer a guaranteed interview to any candidate with a disability who meets the essential criteria for a role.* *https://bridgewater.nhs.uk/careers/vacancies/* **Access to Work support** *A2W can be used by any candidate given an unconditional letter. The Trust would support candidates in their application to the scheme and in the provision of any recommended adjustments for work.* **Recruiting Managers Training and 'Recruiting Within the Law'** *Details specific requirements related to the asking of questions about disability and health at interview.*	Direct disability discrimination Indirect disability discrimination Discrimination arising from disability Failure to make reasonable adjustments Harassment	WDES EDS2022 ET cases

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
		Occupational health *Available to support the recruitment process, including general advice regarding reasonable adjustments.*		
	Employment	**Violence and Aggression Policy, and Reduction and Prevention Standards** * *Led by Michaler Kan the Trust's action plan for the standards recognises that some staff, including those with disabilities are more likely to state they have experienced harassment from patients/families.* **Disability Confident Leader and Action Plan** *A two-year plan to embed best practice and address gaps identified in Disability Confident Leader assessment in 2022. Reports to the Recruitment and Retention POD.* **WDES action plan** *Part of our main equality plans.* **Employee Adjustment Passport and Policy** *Supports reasonable adjustments.* **Our Enabled Network** *Exec sponsor for this staff network is Nick Gallagher.*		ER data NHS Staff Survey EDS2022 WDES Disability Confident (2024)

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
		Access to Work *Support in employment for any disabled staff.*		
	Other – ill health retirement, capability dismissal	**Capability and Performance Management Policy** * *Sets out the Trust's approach to managing capability and performance issues, recognising that some cases may relate to disability or ill-health and require reasonable (and other) adjustments to support the staff member in their role, consider other roles, or in some cases take ill-health retirement where this is the preferred and best option.* **Absence Management Policy** *Allows for reasonable adjustments where absence relates to disability. Currently being reviewed as part of our Just Culture programme. A North West Holistic Wellbeing Policy is being consulted on and is due out in the New Year.* **Conduct, Capability, Ill-Health, and Appeals Policy and Procedures for Medical and Dental Staff** *As for capability policy.*		

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
Gender Reassignment *Gender recognition act, staff records, references, DBS, health checks, transitioning in the workplace, staff ID, right to erasure, pronouns, harassment, health and wellbeing, expression of gender critical views by others*	Recruitment	**Equal Opportunities Policy** *Specific reference to Gender Recognition Act 2004 and consent to disclose of gender recognition certificate (GRC) – as a Trust we take this approach of informed consent for all trans staff (no need to hold a GRC). References potential, cautious, use of occupational requirements – unlikely to be relevant in Trust services.* **Recruitment Policy including NHS Employment Checks and Anonymised Shortlisting** * *Specific reference to sensitive DBS service.*	Gender Recognition Act 2004 – potential level 5 criminal act, questionable under police caution Direct gender reassignment discrimination Indirect gender reassignment discrimination Sex discrimination Harassment Potential disability discrimination if employee meets definition of disability	ET cases Police incidents
	Employment	**Cheshire & Merseyside Trans Task and Finish Group** *Development of Transgender Employee Support Policy (draft).* **LGBTQIA+ Staff Network** *Exec sponsor Sarah Brennan and Jan McCartney.* **Navajo Charter Mark and action plan** * *Awarded to the Trust in September 2022 following external assessment. It recognises work around inclusion for LGBTQIA+ staff and patients.*		Navajo (2024) NHS Staff Survey EDS2022 ER cases ET cases Police incidents

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
	Other - references			Police incidents ET cases
Marriage and Civil Partnership *Only in employment*	Recruitment	Cross cut with policies referenced earlier – an example of discrimination would include refusing employment to a married woman with children for a role that worked nights through 'assumption' that they would not be able to do the shifts.		ET cases
	Employment			ET cases
Pregnancy and Maternity *Organisational change, breastfeeding, not just female/mums, fertility treatment, baby loss, workplace risk,*	Recruitment	Cross cut with policies referenced earlier	Direct pregnancy and maternity discrimination Indirect pregnancy and maternity discrimination Harassment Sex discrimination may be applicable	ET cases
	Employment	**Maternity, Paternity Support and Adoption Leave Policy** * *Specific policy for staff protected under pregnancy and maternity, but also relevant to gender, gender reassignment, and sexual orientation. A lot of work has been undertaken in recent years to make policies such as this inclusive of different gender and sexual identities.* **Shared Parental Leave Policy**		NHS Staff Survey EDS2022 ER cases ET cases

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
mat leave, absence management, paternal mental health, paternity and shared parental leave		**Absence Management Policy** *Particular reference to pregnancy related sickness absence.* **Maternity Risk Assessments** **Paths to Parenthood network** *Looking at issues around fertility treatment support, baby loss.* **Covid 19 risk assessment and mitigations**	Sexual harassment may be applicable	
	Other – organisational change	**Organisational Change Policy** *Our equality analysis and QIA Panels consider any adverse impacts on staff. An example would be a change of work location that impacts adversely on caring for a dependent.*		ET cases
Race/Ethnicity *Racism, individual and structural, bias, disciplinary, representation, career progression, intersectionality,*	Recruitment	**Recruitment Policy including NHS Employment Checks and Anonymised Shortlisting** * *Research shows that a key issue for many Black, Asian, and minority ethnic staff is recruitment where names are given in shortlisting. Our practices remove personal data when shortlisting and selecting.* **Race At Work Charter** *Trust commitment to five pledges for race equality, including in recruitment.*	Direct race discrimination Indirect race discrimination Harassment	WRES EDS2022 ET cases

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
sponsorship in employment (Tier 2)	Employment	**Race Inclusion Network** *Exec sponsor CEO, Colin Scales, and Trust Chair Karen Bliss, Network Chair Dr Aruna Hodson.* **WRES Action Plan** *Mandated action plan, part of our overall equality action plans.* **WRES: Race Disparity Ratio Action Plan** **Anti-racism Framework** *includes commitments and areas of focus.* **Just Culture** * *Supports WRES: A Model Employer which focused on representation in disciplinary initially.* **Race At Work Charter**		NHS Staff Survey EDS2022 WRES ER cases ET cases FTSU Ulysses
Religion or Belief *Intersectionality with racism, Islamophobia, access to faith spaces in*	Recruitment	Cross cut with policies referenced earlier	Direct religion or belief discrimination Indirect religion or belief discrimination Harassment	ET cases
	Employment	**Communications for Key Events i.e. Ramadan** See also race, above, as potential intersectionality		NHS Staff Survey – limited data EDS2022 ER cases

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
workplace, fostering good relations, uniforms, cultural awareness, religious expression, leave for important events, travel to family, expression of gender critical views				ET cases
	Other – bare below the elbow Access to appropriate faith spaces and time to meet faith needs Expressions of faith, including jewellery Expressions of gender critical views	**Uniform and Dress Code Policy**		ER cases ET cases
Sex *Harassment, including sexual harassment, equal pay, gender pay gap, carers, different identities, menopause,*	Recruitment	Cross cut with policies referenced earlier	Direct sex discrimination Indirect discrimination Sexual harassment Equal pay	EDS2022 ET cases
	Employment	**Menopause Support Network** **Menopause Working Group** *Intent to focus on wider gender health topics in future, for example breast cancer awareness.* **Gender Pay Gap reports**		Gender Pay Gap NHS Staff Survey WRES

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
retirement ages, representation, career progression, parental responsibilities, flexible and part time working, women's safety				WDES EDS2022
Sexual Orientation *Harassment, outing, or not being out, health and wellbeing, different identities, career progression*	Recruitment	Cross cut with policies referenced earlier	Direct sexual orientation discrimination Indirect sexual orientation discrimination Harassment	ET cases
	Employment	**Rainbow Badges (including training)**	Direct sexual orientation discrimination Indirect discrimination Harassment based on sexual orientation	Navajo NHS Staff Survey EDS2022 ER cases

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
				ET cases
	Other – outing in work			
Other Groups	Carers	**Special Leave Policy** **Flexible Working Policy** **Employee Adjustment Passport and Policy** **Carers Accreditation Action plan** **Health and Wellbeing Conversation Training** **Carers Support Network**	Not protected under the Equality Act as carers, but a priority group for Trust Direct sex discrimination Indirect sex discrimination	NHS Staff Survey Employers for Carers accreditation
	Armed Forces Community	**Special Leave Policy** **Armed Forces Friendly Action Plan** **Defence Employers Recognition Scheme** **Veterans Aware Accreditation**	Equality Act not directly attributable unless discrimination can be evidenced through protected characteristics Armed Forces Act 2021 Armed Forces Covenant	Veteran's Aware accreditation Defence Employers Recognition Scheme

Protected characteristic *(including potential inequality or discrimination)*	**Employment/Workforce Areas**	**Policies, Procedures, Frameworks etc**	**Equality Act – Potential Risk of Claims and Compensation**	**Measured by** **(i.e. the WRES, WDES, Staff Survey, Incidents, Staff Complaints (invoking of policies and procedures) and Employment Tribunal Claims**
Please note, * details a policy, process, or programme that cross cuts protected characteristic groups, and for brevity are stated just once in this table.				
	'Chaotic lifestyles'	**Alcohol and Substance Misuse Policy** **Health and wellbeing support** **Absence Management Policy** **Domestic Violence Policy** **Flexible Working Policy**		

4. RECOMMENDATION

4.1 It is recommended that the Board take this paper as assurance that the policies, processes, programmes, and action plans of the Trust are actively working to ensure we are an anti-discrimination employer.

5. APPENDICES

Appendix 1 Overview of the legal frameworks - Equality Act and Public Sector Duties

Equality Act 2010 in employment

The Equality Act came into force on 1st October 2010.

The Act was introduced to strengthen equality law, bringing together more than 100 pieces of existing equality legislation, including age, race, sex, disability, and sexual orientation duties and laws, and equal pay legislation.

In addition, new areas of discrimination were also included in the new Act, notably for gender reassignment.

To follow we provide a brief overview of the requirements of the Equality Act in relation to employment.

Public Sector Equality Duty – Due Regard

As a provider of services to the public we have an additional legal duty to protected characteristic groups in the Public Sector Equality Duty which has two elements:

- General Equality Duty requires us to show due regard to three aims:
    - To eliminate discrimination, harassment, victimisation, and other prohibited conduct
    - To advance equality of opportunity between people who share a protected characteristic and those who don't share this, which includes
        - Removing or minimising disadvantages suffered by people due to their protected characteristics
        - Taking steps to meet the needs of people from protected groups where these are different from the needs of other people
        - Encouraging people from protected groups to participate in public life or in other activities where the participation is disproportionately low
    - To foster good relations between people who share a protected characteristic and those who don't share this

- Specific Duties:
    - To publish at least annually evidence of the due regard above
    - To publish at least every four years specific and measurable equality objectives

The Public Sector Equality Duty is in relation to both employment and service delivery, except for marriage and civil partnership which is only applicable in

employment – and discrimination in relation to same sex marriage and civil partnership in service delivery would be tried under sexual orientation.

Due regard has a specific test taken from case law (the Brown Principles), and it is important for public sector organisations firstly that all individuals making decisions that impact on equality are aware of their legal duties, and secondly that evidence of decision making is published and retained.

Due regard, the Brown Principles:

- Decision makers must be aware of their duty to due regard and the three aims of the General Equality Duty
- Due regard must be undertaken in consideration, development and at decision making time, it cannot be undertaken retrospectively
- Due regard should be undertaken with a conscious approach – be aware of equality duties and consider impacts, both positive and negative, in decision making
- Equality evidence should be reviewed robustly and with an open mind so that it is truly considered in the final decision
- Equality and due regard should be embedded throughout the business of the organisation, not tick boxing
- The duty cannot be delegated
- Accurate and contemporaneous records must be kept

Due regard duties also relate indirect areas of business such as procurement, sub-contracts, and partnerships, how these interactions with external organisations who are working with or for us also meet due regard to the three aims of the General Equality Duty. And as referenced above decision makers need to be aware that duties cannot be delegated, and therefore they should be asking questions of how the external body is ensuring it does not discriminate.

Protected characteristic groups

There are nine protected characteristics:

- Age – both specific ages and groups of ages
- Disability, which has a legal definition of a physical, mental, or sensory impairment that has a long term and substantial adverse impact on day-to-day life, can include:
    - Physical
    - Mental
    - Sensory
    - Learning
    - Neurodiverse and other invisible conditions

    - Some long-term conditions, particularly those that are progressive or fluctuate/recurring
    - HIV, cancer, and multiple sclerosis are protected from diagnosis, as are people who are registered blind or partially sighted with the local authority
    - Severe disfigurements are counted as a disability
- Gender Reassignment – people who are proposing, are undergoing, or have undergone a process to align their gender to their preferred identity. There is no need to undertake a medical realignment of gender
- Marriage and Civil Partnership – being single or unmarried is not protected
- Pregnancy and Maternity
- Race – which includes ethnic and national origins, nationality, and colour
- Religion or Belief – includes lack of religion or belief
- Sex – gender, and until very recently has narrowly defined as male/female, however recent case law is recognising other gender identities including non-binary and intersex
- Sexual Orientation – similar to sex (gender) legislation has been quite specific and has not fully recognised the diversity of sexual identities

Discrimination, harassment, and victimisation

The Equality Act 2010 prohibits discrimination, harassment, and victimisation, and requires us to show due regard to how we eliminate these behaviours in day-to-day business.

The word ‘discrimination’ is often used by people to describe being treated unfairly, however unlawful discrimination occurs when unfair or unfavourable treatment relates to a protected characteristic.

Discrimination claims can be brought against both the Trust and against individual staff where discrimination is claimed to have occurred in work. And employers can be responsible for the acts of their employees – taking all reasonable steps to train staff and put process and policy in place to avoid discrimination can avoid this vicarious liability.

There is no minimum length of service for employees to be able to bring a claim for unlawful discrimination. This means that a claim can be made in respect of a job advert, throughout employment, up to job references for ex-employees and beyond.

While there is a series of bandings (Vento bands) used in awarding successful employment discrimination claims it should be noted that awards are uncapped and particularly when injury to feelings and loss of future earning awards are given can be of significant amounts.

There are different types of discrimination, some are always unlawful, and some can be objectively justified in some instances.

Direct discrimination

There are three types of direct discrimination, they occur when someone is treated less favourably because of a protected characteristic:

- Ordinary **direct discrimination** occurs when an individual or group is treated less favourably as a result of a protected characteristic. It is the only type of direct discrimination that can be lawful, if it can be objectively justified as a proportionate means of achieving a legitimate aim. The Equality Act specifies these as:
    - Age – for example protections excluding under 18s from hazardous occupations or areas for health and safety reasons associated with lack of experience
    - Disability – where a disabled person is treated more favourably than a non-disabled person, for example guaranteed interview commitments
    - For some specific exemptions – positive action schemes (not positive discrimination which is unlawful) for recruitment and leadership development in under-represented protected characteristic groups for example. There are also a very few occupational requirements and work-related exemptions
- **Discrimination based on association** is direct discrimination against someone because they associate (or are believed to associate) with someone who has a protected characteristic
- **Discrimination based on perception** is direct discrimination against someone who is perceived (not necessarily correctly) to have a protected characteristic
- Direct discrimination requires a comparator group to demonstrate the unfair treatment – however this unfair treatment does not need to be experienced, just evidenced as would be experienced
- Generally direct discrimination is an intentional act or exclusion, but not always, and employers should be aware that unintentional direct discrimination claims can also succeed at tribunal

Indirect discrimination

Indirect discrimination is usually less obvious than direct discrimination and is usually unintentional.

It generally occurs when a rule or plan is put into place which applies to everyone; in itself it is not discriminatory, but it could put those with a certain protected characteristic at a disadvantage.

In law it is where a ‘provision, criterion, or practice’, often just termed PCP, involves all the four things below:

1. The PCP is applied equally to a group of people, only some of those will share the protected characteristic
2. The PCP has, or will have, the effect of putting those who share the protected characteristic at a particular disadvantage when compared to those who don’t share that protected characteristic
3. It puts, or would put, the person at that disadvantage
4. The employer cannot objectively justify if as a proportionate means of achieving a legitimate aim.

While the Equality Act 2010 does not specify what a PCP is, ACAS say the term is ‘most likely to include an employer’s policies, procedures, rules and arrangements, even if informal, and whether written down or not’.

All four of the above must apply for a successful claim, but it is the claimant’s responsibility to demonstrate point 2, and to also demonstrate that point 3 applies personally to themselves.

Objective justification

A proportionate means of achieving a legitimate aim, the objective justification test, is applicable to indirect discrimination and also to some other forms of discrimination for example direct discrimination because of age, and discrimination arising from disability.

It is to the employer to evidence the justification, and it must be specific and robust, generalisations will not satisfy the test. Employers should ask themselves two things:

- Is the aim of the PCP legal and non-discriminatory and does it represent a real, objective consideration?
- If the aim is legitimate, is the means of achieving it proportionate – that is appropriate and necessary in all circumstances?

Discrimination arising from disability

This occurs when someone is treated unfairly because of something to do with their disability, it only applies to people with disabilities. It also only applies where the employer knows, or could reasonably be expected to know, that an individual has a disability, but this can be difficult to defend as, for example, prolonged periods of sickness absence for stress and anxiety should be triggering questions about a legal protection of disability due to it potentially meeting the substantial and long-term effect definition.

The Act says that treatment of a disabled person amounts to discrimination where:

- An employer treats the disabled person unfavourably;

- This treatment is because of something arising in consequence of the disabled person's disability;
- And the employer cannot show that this treatment is a proportionate means of achieving a legitimate aim.

Discrimination arising from disability is different to direct disability discrimination which is where someone is treated different because of disability itself, examples are given below:

- An employer refuses to appoint a candidate who advises at interview that they have multiple sclerosis despite being the highest scoring candidate because they assume the individual will have more sickness absence. This is direct discrimination as the individual is disadvantaged because of their disability

- An employer dismisses a worker because she has had three months' sick leave. The employer is aware that the worker has multiple sclerosis and most of her sick leave is disability-related. The employer's decision to dismiss is not because of the worker's disability itself. However, the worker has been treated unfavourably because of something arising in consequence of her disability (namely, the need to take a period of disability-related sick leave).

The second example above does not mean that a person with a disability can never be dismissed through sickness absence procedures, but reasonable adjustments must be considered, and each case should be considered individually and on its merits.

Harassment

Harassment is a form of discrimination.

Harassment is unwanted conduct related to a protected characteristic that has the purpose or effect of violating a person's dignity, or creating an intimidating, hostile, degrading, humiliating, or offensive environment for them.

Bullying, nicknames, gossip, intrusive or inappropriate questions and comments can all be harassment. Excluding someone, for example not inviting them to events or meetings can count as harassment.

To say the behaviour was not meant to cause offense, or was just 'banter', is not a defence.

With harassment, how the victim sees the conduct is what is important, not how the harasser(s) sees it. And someone who witnesses this type of behaviour can also claim harassment if it has a negative impact on their dignity at work, even if they do not share the protected characteristic as the individual who was harassed.

Victimisation

Victimisation is the final type of discrimination. It occurs when someone suffers a detriment because that have done (or are suspected to have done or will do) one of the following things in good faith:

- Make an allegation of discrimination
- Support a complaint of discrimination
- Give evidence relating to a complaint about discrimination
- Raise a grievance concerning equality or discrimination
- Do anything else for the purposes of (or in connection with) the Equality Act, for example bringing an employment tribunal claim of discrimination

A detriment can include a loss, disadvantage, damage, or harm; for example being labelled a trouble maker, being left out and ignored, being denied training or promotion opportunities, or being made redundant.

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	16 November 2022	Date of next meeting:	18 January 2023
Chair:	Abdul Siddique, Non-Executive Director	Parent Committee:	Board of Directors
Members present/attendees:	Members Abdul Hafeez Siddique, Non-Executive Director (Chair) Tina Wilkins, Non-Executive Director Sally Yeoman, Non-Executive Director (left after item 102/22) Paula Woods, Director of People & Organisational Development Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer 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 Denise Bradley, Unison Bridgewater Branch Secretary & Staff Side Chair Katherine Summers, IPC Nurse Jan McCartney, Trust Secretary Ruth Besford, Equality and Inclusion Manager **Observers** Rachel Game, Governor Observer Sarah Power, Governor Observer	Quorate (Yes/No):	Yes
		Key Members not present:	Dr Ted Adams, Medical Director Linda Chivers, Non-Executive Director Helen Hollett, Head of Leadership and Organisational Development Susan Burton, Deputy Chief Nurse

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Committee Chair's Report

NHS
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This particular Committee meeting was extended by one hour, following the standing down of the rearranged September Committee meeting on 29th September, due to quoracy. The scheduled meeting on the 14th September was stood down as per the period of mourning due to the passing of Her Majesty Queen Elizabeth II. The 14th of September Committee papers were provided again separately, and business cycle items were highlighted.

Key Agenda Items (aligned to the BAF and Well-led Action Plan Recommendations – WLR):	BAF & WLR	RAG	Key Points/Assurance Given	Action/decision
MEDICAL APPRAISAL AND GMC REVALIDATION REPORT			Medical Appraisal and GMC Revalidation Report was approved via e-governance (20 September) and went to Board in October as per the Committee Chair's Report	
COMMITTEE BUSINESS CYCLE REVIEW			The Committee Business Cycle was presented by the Trust Secretary for approval.	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. In relation to an SLA with Mid Mersey Digital Alliance (MMDA), as a new extranet will need to be procured and built, an estimated date would be around the end of March 2023. This date is only a suggestion at this stage and may need to extend beyond this timeframe once a new extranet provider has been procured and scoped. The Deputy Director of Communications and Engagement confirmed he's had assurance from the Information Team that MMDA would not cease the current SLA without sufficient communication with the Trust and any ending of the SLA would be managed professionally	The Committee were assured on the progress and governance around the management of risks through Risk Council. Updates will be provided at future meetings.

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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
IQPR – PEOPLE INDICATORS	5, 6 and WLR 9		The 5 IQPR people indicators were presented to the Committee for month 6. Four of the five People Indicators were reporting as red – the exception being Induction which is reporting green. 2 of the 5 indicators slightly improved in month 6, one remained static; however PDR's, Sickness and Turnover still remain adrift from the Trust target. Tina Wilkins queried as to what the Trust is doing to support Flexible Working in support of Retention. Jo Waldron, Deputy Director of People and OD confirmed that this is being considered in the Recruitment and Retention POD – further details were contained in the People Operational Delivery (POD) Group Report later in the agenda. There was a discussion around reasons for leaving and the ability to get underneath the data; once again it was confirmed that this is being considered in the Recruitment and Retention POD and Directorate data will be presented to DLT's once the infrastructure has been set up in the early New Year. Further details of the current progress were outlined in the POD report later in the agenda. The Committee Chair asked how other Trusts are doing in relation to the Retention. The Deputy Director of People and OD advised that this is a significant issue across the Country, Region and System and it was agreed that some benchmark information would be brought to the next Committee with the support of the ICS Retention Lead.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings. Benchmarking information in relation to Retention across the ICS will be brought to the next meeting.

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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
			Papers presented later in the agenda outlined the actions being taken to address those indicators that remain below the Trust target.	
DIRECTOR'S UPDATE REPORT	5 and 6		The Director's Update Report was presented by Paula Woods, Director of People and OD, 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. Paula Woods, Director of People and OD highlighted her intention at the last meeting to refer to our People Strategy and highlight that as we come close the end of the financial year, we will be reporting on how we have measured our success against our People Strategy. This will be published alongside our People Strategy in the form of an annual report of achievements and areas of further focus and/or development. With regard to focusing on our People Strategy delivery, the last report covered the following that support the delivery of the NHS People Plan, Promises and the Trust's People Strategy: • NHS Workforce Strategy • NHS Nursing & Midwifery Retention Tool • National AfC review of Nursing & Midwifery national job evaluation profiles • Overhauling Recruitment in the NHS – Expression of Interest	The Committee noted the report and its contents. Further updates on the workstreams will be provided in future meetings as they progress.

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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
			• Flexible Working / Retire and Return – national support • NHS Cheshire and Merseyside – appointment of Retention Lead • Greater Manchester Health and Care Research Award – Ruth Besford shortlisted • Rugby League Cares – Side by Side Programme - update and feedback from staff • SLT and EMT Agendas • Trust Workforce Plans and Workforce Planning • Cost of Living: Financial Support and Mileage Rates • Staff Uniforms – proposals seeking feedback from staff • Working Carers Accreditation • Bridgewater's First Line Managers Programme • Staff Health & Wellbeing Fortnight – evaluation underway • Covid 19 Booster and Flu Vaccine Programmes • Bringing Transactional Training Services back in-house from WHH – update on progress • Thank you to Rita Chapman In relation to the November report, The Director of People and OD highlighted the following to the Committee: **Industrial Action** At the time of writing, we had received three formal Ballot notifications with regards to strike action and/or action short of a strike. Such action involves working to rule, no overtime etc:	

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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
			• RCN (Royal College of Nursing): Ballot closed 2nd November (any action would be taken during the 18th November 22 – 2nd May 23) • UNISON: Ballot closes 25th November (any action would be taken from the 9th December 22 – 24th May 23) • CSP (Chartered Society of Physiotherapists): Ballot closes 12th December (any action would be taken from the 26th December 22 to 11th June 23) Paula Woods updated that since the time of writing we had received formal notification from the RCN of their intention to strike having met the thresholds following ballot. We are preparing for any formal industrial action as part of our winter planning preparedness. We will be supported by NHS Employers with co-ordination being assured on at ICS level. We are working in partnership with local staff-side reps and Regional Officers. There is a recognition that action proposed is against the Government and staff will be supported in their decision making and Health and Wellbeing of all staff, including those who take part in strike action, will be a priority. Sarah Brennan, Chief of Operations (COO)confirmed that she is working with other COO's across the system to ensure a coordinated approach. **NHS Workforce Strategy** The emergence of a long-term Workforce Strategy and Plan for the NHS is anticipated at the end of the year.	

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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
			Government investment in the strategy still remains unclear, as does what the Strategy will comprise of. Recruitment and retention challenges remain significant and various professional bodies are making representations to the Government on the need to have a long-term plan that is financed. **ESR Transformation** NHS Business Services Authority have a Senior ESR Transformation Lead looking at digital people and workforce solutions. Whilst a new workforce solution is procured based on user needs, organisations have been asked to prepare by maximising the capabilities within ESR. Digital assessments are taking place and there is a programme for work to the end of 2024. Overall, the transformation and transition period spans to 2030. The NW HR Directors Network has received a presentation on the above and we have a NW working group feeding into this programme **National People Policies** Action 5 of the Future of the NHS HR and OD report calls for the development of a core set of simplified and standardised NHS people policies by 2025 • A Task and Finish Group of Chief People Officers has been formed to oversee the project • The Group has committed to initially draft a Policy Framework and Template for the development of	

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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
			local policies, so that all people policies begin to look more standardised by March 2023 • People policies will be written by a Working Group comprising of key stakeholders. During 2023, 2024 and 2025 more and more polices will be developed until the NHS has a core set of national people polices. **Warrington Together: Workforce Enabling Group** Warrington Together are looking at the development of an Integrated People Plan. Key priorities are about having shared approaches to people practices such as workforce planning, recruitment, health and wellbeing, coaching, mentoring, career pathways, and maximising digital learning. A Workforce & OD Enabling Group is in the process of meeting. Paula Woods, Director of People and OD will chair this group which will report into its Senior Responsible Officer (SRO) Denise Roberts, Associate Director of Quality and Safety Improvement (NHS Cheshire & Merseyside). **North West Wellbeing Pledge: Sickness Absence Policy** The Trust has signed up to the North West Wellbeing Pledge. A Task & Finish Group of Management and Staff-side have been working on the development of a policy that reflects 'holistic' wellbeing with less of a focus on absence triggers. The aim is to have one policy for the whole of the North West. We have been advised that this work is nearing completion and once consultation has concluded, it will be shared with Trusts. **NHS Staff Survey 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
			Paula Woods updated that the Trust's staff survey response rate for 2022 is 53%, which is our highest response rate to date - 50% for two years on the run. We have offered staff incentives which have included tickets to the final of the Rugby League World Cup. The survey closes on the 25th November, after which we can expect the results to be published in the new year (February). **Staff Health & Wellbeing: Health & Wellbeing Fortnight Evaluation and Feedback** An appendix was added to the report in relation to the evaluation of the Trust's Health and Wellbeing Fortnight as requested at the last Committee. **Transfer of Services (TUPE): Bringing Transactional Training Services back in house** Our Transactional Training Services have now been brought back in house with effect from 1st November 2022. The transition of services was a smooth one and the support we received from the HR and Workforce Teams at Warrington & Halton Hospitals (WHH) was excellent. **Sally Yeoman MBE – Thank you** Paula Woods personally thanked Sally for her invaluable contribution to this Committee and the work of the Trust's People agendas.	
PEOPLE STRATEGY AND PEOPLE PLAN – PEOPLE OPERATIONAL DELIVERY PLAN REPORT			The People Plan and Promise: People Operational Plan Report was presented by Jo Waldron, Deputy Director of People and OD 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	The Committee noted the report and its contents. Further updates on the workstreams will be provided in future meetings as they 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
			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 following gives a high level update as to the areas of focus in each POD **1. Recruitment and Retention** • Review of data to understand key issues and hotspots • Review of Exit Interviews and Onboarding Survey process and reporting • Flexible Working – process, promotion and innovation • Recruitment process and Job descriptions • Development of new roles to support newly qualified Nursing staff **2. Health and Wellbeing** • Review of data to understand key issues and hotspots • Focus on the proactive support and management of stress • Robust communication in relation to the extensive support available Nationally, Regionally and Trust wide in relation to cost of living crisis **3. Education and Professional Development** • Monitoring of CPD expenditure • Trust Wide Competency Framework • Leadership Programmes – Operations and First Line Managers, Mary Sealcole	

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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
			• Scope for Growth – Talent Management and Succession Planning **4. Culture and Leadership** • Just Culture Journey – Progress/Monitoring • Staff Survey – Results and Trust wide action planning The Committee were assured and recognised the extensive work of those involved.	
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 presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes. Trust sickness absence for the period 01 October 2021 to 30 September 2022 was 6.96% compared to 01 October 2020 to 30 September 2022 (5.84%). The trust sickness absence target is 4.80. Over the rolling 12-month period, rolling sickness absence rates has increased month on month from October 2021 to July 2022, however decreased in August 2022 from to 7.05% to 6.96% Actual sickness absence % rate has fluctuated month on month from December 2021 to September 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.	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.

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			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 for a case conference with occupational health for complex cases. Task and Finish Group has been set up to address Stress rates as per NHSE/I Health and Wellbeing Framework.	
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. The report details numbers of ER Cases, numbers of FTSU cases and as per our Just and Learning Journey the report this time contained numbers of those who had been engaged in the Just and Learning 4 Step Process and the numbers of those who had progressed to formal procedures. It was noted that those who had taken part in the 4 step process, despite progressing for formal procedures, felt supported throughout and welcomed the opportunity to discuss the incident fully before decisions were made.	The report was noted by the Committee.
SYSTEM STAFFING IMPLEMENTATION UPDATE	5 and 6		The System Staffing Implementation Update report was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes.	The Committee noted the reports and were assured on the progress and plans

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			All services with exception of Dental are now live on the system and rostering in advance on 6 weeks. All teams with the exception of Dental services are now live on the system and are rostering six weeks in advance. This is due to the ongoing work to reconfigure the system to support recording of hours and annual leave calculations for non-agenda for change staff. The E Roster team are working with Allocate to support this process. The E Roster team have developed a reporting template by borough and service. This will inform where we can improve roster performance and more timely information. As per the request at the last Committee, services have reported the following benefits: • Management of annual leave. • Rosters are available 6 weeks in advance for all staff • Increased visibility of the roster for managing staffing levels • The under/over calculations of hours worked for each roster period • Reduction of duplicated processes – Recording of absence, approval of leave processing • enhancements and overpay are now actioned on one system. • Audit trail functionality within system • Ability to add notes so that users can see reasons behind changes etc • The ability to tailor user profiles to suit service	

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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
			• Attaching locations to shifts for staff that work across sites • The systems functionality is easier to navigate and user friendly compared to previous systems.	
HR POLICIES AND PROCEDURES	5		The progress with the review and approval of HR Policies and Procedures was presented by Tania Strong, Interim Head of HR for information and assurance purposes. There were four policies presented to October HRPG, reviewed as described below. The four policies were reviewed and approved by staff-side colleagues in October and will be presented to December's JNCC for final sign off and uploaded to the Trust website by the end of the month as follows: • Leavers Policy • Staffing Levels & Temporary Staffing Solutions (including the use of bank staff, self-employed contractors, and the engagement of agency workers) • Underpayment/Overpayment Policy • Overtime Policy **Local Clinical Excellence Awards (LCEA) 2022/23** – The LCEA Policy was removed from the intranet 1st April 2022 whilst we awaited new guidance from NHS Employers on the process for awarding the awards in 22/23. In May 22, NHS Employers confirmed that it was for local agreement to decide how to roll out the award this year and so it has been agreed that Bridgewater will liaise with other organisations from across the NW to agree a consistent approach across all organisations. The policy will be updated following the	The Committee noted the content of the report.

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			agreement and awards for 2022/23 agreed on that basis. The People Committee will be kept fully informed as the process and policy develops.	
FACILITIES TIME OFF ANNUAL REPORT			The Facilities Time Off Annual Report – Trade Union Facilities Time Statutory Return 21/22 was presented by Tania Strong, Interim Head of HR for information and assurance purposes. The paper detailed the statutory submission for the period April 2021 to March2022 as per the Trade Union (Facility Time Publication Requirements) Regulations 2017, which took effect from 1 April 2017. All public sector organisations are normally required to report their facility time data by 31st July each year. All public sector data will be published on the gov.uk website following quality assurance of returns, so this can be benchmarked. The Trust is required to publish this information within its annual report and on the Trust external website. Comparison and analysis of data for the preceding 2 years is provided as part of this report. Looking back to 2020/21, a larger proportion of officials performed no activity in this reporting period, largely due in part to the pandemic and the number of routine communication forums being stood down in response to this – for example the Joint Negotiation and Consultation Committee (JNCC) and the Local Negotiation Committee (LNC) were suspended and alternative pandemic response systems implemented. Business as usual in terms of the	The Committee noted the content of the report.

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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
			operation of these forums and processes has since been re-established in 2021/22.	
NATIONAL STAFF OPINION SURVEY – LAUNCH REPORT			The National Staff Opinion Survey – Launch Report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. The 2021 NHS Staff survey results were made public in March 2022. Despite the challenges Bridgewater staff have faced during this period, the results gave a fair and honest account compared to other benchmarked NHS trusts. The previous results saw the biggest changes to the survey. It had a very different look and feel. For the first time there was a consistent and robust way of measuring employee experience across the NHS. The only two themes that stayed consistent to previous years are 'Staff Engagement' and 'Morale' The full nine elements covered in the survey are as follows: 1. Promise 1 – We are compassionate and inclusive 2. Promise 2 – We are recognised and rewarded 3. Promise 3 – We each have a voice that counts 4. Promise 4 – We are safe and healthy 5. Promise 5 – We are always learning 6. Promise 6 – We work flexibly 7. Promise 7 – We are a team	The Committee noted the reports and were assured on the progress and plans

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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
			8. Theme 8 – Staff Engagement 9. Theme 9 – Morale Since the publication of the results in March, the Trust has been working on engagement and action plans with borough and service leads in preparation for the forthcoming 2022 survey period. As per the standing down of the September 22 Committee, Deputy Director of Communications and Engagement, Mike Baker provided an up-to-date position on the progress since the launch. Survey launched as planned on 21st September 22. Communications campaign has worked well, and current uptake is at 55% - our highest response rate so far. Survey closes o 25 November 22.	
COMMUNICATIONS UPDATE REPORT			The Communications Update Report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes as follows: **Internal Communication and Engagement** • Trust brand and style guide. Work has now almost concluded on this piece of work. • NHS Staff Survey. In addition to the separate Staff Survey report (agenda item 98/22), the report highlights work taking place behind the scenes now that a date has been confirmed for the survey this year. • Staff Awards and AMM. Final preparations are underway for the events on Wednesday 21 September.	The Committee noted the reports and were assured on the progress and plans

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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
			• Staff bulletins and communication. Despite a delay with governance, IT and procurement, we now have the greenlight to progress this task • 'Leader in me' event. The team delivered a very successful 'Leader in Me' event on 1 July. • Reward and recognition. Following a paper explaining 'reward and recognition' at the last People Committee, work is now underway to bring the content of the report to life. • Staff Engagement Champions Booklet. Knowing how important the staff engagement champions are to the Trust, a comprehensive booklet/guide is being produced to help. • PEOPLE value tweak. Following a survey to staff, it was agreed that there could be a tweak to one of the PEOPLE values. **External Communication** • Media Awareness. Awareness included both proactive and reactive media around the Widnes Urgent Treatment Centre during this reporting period. • Trust website. In line with the Gov.uk website and the NHS England/NHS website, we have almost completed a facelift of the public Bridgewater website. Partnership Update • System engagement. This remains concerning as very little communications engagement has taken place since the official launch of integrated care systems on 1 July. **Horizon Planning**	

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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
			• Induction presentations. Plans to refresh the whole induction to bring into line with the new Trust branding. • Non-Executive Director Recruitment. Support to help support the recruitment of a new Non- Executive Director. • Widnes Urgent Treatment Centre. As we head towards autumn and winter, and following a request nationally, a large-scale marketing drive is being planned for Widnes Urgent Treatment Centre. • Northwest Driving Assessment Service (NWDAS). There has been an urgent request to support a large marketing and communications drive for NWDAS following a commissioner • meeting. • Building on our Strengths Together (BOOST). As part of the resetting and realigning of the organisation; comprehensive communications support will be required here. • Recruitment. Further support is needed to help reduce the vacancy rate of the Trust. • Staff Covid-19 booster and flu vaccination. A date of early October has been earmarked to deliver our vaccination programme.	
EQUALITY, DIVERSITY AND INCLUSION ***(i)*** **Objectives and action plan updates**			The following was presented by Ruth Besford, EDI Lead for information and assurance purposes as follows:	The Committee noted the reports and were assured on the progress and plans

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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
(ii) **Including Dashboard as requested by the Committee**			An update on equality action plans that support legal and contractual requirements, and the overarching strategic equality objective of the Trust. The Trust has an action plan for workforce equality, diversity, and inclusion that brings together required actions for national NHS mandate, legal compliance, and local contractual requirements. The action plans also address key priority areas identified by the Cheshire and Merseyside equality collaborative for partnership approaches to workforce equality and inclusion. The action plan is published on our webpage and is updated bi-monthly. For brevity only recent actions undertaken and any exceptions for highlighting are reported here for this Committee to note. A draft equality dashboard, a key deliverable in the NHS anti-racism framework committed to by our Board. This also relates to an action from the last committee meeting in July. This is just a first draft and needs refinement to ensure it accurately reflects the Trust's equality performance on a regular basis in a way that is accessible to our staff, partners, patients, and communities. The mandated Equality Delivery System 2022 is still being discussed by Cheshire and Merseyside commissioners and providers in relation to domain 1, service delivery. For	

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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
			domain 2, workforce, I have asked that the new toolkit be added to the agenda of the next people operational delivery meetings for culture and leadership, and health and wellbeing. Domain 3 remains to be fully understood and addressed. Submission is by 28th February 2023 with agreement and sign off of equality grades by partners before this date. The Board session on Anti-Racism took place as planned on 12 September 22 with RARA Education Project. The session was well received by those in attendance and there is a commitment to use their expertise in our forthcoming Leader In Me Event to support embedding the Trust's commitment to Anti-Racism and awareness of unconscious bias.	
VACCINATIONS CAMPAIGN AND STAFF TAKE UP REPORT			The Vaccinations Campaign and Staff Take Up Report was presented by Katherine Summers, Adult immunisation and Infection prevention and control (IPC) nurse, for information and assurance purposes. The annual staff flu vaccination programme commenced in October 2022 and will be delivered as a roving model until March 2023. After being suspended since 2020 during the Covid-19 pandemic, the Commissioning for Quality & Innovation (CQUIN) scheme has been reintroduced for 2022/23 to support the NHS in its recovery campaign. The CQUIN goal is to achieve an uptake of 70% to 90% of frontline healthcare workers. A Covid-19 autumn booster vaccination week took place during the week of 10th October 2022 at Spencer House and	The Committee noted the reports and were assured on the progress and plans

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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 flu vaccine was also promoted and encouraged during this week. Staff receiving their vaccinations elsewhere are asked to inform the IPC team so the uptake rates can be captured. **Covid-19 Autumn Booster Vaccine** A total of 407 BCHFT staff received their Covid-19 autumn booster vaccination during the week 10th October 22. This equates to 27% of staff overall and 25% of patient facing staff. Further Covid-19 autumn booster sessions are in the planning stages and are provisionally planned to take place on 28th and 29th November 2022. **Flu Vaccine** Flu vaccines were delivered on 7th October 2022. The flu vaccine was offered to all BCHFT staff during the autumn booster week at Spencer House. Staff were able to drop into the vaccination centre for their flu vaccine at any point that week, there was no requirement to book an appointment. Over the course of the week, 392 BCHFT staff received their flu vaccine at the vaccination centre. Overall the current uptake position is 517 staff have had the flu vaccine, equating to 34% of staff overall, 32% patient facing. Flu vaccines will continue to be offered as a roving model. Bespoke sessions are offered to teams and peer immunisers are available to immunise their own teams. Flu clinics are advertised through the Bridgewater bulletin for staff to drop in at various locations across the Trust.	

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			Data and uptake rates continue to be monitored with support from the data warehouse team and will be reported in to the CQUIN group and TIG. As an incentive for receiving the flu vaccine, a monthly drawer takes place to win a £50 voucher. This incentive also includes those staff that have received their flu vaccine elsewhere if they have informed the IPC team of their vaccination.	
PAYROLL PROVIDER PEFORMANCE REVIEW (ANNUAL UPDATE)			The Payroll Provider Performance Review (Annual Update) was presented by Kathryn Sharkey, Head of Workforce, for information and assurance purposes. The Trust has a contract for payroll services from St Helens & Knowsley Hospitals (STHK). The SLA has been in place with effect from October 2018. There are Key Performance Indicators within our contractual arrangements with STHK that are reported on monthly. There is an 'Assurance Schedule', details of supplementary payrolls, overpayments, advances, unapproved SVLS, BACS Stops, pension activity, compliments and complaints. Each year an audit of the services provided to us by STHK is carried out by Mersey Internal Audit (MIAA). The Audit was completed February 2022 and all recommendations have been completed. We received 'moderate' assurance on the audit with 5 recommendations to action. The recommendations were based on the ESR forms, Repayment plans and salary over payments. The rationale for the	The Committee noted the reports and were assured on the progress and plans

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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
			moderate assurance rating was due to Managers not completing forms in a timely manner which then results in overpayments and underpayments of salaries to staff, resulting in arrears and out of payroll schedule payments. The next payroll audit is due to commence January 2023. There have been 3 overpayment payroll errors due to incorrect input and there have been 2 advances raised due to payroll errors. In total 5 payroll errors over the period. This has been an improvement on the previous year where 9 payroll errors were made. All advances are approved via the Trust. For the period Pensions Team have completed 21 AW8 Pensions applications, 9 opt out pension applications and 5 pension refunds. The current SLA is due for renewal and a review of SLA is underway.	
REVIEW OF SLA PERFORMANCE OF TRANSACATIONAL TRAINING SERVICES			The Review of SLA Performance of Transactional Training Services was presented by Jo Waldron, Deputy Director of People and OD, for information and assurance purposes. The report gave an overview of performance of the SLA in line with the agreed parameters. Whilst delivery of the Workforce Reporting element of the service has been good, there have been challenges and issues with the Learning and Development element of the service which the Bridgewater Team have had to manage locally over	The Committee noted the reports and were assured on the progress and plans

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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 previous year. Details of this are outlined in detail to the Committee. Strategic plans for Bridgewater to align to Warrington and Halton Hospitals were ceased as a result of the White Paper and the integration agenda. As skills in the EPD Team enhanced and with the opportunities presented with Qlik, the decision was taken to end the SLA with effect from 31st October 2022. The report outlined the internal progress and future planning for the ceasing of the SLA and the Committee were assured on planning and progress so far.	
CHAIRS REPORT: MEDICAL AND DENTAL PROFESSIONAL GOVERNANCE MEETING			This report was approved via E-Governance and was presented to October 22 Board.	
ORGANISATIONAL DEVELOPMENT UPDATES:	5 and 6		Four reports were presented for information and assurance purposes – PPDR & Mandatory and Statutory Training Compliance, Apprenticeship Scheme and Levy Update, Talent Management and Succession Planning and Staff Engagement and Recognition Report.	
PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE	5 and 6 and WLR 7 and 8		The PDR and Statutory and Mandatory Training Compliance Report was presented by Adie Richards, Education and Professional Development Leads, for information and assurance purposes. M2 compliance with Mandatory Training shows 13 requirements at green, 7 at amber and 2 at red.	The Committee noted the reports and were assured on the progress and plans

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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
			M6 (latest available data when this paper was written) compliance with Mandatory Training shows 15 requirements at green, 5 at amber and 2 at red. This shows a decrease in 2requirements (Safeguarding Children Level 3 and Resus Level 1) that were green and are now reporting amber. The decrease in the Level 1 Resus compliance was anticipated andis reflective of updates applied to the competency requirements for this module and the Oracle Learning Management System. This is now an annual eLearning module with embedded Trust specific adaptations rather than a three year face to face requirement. This update has been approved through the Resus Advisory Group and will release additional places on the face to face training classes for clinical staff with level 2 resus training requirements. PPDR compliance has shown a steady increase to 67.42% and is still significantly adrift of the 85% target. Work continues to identify when meaningful conversations have taken place. Reminders continue to be communicated to managers in various forums and via the Trust Bulletin. There was a commitment to focus on specific trajectories on the completion of specific modules, based on the associated risk of non-compliance and it was noted that whist there had been significant progress in all of the Mandatory Training modules, unfortunately the trajectories were not met. A discussion took place as to the how realistic the targets were given the pressures on teams. Lynne Carter, Chief Nurse/Deputy CEO and Sarah Brennan assured that the trajectories were appropriate to ensure we see the required	

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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
			improvements. Sarah Brennan assured that there was a real focus on this across operational teams and we need to support staff to ensure their compliance with the targets set.	
APPRENTICESHIP SCHEME AND LEVY UPDATE			The Apprenticeship Scheme and Levy update was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes. There are currently 44 employees registered as apprentices across the organisation with a 50 further apprenticeships starts for 2022/23. Of the 94 existing and planned apprenticeships 42.5% were or will be directly recruited into apprenticeship positions. Of the 94 existing and planned apprenticeships, approximately 70% are or will be undertaking programmes that are clinical in nature, many leading to professional registration, with either the NMC or the HCPC. The projected Apprenticeship Levy expiry for 2022/23 is £24,609.27 significantly lower than the £93,241.23 that expired from the Trust's Levy account in 2021/22. However, as we approach the halfway point of the current financial year, it is possible to project that this year's likely expired funds, will be significantly lower than previous years. Average monthly expiry for the year to date is below £5000 and is expected to drop to £0 from Sept and remain at zero expiration until the end of the financial year, following an influx of planned apprenticeship starts this coming month.	The Committee noted the reports and were assured on the progress and plans

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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 outlined the various programmes in place to support the Trusts commitment to growing our own with pathways into the Nursing profession for non-nhs candidates with the right opportunities to engage in Apprenticeships. Members of previous cohorts of non-nhs candidates have gone on to progress onto Degree Nurse Apprenticeships which is a great success story for the Trust.	
TALENT MANAGEMENT AND SUCCESSION PLANNING	5		The Talent Management and Succession Planning paper was presented by Jo Waldron, Deputy Director of People and OD for information and assurance purposes. The 21-22 Mary Seacole Programme was a great success with all 13 participants achieving excellent pass results. Current cohort of 15 is due to complete in January 23 with a new cohort planned for late 2023. The Operational Managers Programme has a cohort of 28 Operational Managers. The Leadership Development aspect of Operational Managers programme will complete in mid-November 2022 and the Transactional aspects of the programme will commence in January 2023. Following feedback from Managers and Teams that there was a gap in knowledge and skills for first line managers and by way of supporting future talent management and development, a programme has been developed. The first programme commenced in October 2022 with a cohort of 31. This is a positive uptake and will support the future development of managers across the Trust.	The Committee noted the reports and were assured on the progress and plans

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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
			Progress towards the launch of Scope for growth has been delayed due to operational and capacity issues, however plans continue to be developed with a focus on ensuring the OD Team have the capacity and skills to progress this at speed. Currently, the Team continue to promote the well-established PPDR process	
STAFF ENGAGEMENT AND RECOGNITION REPORT			The Staff Engagement and Recognition Report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes as follows: **Staff Engagement** • **NHS Staff Survey** – as outlined in earlier paper • **Staff Engagement Champions** – Event took place in October to review the profile of the Staff Engagement Champions which was received well. Follow up event arranged for 28 November 22. **Staff Recognition** • **Reward and Recognition Package** – including Celebrating Our Stars Nomination Scheme, Trust People Values Recognition Badges, Birthday Messages, Employment Anniversary Messages, Review of Long Service and Retirement Awards. • **2022 Bridgewater 'Thank You' Awards** – Refined nomination and shortlisting process.	The Committee noted the reports and were assured on the progress and plans

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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
MIAA INTERNAL AUDIT UPDATE – WITHIN REMIT OF THE PEOPLE COMMITTEE - E-ROSTER AUDIT REPORT AND RECOMMENDATIONS – FINAL REPORT AND ACTION PLAN	5 and 6		The MIAA Internal Audit Update – E-Roster Audit Report and Recommendations – Final Report and Action Plan was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes. The key findings acknowledged the progress made on a complex implementation during a pandemic. A summary of key themes identified areas of good practice, along with areas for improvement. The findings were as expected as some of the work was in train or being drafted. Some achievements were impacted by the very challenging timeframes and stringent external performance management on the required system implementation (nationally). The detailed findings and recommendations have been reviewed. The Trust's Transactional Services Manager is the Responsible Officer for the actions and these have implementation dates of 1st October 2022. MIAA will carry out a follow up exercise before the end of the year to evaluate the progress being made and obtain evidence that the agreed actions have been implemented. Over and above the audit, the work we have done on implementing the system as a Community Trust has been recognised nationally and our Head of Workforce has spoken at a number of conferences.	The Committee noted the reports and were assured on the progress and plans

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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
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	5 and 6		A review of BAF5 was undertaken. Agreed that Principle Risk needs to be reviewed to reflect the reality of Industrial Action pending. Controls should include the strong partnership working we have with our Regional and Local Staff-Side Colleagues. Agency Cap should be added to reflect the potential impact on staffing and quality. Risk Score was reviewed in light of the above and likelihood was increased in relation to the pending Industrial Action. Risk score – 16.	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		There were no items for escalation to Board.	
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. Sarah Power, as new staff Governor noted that she found the meeting interesting in understanding the wider People activities and enjoyed listening to the conversations and support across the Committee.	
Risks Escalated			Risk score of BAF 5 – increased likelihood in relation to pending Industrial Action – Risk Score changed to 16	
•				

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Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 December 2022**
Agenda Item	**91/22i**		
Report Title	**ACCOUNTABILITY FRAMEWORK PART 2**		
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**

Executive Summary

- This report recommends the Accountability Framework Part 2 which moves the Trust from a command-and-control structure to establishing and embedding autonomy and a refreshed accountability framework.
- Appendix A is the Accountability Framework Part 2, which the Board is asked to approve.

Previously considered by:

N/A

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	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

of corporate governance							

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 December 2022**
Agenda Item	**91/22i**		
Report Title	**ACCOUTABILITY FRAMEWORK PART 2**		
Report Author	Jan McCartney, Trust Secretary		
Purpose	To ask the Board to approve the attached Accountability Framework Part 2		

1. INTRODUCTION

1.1 The 2019 Long Term Plan set out the ambition for personalised care which is tailored around the needs of the individual. This enables people to have more autonomy over their own health and wellbeing. It describes that if people who are empowered to participate in their care they live better with long term conditions, targeted prevention is more effective resulting in improved outcomes, increased efficiencies, and less pressure on the system.

1.2 Autonomy is often referred in relation to devolved governments and concerns the power of self-governance or being able to organise its own activities. Within healthcare autonomy refers to healthcare professionals' ability to think critically, use expert skill and judgement and take appropriate actions related to a patient's care.

1.3 At Bridgewater we strongly believe in the benefits of autonomy, for our patients, our staff, our place and our organisation. This paper sets out the updates the Trust proposes to the Accountability Framework Part 2 which will commence from 1 January 2023.

2. BACKGROUND

2.1 During the pandemic established a command-and-control structure in order that the EMT was close to the risks and lead the Trust safely through this time.

2.2 Service reset was the time for EMT to disengage from operational issues and move back into strategically leading the organisation. During this time the Accountability Framework started to be refreshed to outline the changes and the Board approved the first part of the framework at its October Board.

3. OPERATIONAL DIRECTORATES

3.1 Achieving a culture of high performance will only happen when managing performance becomes an integral part of the organisations environment and is acknowledged as a positive, not punitive activity. The implementation of a clear accountability framework and performance management framework will support the Trust and provide to the senior team clarity of what is expected.

3.2 Part 2 of the framework describes the Directorate Leadership Teams (DLTs) and the governance around them. It also provides the basis for the Terms of Reference for these teams. These teams will be wholly responsible for the delivery of the Trusts objectives within their Directorates, whilst meeting regulation and standard obligations.

3.4 The success of these DLTs rely on support by aligned corporate roles. Whilst working under a separate management structure, these expert roles allow for the DLTs to be agile and removes the delay of bureaucratic processes.

3.5 The DLTs will be accountable to EMT via the Directorate Quarterly Review Meetings with the Executive Management Team. The purpose of these reviews is for assurance and not for escalating decisions or issues, there are other routes within the governance structure, such as the performance, quality and risk councils.

3.6 The Accountability Framework Part 2 is to be used alongside the Accountability Framework Part 1 which in its entirety forms part of the Trust's Corporate Governance Manual and describes how accountability and responsibility is devolved throughout the Trust. These documents will be available on the Trust's website.

4. NEXT STEPS

4.1 The next stage of this process is the development of the performance framework. This is being drafted by the Chief Operating Officer and will be presented at Board in April 2023. The performance framework will clearly set out the expectations of the directorates, setting goals and monitoring progress to ensure performance is delivered with continuous quality improvement for our patients. A clear framework will ensure a consistent approach to escalation, oversight, intervention, and support.

5. RECOMMENDATION

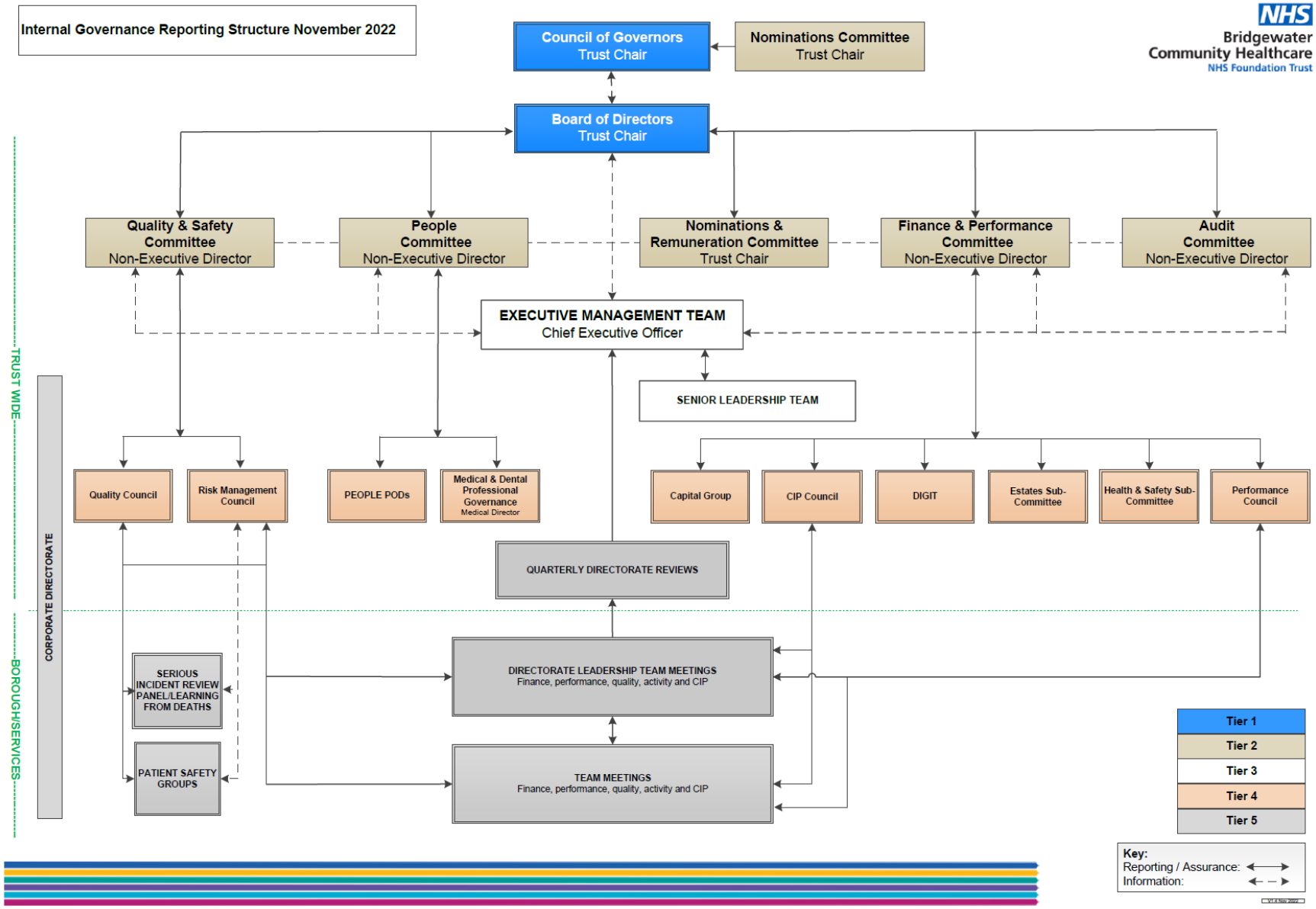
5.1 It is recommended that the Board approve Part 2 of the accountability framework found in Appendix A. This will sit alongside Part 1 which was approved in October 2022.

Bridgewater Community Healthcare
NHS Foundation Trust

ACCOUNTABILITY FRAMEWORK

Part 2 – Directorate Accountability

Internal Corporate Governance Structure



Part C: Accountability

10. Directorate Accountability

10.1 Tier 5, Directorate Leadership Team (DLT)

As the NHS system undergoes change it is vital that the Executive Management Team (EMT) increasingly occupy strategic territory. By withdrawing from daily operational issues, the EMT will have the capacity to influence emerging place-based strategy with partners and to shape and be an integral part of the provider collaborative.

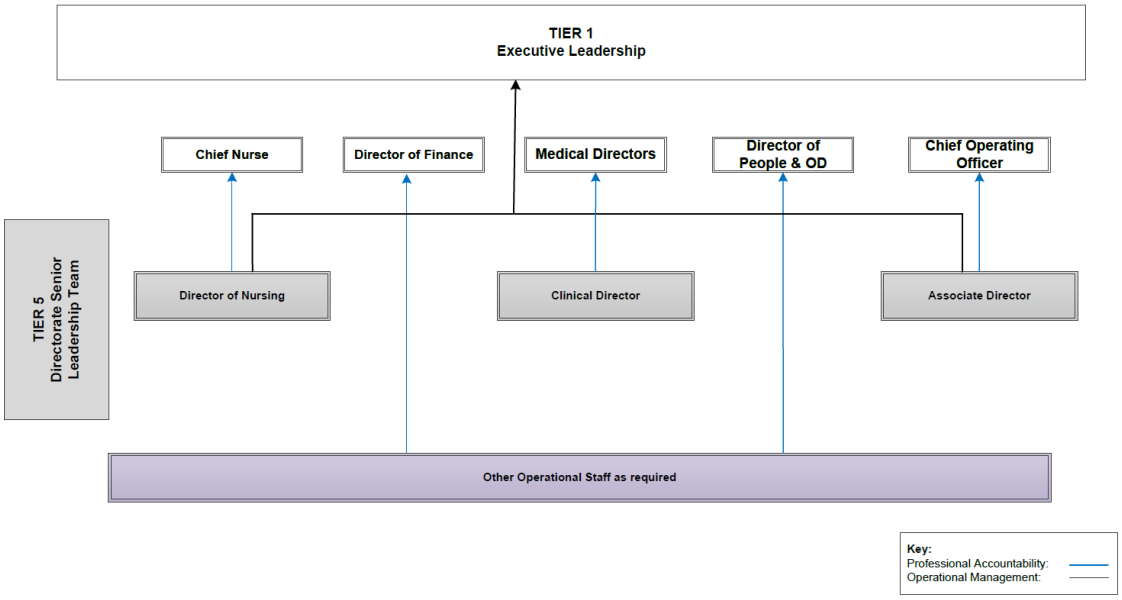
The function of each Directorate is to deliver on the NHS Triple Aim:

- better population health
- better quality of patient care
- financially sustainable services

Our Directorates are managed by clinically led teams comprised of an Associate Director, a Director of Nursing and / or a Clinical Director who have devolved autonomy from the Executive Team. These individuals have responsibility and accountability for specific aspects of the Directorate portfolio. These individuals have the following lines of professional and operational accountability:

- Associate Directors – operationally and professionally accountable to the Chief Operating Officer
- Clinical Directors – operationally accountable to the Chief Operating Officer and professionally to the Medical Director(s)
- The Directors of Nursing – professionally and operationally accountable to the Chief Nurse

Directorates are held accountable through the various councils such as the Performance Council, Quality Council and Risk Management Council. They will also provide assurance to the Directorate Quarterly Reviews which are led by the Executive Management Team. Tier 5 have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight and co-ordination of performance within and across all services within their team. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Executive Management Team key areas of risk that may affect delivery of organisational objectives and strategy.



The Directorate Leadership Team also comprises of a wider team including HR Business Partners, Finance Business Partners and other Leads; these are individual members of the team who also have professional accountability to the relevant members of the Executive Management Team as follows:

- Finance Business Partner – professionally accountable to the Director of Finance
- HR Business Partner – professionally accountable to the Director of People and Organisational Development

Additionally there are members who have responsibility and accountability for specific aspects / services within the Directorate portfolio.

- Senior Nurses and AHPs – operationally accountable to Associate Director clinically accountable to the Chief Nurse
- Clinical Directors – operationally accountable to the Associate Director and professionally accountable to the Medical Director(s)
  Dental Clinical Directors – operationally and professionally accountable to Medical Director(s)
- Dental Nurses – operationally responsible to the Head of Service and professionally accountable to Chief Nurse
- Heads of Service are accountable to the Associate Director
- Directors of Nursing & Quality Matrons - operationally and professionally accountable to the Chief Nurse

All services have clinical and operational input. Each of our Services is led by Clinical and / or Operational Leads and they have responsibility for ensuring delivery of agreed organisational policies, objectives and key performance metrics and the governance, oversight and co-ordination of performance within and across their service. In addition, they are responsible for the development and implementation of robust remedial plans for areas of underperformance and escalating to the Directorate Leadership Team key areas of risk that may affect delivery of organisational objectives and strategy.

Clinical Leads and Operational Leads have key responsibilities and accountability for ensuring effective clinical and quality governance and that the values and professional standards are instilled within their workforce. They ensure that their teams are aware of and contribute to the organisation wide ambitions and promote essential standards to be delivered.

Services are held accountable through the Directorate Leadership Team. The Directorate Leadership Team is accountable for supporting managers / leaders within individual services, who manage and lead our frontline staff on a day-to-day basis.

10.2 All Staff

All staff have a responsibility for performance management and improvement, relevant to their role and are supported to identify improvement opportunities and to take action required. Specific and generic roles and responsibilities are outlined within all job description.

Part D: Directorate Governance

11. Directorate Governance Structure

To deliver the NHS Triple Aim, Directorates are required to have a clear and cohesive structure which sets out the framework within which the performance of their directorate is governed. Whilst it is recognised that directorate structures need to be tailored to meet the governance requirements of each directorate, as a minimum they must have:

- A clear line of accountability into the Corporate Governance Structure through the Quarterly Directorate Reviews and Executive Management Team as appropriate
- A Directorate Leadership Team which will be fully constituted with documented and approved Terms of Reference and Membership, with meetings being held as a minimum on a monthly basis
- A business cycle which covers all aspects of directorate strategy, performance, risk and governance, aligned with the Trust's Strategic Objectives.
- A documented and approved process for the management, escalation and oversight of risk, in accordance with the Risk Management Framework
- Directorate Quarterly Reviews, which align with the Performance Management Framework set out within this document
- Arrangements to ensure accurate and timely information flows in order to discharge their responsibilities

12. Directorate Leadership Team – Core Responsibilities

To ensure consistency across the organisation, each Directorate Senior Leadership Team should have a core set of responsibilities which enable the effective oversight and scrutiny of their Directorate. These are outlined below and will be contained in the Terms of Reference.

Quality

- Oversee continuous quality improvement in patient safety, clinical effectiveness and patient experience, including the wellbeing and safety of Trust employees
- Identify and manage quality risks and concerns
- Responsible for delivering the Trust's Quality Governance Framework

Strategy

- Oversee development and implementation of strategy and operational plans at a Directorate level and associated Scorecards, ensuring the adoption of best practice where available
- Develop and oversee implementation of Directorate Annual Plans
- Responsibility for implementing innovative approaches, transformation and redesign, using BOOST Transformation plans
- Consult upon policies and agree any relevant procedures, guidelines, standard operating procedures and protocols and monitor their implementation, where relevant, at a Directorate level

Performance

- Triangulation of key measures
- Monitor the operational systems and processes which ensure competent management within the Directorate
- Identify, delegate and review relevant actions to improve performance

- Report any exceptions, (delivery of strategy or areas of underperformance) to the relevant Council and escalate to the Executive Management Team via the Directorate Quarterly Reviews

Risk Management

- Where relevant, monitor Root Cause Analysis / trends relating to adverse incidents, ensuring that appropriate action is taken and lessons are learned
- Ensure that any risks are managed and reviewed via the Risk Register and in accordance with the Risk Management Framework

People

- Monitor, update and implement the work programmes associated with the People Plan and Promise in collaboration with the People Operational Delivery Groups (PODs). For example, workforce plans, staff survey action plans and initiatives such as Just Culture, Civility & Respect
- Implement plans for improvement linked to People Indicators/Scorecards
- Implement and monitor agreed recruitment and retention strategies for the Borough/Network, incorporating financial oversight
- Responsible for recruiting staff (and skill mixing) in line with budgets, workforce plans and our commitment to 'growing our own' and 'new ways of working'

Governance

- Demonstrate the Trust is Well Led with leadership, management and governance of the directorate providing assurance on the delivery of high quality and person-centred care, that it supports learning and innovation, and promotes an open and fair culture
- Review national legislation, guidance and best practice and address local implications of such guidance as appropriate
- Oversee / monitor implementation of action plans arising from internal / external review, audit, assessment or accreditation
- Undertake an annual self-assessment of effectiveness in order to inform any changes to Terms of Reference and Membership

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**8 December 2022**
Agenda Item	**91/22ii**		
Report Title	**COVID-19 PUBLIC INQUIRY**		
Executive Lead	Colin Scales		
Report Author	Jan McCartney, Trust Secretary		
Presented by	Jan McCartney, Trust Secretary		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

This report informs the Board of Directors that,

- the Covid-19 Public Inquiry has commenced, and
- provides assurance that the Trust is prepared and equipped to contribute as required.

Previously considered by:

Executive Management Team

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

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	8 December 2022
Agenda Item	91/22ii		
Report Title	COVID-19 PUBLIC INQUIRY		
Report Author	Jan McCartney, Trust Secretary		
Purpose	To provide an update on the progress on the Covid-19 Public Inquiry and to provide assurance on the readiness of the Trust		

1. INQUIRY METHODOLOGY

1.1 The UK Covid-19 Inquiry (the Inquiry) held a preliminary hearing on 4 October 2022 to look at the scope and procedures for the forthcoming public hearing. This first part of the Inquiry will concentrate on government planning and preparedness, resourcing, risk management, pandemic readiness and lessons learned from previous pandemics; this will be module1.

1.2 Module 2 will cover core political decision making, and module 3 will cover the health care system. Details about further modules will be announced in coming months.

1.3 This paper provides an update on the Inquiry and how the Trust has prepared for its possible inclusion.

2. SUMMARY OF PROGRESS TO DATE

2.1 The Inquiry is being chaired by Baroness Hallett who acknowledged in her opening remarks that the pandemic has had an immense impact on the NHS and today's care.

2.2 During the autumn of 2022 the listening exercise will being, this process will hear from people across the UK ensuring that those who have suffered can take part in the work. The evidence from the listening exercise will be analysed and passed to the Inquiry for use in the hearings and will contribute to the Inquiry's understanding.

3. WRITTEN REQUESTS FOR EVIDENCE

3.1 The Inquiry will also gather evidence by way of direct requests for evidence. Rule 9 of the Inquiry Rules 2006 requires that any person or organisation provide whatever information is requests.

3.2 Evidence requests have already been issued to various departments including the DHCS, the Department for Levelling Up, Housing and Communities (DLUHC) and the Cabinet Office.

3.3 Whilst it is unlikely that Bridgewater would become a core participant of the Inquiry, we have been informed that each Trust has been asked to complete a short questionnaire which is to be returned to the Public Inquiry. This information will help assist the Inquiry understand the sector's experience of the pandemic and to secure best learning outcomes for the future. This information will not be considered a formal statement or used in evidence during the Inquiry.

4. ACTIONS FOR THE TRUST

4.1 Whilst the Trust does not know if there will be any requirement it to be involved in the Inquiry there are some actions that needs to be put in place now.

4.2 The must be an individual to be the organisational lead on engagement over the Inquiry. This will be the Trust Secretary. All requests will be directed to the Trust Secretary to ensure a clear record of information provided.

4.3 A Board level director needs to be appointed to have an overview and support the Trust Secretary in their duties. This is the Director of Finance.

4.4 A team should be identified to support the document management and evidence requests on matters relating to the Inquiry. Any such tasks will be conducted by the Corporate Governance Team. All relevant decisions, including the setting up of Command-and-Control systems, have been documented, securely recorded and can be easily accessed should it be needed.

4.5 Any related Freedom of Information (FOI) requests will be directed to the Trust Secretary to provide a response.

5. RECOMMENDATION

5.1 It is recommended that the Board note the progress of the Inquiry and take assurance that the Trust is fully prepared to contribute should it be required to do so.