PUBLIC BOARD MEETING

Thursday 1 June 2023, 10am
Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
31/23	10.00	(i) Apologies for Absence (ii) Quoracy Statement (iii) Declarations of Interest in items on the agenda		Information Assurance
32/23 Page 4	10.00	Minutes of the last meeting: (i) Board meeting held 6 April 2023		Assurance/ Approval
33/23 Page 12	10.05	Matters Arising from the Action Log		Assurance
34/23	10.10	Any urgent items to be taken at the discretion of the Chair		
35/23	10.10	Patient Story – Halton Family Nurse Partnership		Information
36/23 Page 18	10.30	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Assurance/ Approval
37/23 Page 35	10.45	Key Corporate Messages – presented by the Chief Executive	1	Information
QUALITY: We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered				
38/23 (i) Page 41 (ii) Page 70	10.55	(i) IQPR – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 20 April 2023 – presented by the Committee Chair	ALL 2,3,6	Assurance Assurance
BREAK				

RESOURCES: We will ensure that we use our resources in a sustainable and effective way					
39/23 (i) Page 81 (iii) Page 87 and page 94 (iv) Page 99 and page 101	11.25	(i) Finance Report – presented by the Director of Finance		4	Assurance
		(ii) Adaptive Reserve Report – presented by the Director of Finance (verbal report)		4	Information
		(iii) Report from the Audit Committee held on 27 April and 18 May 2023 presented by the Committee Chair		1, 4	Assurance
		(iv) Report from the Finance and Performance Committee held on 5 May and 18 May 2023 – presented by the Committee Chair		4,7,8	Assurance
PARTNERSHIPS: We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local ommunities					
40/23 (i) Page 107 (ii) Page 112 (iii) Page 149	12.15	(i) Integration and Collaboration Update – presented by the Programme Director of Integration and Collaboration		3-8	Assurance
		(ii) ICB Joint Forward Plans - presented by the Programme Director of Integration and Collaboration		3-8	Approval
		(iii) Communities Matter - Trust Strategy update – presented by the Programme Director of Integration and Collaboration		1-8	Information
STAFF: We will ensure that the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive					
41/23 (i) Page 156 (ii) Page 181 (iii) Page 189 (iv) Page 195 (v) Page 223	12.55	(i) Report from the People Committee held on 10 May 2023 - presented by the Committee Chair		5, 6	Assurance
		(ii) Update on Industrial Action and Pay Deal – presented by the Deputy Director of Communications and Engagement		5, 6	Assurance
		(iii) Statutory and Mandatory Training and PPDR Action Plans – presented by the Deputy Director of Communications and Engagement		5, 6	Assurance
		(iv) NHS Staff Survey Update – presented by the Deputy Director of Communication and Engagement		5, 6	Assurance
		(v) Freedom to Speak Up Annual Report – presented by the Head of Human Resources		5, 6	Assurance

OVERARCHING CORPORATE GOVERNANCE ITEMS					
42/23 (i) Page 304 (ii) Page 346 (iii) Page 350	1.35	(i) Well-Led Report – presented by the Chief Executive and Trust Secretary	1	Approval
		(ii) Fit and Proper Annual Review – presented by the Trust Secretary	1	Assurance
		(iii) NHS Provider Licence Self-Certification – presented by the Trust Secretary	1	Approval
43/23	1.50	Review of meeting and Items to be added to the Board Assurance Framework		Information
44/23	1.55	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 3 August 2023, 10am at Spencer House, Dewhurst Road, Birchwood, Warrington

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

<u>Unapproved Minutes from a Public Board Meeting</u>
<u>Held on Thursday 6 April 2023, 10am</u>
<u>Meeting Rooms A1 and A2, Spencer House, Dewhurst Road, Birchwood, Warrington</u>

<u>Present</u>
Karen Bliss, Chair
Colin Scales, Chief Executive
Ted Adams, Medical Director
Gail Briers, Non-Executive Director
Sarah Brennan, Chief Operating Officer
Linda Chivers, Non-Executive Director
Nick Gallagher, Director of Finance
Elaine Inglesby, Non-Executive Director
Abdul Siddique, Non-Executive Director
Martyn Taylor, Non-Executive Director
Tina Wilkins, Non-Executive Director
Paula Woods, Director of People and Organisational Development

<u>In Attendance</u>
Jeanette Hogan, Deputy Chief Nurse
David Mills, Clinical Lead for Dental Services (to item 24/23ii)
Rob Foster, Programme Director of Integration and Collaboration
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

<u>For Patient Story (item 20/23)</u>
Steven
Val Harper, Complaints Manager, Patient Services

<u>Observers/members of the Public</u>
Peter Hollett, Public Governor, Halton (to item 23/23iv)

16/23   **(i) APOLOGIES FOR ABSENCE**
Lynne Carter, Chief Nurse
Aruna Hodgson, Medical Director

(ii) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(iii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made.

17/23   **MINUTES OF THE LAST MEETING HELD ON 2 FEBRUARY 2023**

One typographical error to be corrected on page two. The minutes were otherwise approved as an accurate record.

18/23   **MATTERS ARISING FROM THE ACTION LOG**

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

55/22 Board Assurance Framework

The Board time out session to review the framework was to take place in May 2023. This action could therefore be rated as blue.

88/22i Integration and Collaboration Update

The Board session related to involvement of external partners in children's transformation work in the context of the strategy had now been included in the Board development programme. This action could be rated as blue.

91/22i Accountability Framework (Performance Framework)

The Performance Framework was included on the agenda.

08/23i IQPR

A report concerning statutory and mandatory training was included on the agenda.

09/23ii Trust's response to the planning priorities guidance

An update report was included on the agenda.

09/23iv Chair's report from the Audit Committee (effectiveness survey responses)

The Trust Secretary confirmed that the responses to Board and Committee effectiveness surveys going forwards would no longer be collected on an anonymous basis: the output would be reported as anonymous, however names of responders would be known to the corporate governance team in order to follow up responses. It was noted that the response rate had recently increased for recent surveys since this was implemented.

It was agreed that the following blue rated items were completed and could be removed from the action log:
75/22ii Cheshire and Merseyside Prevention Pledge
90/22i Committee Chair's Report from People Committee
92/22 Items to be added to the Board Assurance Framework
11/23i Gender Pay Gap Report

19/23   **ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR**

The Board noted that item 27/23ii Medical Appraisal and Revalidation Report would be taken following item 23/23iv Learning from Deaths Report to allow the presenter to leave to attend another meeting.

(i) BAME Assembly Statement

The Board received the letter issued by the Chair and Regional Director of NHS England following the recent employment tribunal case of a senior nurse which found that she had been treated unfavourably due to her race. The Chair commented that the letter had been

included on the agenda today as a public acknowledgement of the Board's commitment to being an anti-racism organisation and to take action against inequalities. She highlighted that the letter asked NHS leaders to make a number of commitments which the organisation fully supported. She noted that the Trust included Equality, Diversity and Inclusion as part of its strategic objectives and as part of individual director's objectives. The Director of People advised that an action plan would be presented to the Board and highlighted the work of the Trust on Equality, Diversity and Inclusion which was evidenced within the Equality, Diversity and Inclusion Annual Report included on the agenda. She noted that the 2023/24 action plan would also provide assurances on work being done across the Trust. The Chief Operating Officer added that there were new objectives within the Trust strategy and related indicators within the new scorecard. There would also be opportunities to challenge issues as members of the system. The Board noted the contents of the letter and supported the approach being taken.

20/23   PATIENT STORY – STOMA SERVICE

Following a change to the planned patient story, the Board received a story from Steven who shared his experiences of the Stoma Service: He had been supported by the team from his time in hospital with a seamless service being provided through to and beyond discharge. The team had provided valuable re-assurance and advice, answering any questions that Steven had. The service had provided equipment for him and helped him in using and managing this at home. The Board noted that the stoma team comprised two members of staff who cared for 600 patients ranging from infants to older persons. The Board wished to place its thanks on record to the service for its important work. The Board also recognised the importance of screening, emotional as well as physical support and ongoing care, ensuring that patients could achieve the best possible outcomes.

21/23   BOARD ASSURANCE FRAMEWORK

The Trust Secretary presented the Board Assurance Framework and the detail of changes made by Board Committees during February and March 2023 for the Board's approval:

BAF3: Following the Quality and Safety Committee in February the following changes were recommended: The Principal Risk would be updated to remove references to the Covid pandemic; The rationale for current score to be updated to remove references to the pandemic; The Controls sections had been updated to reflect the work of the Performance Council and Directorate Leadership Teams in waiting list management. The Executive management performance dashboard had been added along with the daily joint operations and nursing meetings; The Assurance section was updated to reflect the Dermatology action plan and Rapid Improvement Events and removed 'waiting lists seeing reductions.'

BAF5: The People Committee met on 15 March 2023 where the Committee recommended: An update to the principal risk section recognising the industrial action had occurred and was no longer a risk, although it was noted that there may be additional action.
The Committee also asked for the Gaps in Control be updated to reflect the reference Warrington Adults staff survey results and pay deals under negotiation. Equality, Diversity and Inclusion would also be added to the objectives.

BAF8: The Finance and Performance Committee had discussed BAF8 in detail and there were a number of changes recommended by DIGIT and the Committee:
That the principal risk be updated to reflect the biggest risk as failure to deliver the Digital Strategy and to note Cyber-related threats. In addition, under the gaps in control a reference to population health data not being fully utilised was removed as the Committee agreed that this should be dealt with under Quality and Safety. The Committee held a thorough discussion on the current risk rating, noting that the rating had always remained high due to the ongoing cyber related risk. The threat of cyber-related risks was recognised and accepted as an ongoing high risk and, as such, the Committee considered that this risk had been mitigated to its full extent and no additional actions could be taken. This was supported with external review and ongoing monitoring. With this in mind, the Committee agreed the

overall current risk rating should be reduced to 4(c) x 2 (l) = eight (medium), which was the target risk rating for this BAF.

Non-Executive Director, Linda Chivers added that there was a need to include discussion on the current risk score to risk appetite: it had been agreed for a high tolerance of risk to be in place for digital elements to progress the organisation forwards. Whilst it would need to be recognised that some risks were outside of the control of the Trust, it could be demonstrated that the organisation was managing those risks well. Non-Executive Director, Tina Wilkins as the Committee Chair advised that BAF8 was reviewed in detail and the Committee was in full agreement to reduce the risk rating to a score of eight.

The Board also reviewed the risk tracker which was now included at appendix B of the report. On reviewing the tracker, **it was agreed that setting of achievable target risks should be included as part of the Board's dedicated session in May to consider risk appetite for the next year.**

The Board accepted the recommendations from the Committees for the amendments set out to be made to the BAF.

22/23   KEY CORPORATE MESSAGES

The Chief Executive took the report as read and highlighted the extent of engagement externally and internally of Executive and Non-Executive Directors. He drew attention to the detail of external publications and reports listed at section four of the report and particularly highlighted NHS Confederation Briefing – How have provider collaboratives been set up?

The Board received the report for note.

23/23   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 across operations, quality, people and finance.

The Board noted that there had been an improvement in the majority of indicators from an operations perspective with cancer indicators improving and a significant improvement in A&E attendances in relation to the Widnes Urgent Treatment Centre, and improvements in dental long waiters. The Chief Operating Officer advised that some long waiters had been identified week commencing 3 April which were being addressed. She reported that there had been a decrease in the number of waits for oral surgery in Cheshire and Merseyside with an increase in referrals across Greater Manchester West and Bury, Oldham and Rochdale, as well as an increase in referrals for inhalation sedation. In terms of quality, the Duty of Candour indicator had moved to a green rating. Concerning the People indicators, there had been an increase in PPDR (appraisals) compliance with a focus on this and a reduction noted in sickness absence.

A discussion took place concerning disaggregated data and elements that may be useful to include in the IQPR going forwards to provide further assurances to the Board on key matters. **This would be discussed by the Executive Management Team.**

(ii) Performance Framework

The Chief Operating Officer presented the performance framework which set out governance and responsibilities for performance within the Trust at each level and was aligned as part of a 'golden thread' to the Accountability Framework and the Trust strategy. A discussion took place concerning assurance between the Trust's Council meetings (Performance, Quality and Risk Management) and how this could continue to be strengthened. The importance of the Council Chair's roles was emphasised in ensuring that the right questions being

asked, that the right discussions were taking place and that appropriate feedback was being fed into Board Committees. **It was agreed that an arrangement would be established between Council and Committee Chairs to set expectations concerning what the Committee Chairs would expect to receive and to build relationships with the Councils with a supportive/mentoring aspect. This could take place every quarter.** The Board approved the framework which it considered to be a good piece of work with clear information.

(iii) Report from the Quality and Safety Committee held on 23 February 2023

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

Non-Executive Director, Tina Wilkins questioned the progress being made by the Trust in relation to the Patient Safety Incident Reporting Framework (PSIRF) and the Ulysses system: whether the Trust would be moving to an alternative system from Ulysses. The Deputy Chief Nurse advised that the priority would be to have PSIRF in place before any change in the risk management reporting systems was undertaken as there was a national requirement to introduce PSIRF. **It was agreed that a discussion would take place concerning the potential change from Ulysses for the Trust and providing assurance on this issue to the Quality and Safety and Finance and Performance Committees including advice related to the practicalities of any transition, along with the benefits and potential issues.**

(iv) Learning from Deaths Report

The Board noted that 142 patient deaths had occurred during the reporting period. Those patients did not suffer any detriment from any care delivered by the Trust. It was agreed that further detail was required for future reports around unexpected deaths, a review of terminology used within the report and a stronger emphasis on the learning from deaths. The Trust would also seek to work with other partners to ensure a more rounded approach which would provide a better depth of information and cross-organisational learning. This would be supported by the imminent introduction of the patient safety incident response framework in the medium term which would provide a system wide approach with the ICB.

Following Non-Executive Director challenge and some comments from the Chief Executive, i**t was agreed that further detail was required for future reports around unexpected deaths, a review of terminology used within the report, particularly around child deaths, and a stronger emphasis on the learning from deaths opposed to focussing on data. The Deputy Chief Nurse would liaise with the Medical Director to discuss refining this report.**

24/23 **SUSTAINABILITY –– to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability**

(i) Finance Report – month 11

The Director of Finance presented the report detailing the Trust's financial position at month 11. He reported that the Trust was in line with plan and was confident of achieving a surplus. A discussion took place on agency staffing, converting to substantive roles and opportunities around this with the Trust seeking to be more agile with an agile workforce. A bank (NHS Professionals) would be utilised by the Trust for use of agency staff with a view to then offering substantive roles. However it was noted that there were significantly higher incentives and rewards being offered to potential staff by other organisations which went against the system's agreed principles and prevented a level field. **This would be raised with the organisations responsible at Chief Executive level.**

(ii) 2023/24 Plan

The Director of Finance presented the plan which was approved by the Board. The Director of Finance highlighted that any changes to the plan would be presented back to the Board, however a breakeven plan would be re-submitted each time. The Board acknowledged the significant work of the Finance Team in producing the plan and achieving the reported position.

(iii) Report from the Finance and Performance Committee held on 23 March 2023

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.

25/23   INNOVATION AND COLLABORATION – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living

(i) Bridgewater Organisational Strategy

The Board approved the strategy and recognised the need for ongoing engagement with the public and the Council of Governors. It would be of key importance to track the delivery of the strategy; this would need to be considered and fed back into future forward planning including the work plan for Board time out sessions. This would be discussed as part of the closed Board meeting.

(ii) Integration and Collaboration Update

The Programme Director of Integration and Collaboration presented a report to the Board detailing progress with integration and collaboration development and opportunities across the Trust. This included an update concerning Warrington Together, One Halton and the Provider Collaborative. The Board received the report for information.

26/23   EQUALITY, DIVERSITY AND INCLUSION: to actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive

(i) Equality, Diversity and Inclusion Annual Report

The Board received the Trust's Public Sector Equality Duty Annual Report for 2023 which had been taken through the People Committee and was assured that the work being undertaken ensured that the Trust met the necessary legal and moral duties to staff, patients, and communities.

(ii) Equality Delivery System 2022

The Board noted that the report was approved via e-governance during the period between the February and April Board meetings. The report was now available to view on the Trust's website.

27/23   PEOPLE – to be a highly effective organisation with empowered, highly skilled and competent staff

(i) Report from the People Committee held on 15 March 2023

The Committee Chair and Non-Executive Director, Abdul Siddique presented the report setting out the key considerations of the January People Committee.

(ii) Medical Appraisal and Revalidation Report

The Clinical Lead for Dental Services presented the report which set out that as of February 2023, there had been 18 doctors aligned to the Trust for appraisal. There had been 16 doctors with appraisals conducted for 2022/23 prior to 28 February 2023, with two approved

postponements.

The Board received the report as assurance that the Trust was meeting its statutory responsibilities related to medical appraisal and revalidation and medical governance, and that those matters were discussed and monitored on a regular basis by the Medical and Dental Professional Governance meeting.

(iii) Staff Survey Results and Action Plan

The Board received the report which demonstrated that the Trust compared favourably to other Trusts across the different categories of the survey. The first iteration of the action plans would be available later in April with individual action owners to present to relevant forums on progress. The action plans would be discussed in depth at the Performance Council. An impact assessment would be undertaken to evaluate plans set from the 2021 survey and the impact for 2022 which would be taken through the People Committee.

Following a query from Non-Executive Director, Tina Wilkins, **the Director of People agreed to provide information to clarify information within table four within the report**.

Following a suggestion from the Chief Executive, it was agreed that the Director of People would contact the organisation supporting the staff survey to explore comparators on a regional or sub-regional basis as this would add more value opposed to community organisation to community organisation comparisons.

(iv) People Plan

The Board received the report for assurance that the Trust was delivering on its People Plan. This was aligned to the Trust's strategy.

(v) Statutory and Mandatory Training and PPDR Action Plans

The Board was assured that full staff compliance with mandatory training would be achieved by 31 July 2023 and noted the progress that had been made since this target was set in July 2022. The importance of staff completing the training was acknowledged to ensure that they were safe to practice/undertake their roles and the responsibilities of staff and managers to ensure that appropriate conditions were in place for staff to undertake the training. A set of principles were under development and would be discussed with staff side colleagues concerning the managing of continued non-compliance of staff where appropriate. This would take place during April.

Following a challenge by Non-Executive Director, Elaine Inglesby **the Director of People would undertake a review/cleanse of information to provide assurance that staff were undertaking the appropriate statutory and mandatory training as relevant to their roles**.

(vi) Update Report on Industrial Action

The Director of People presented an update report informing the Board that following recent strike action, the Government had made an 'offer in principle' for the Agenda for Change workforce which was currently subject to consultation: Union bodies would consult with their members as to whether or not to accept the offer being made. The report also detailed actions taken by the Trust to support staff health and wellbeing and the lessons learned from strike action. The Board would be kept updated.

28/23   OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Results of the annual Board effectiveness survey

The Trust Secretary presented the results of the annual survey. She noted that the results were positive with particular highlights including that the Board was run well, with a good

composition of skills. The response rate from Board members was also noted as high. One area for improvement related to the timings for items on the agenda which may require some review to ensure sufficient discussion time on key items. In addition, the Board was keen to receive more patient stories going forwards with a balance of good news and bad news stories, with a reflection on what could be improved and what lessons could have/had been learned. This could be undertaken by approaching previous complainants who may be interested in sharing their story with the Board.

(ii) Code of Governance Updates

The Trust Secretary presented a report to the Board which advised on three Codes of Governance to brought into effect in April 2023, acting as a revision to the Foundation Trust Code of Governance (2014): Code of Governance for NHS Provider Trusts: Guidance on Good Governance and Collaboration and: System Working and Collaboration: Role of Foundation Trust Council of Governors. The Board noted the content of the report.

(iii) Board business cycle

The Board reviewed and approved the business cycle for 2023/24, noting that this was a fluid document.

29/23   REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

There were no further items to be added to the Board Assurance Framework.
The Board noted that there had been only one Governor observer today and no Governors observing the second half of the meeting today. It was agreed that Governors should continue to be encouraged to observe Board meetings.

30/23   OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

There were no questions raised.

DATE AND TIME OF NEXT MEETING

Thursday 1 June 2023, 10am, at Spencer House, Dewhurst Road, Birchwood, Warrington.

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	Due Date/BRAG Status	Comments/Further Action
					Completion Date	
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	**BLUE**	Now part of the Board Development programme
08.12.22	88/22i	Integration and Collaboration Update	**The Board agreed that a time out session should consider involvement of external partners in children's transformation work in the context of the strategy.**	Jan McCartney/Rob Foster	**BLUE**	This has been included on the future Board development/time out programme for July 2023.
08.12.22	88/22ii	Update on Provider Collaboratives	**The Board agreed that regular meetings would be required at least quarterly with Executive and Non-Executive Directors from each of the organisations within the Collaborative to discuss key matters and strategies. The Chair agreed to raise this at the meeting of CEOs and Chairs of the Collaborative in January 2023.** **The Board would also welcome presentation of the report which was provided to all of the Boards within the Collaborative on a regular basis.**	Karen Bliss	**GREEN**	February 2023: The Board noted that further discussions would take place on this matter and that this action would remain on the log pending further updates in due course. June 2023: Update will be provided by the Chair.

ACTION LOG

Key

Red	Significantly Delayed and / or of High Risk
Amber	Slightly Delayed and / or of Low Risk
Green	Progressing to timescale
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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
08.12.22	91/22i	Accountability Framework	**Whilst the Board approved the second part of the Accountability Framework, the updated performance framework must be in place to support this and the associated timescales for that framework must be reviewed.**	Sarah Brennan/Jan McCartney	**BLUE**	February 2023: The Board agreed that a discussion needed to take place concerning the IQPR metrics that the Trust wanted to deliver against the strategy and the associated timescales. This would need to be discussed at a dedicated Board time out session prior to the Finance and Performance Committee taking place in late March 2023. A date would be set for this to take place. March 2023: Item included on the agenda.
02.02.23	08/23i	IQPR	**A discussion took place concerning mandatory and statutory training and it was agreed that consideration would be given to the consequences for staff of not being compliant with this training, with discussion to take place with staff side colleagues. This would be taken forward by the EMT. The Board would be updated on this at its next meeting.**	Colin Scales/EMT	**BLUE**	April 2023: Report included on the agenda.

ACTION LOG

Key

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Blue	**Completed**

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

Date	Minute Ref	Issue	Action	Director	Completion Date	Comments/Further Action
					Due Date/BRAG Status	
02.02.23	09/23ii	Trust's response to the planning priorities guidance	**It was agreed that a bespoke Board session would be scheduled to enable a review of plans, both draft and final, and it was noted that some e-governance may be required, depending on the timescales for submission.**	Jan McCartney/Nick Gallagher	**BLUE**	March 2023: in train, first session held on 28 February 2023. April 2023: update included on the agenda.
02.02.23	09/23iv	Chair's Report from the Audit Committee	**The Board agreed that self-effectiveness survey feedback should no longer be provided anonymously going forwards. An approach would also be agreed where the outputs of the surveys would be reviewed by the Board at a time out session.**	Jan McCartney	**BLUE**	March 2023: Completed, the first effectiveness review has been conducted for the People Committee. Due to being able to target those non-compliant the response rate has increased.
06.04.23	21/23	Board Assurance Framework	**It was agreed that setting of achievable target risks should be included as part of the Board's dedicated session to consider risk appetite for the next year.**	Jan McCartney	**GREEN**	Board session to take place on 11 May 2023.
06.04.23	23/23i	IQPR	**The Executive Management Team to discuss disaggregated data and elements that may be useful to include in the IQPR going forwards to provide further assurances to the Board on key matters.**	Colin Scales	**GREEN**	June 2023: Information will be included in the IQPR report.

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
06.04.23	23/23ii	Performance Framework	**It was agreed that Committee Chairs would engage with Chairs of the Risk Management, Quality and Performance Councils and meet at regular intervals to discuss expectations around reporting and information through to Committees, building relationships and supporting/mentoring as needed.**	Jan McCartney	**GREEN**	June 2023: work is ongoing – verbal update to be provided by the Trust Secretary
06.04.23	23/23iii	Committee Chair's report from the Quality and Safety Committee	**Discussion to take place concerning the potential change from Ulysses to Datix systems for the Trust and providing assurance on this issue to the Quality and Safety and Finance and Performance Committees including advice related to the practicalities of any transition.**	Colin Scales, Jan McCartney, Jeanette Hogan	**GREEN**	June 2023: verbal update to be provided by the Trust Secretary.
06.04.23	23/23iv	Learning from Deaths	**It was agreed that further detail was required for future reports around unexpected deaths, a review of terminology used within the report and a stronger emphasis on the learning from deaths. The Deputy Chief Nurse would liaise with the Medical Director.**	Jeanette Hogan/Ted Adams	**GREEN**	June 2023: Feedback has been provided to the report author. Work is ongoing to refine the report.

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
06.04.23	24/23i	Finance Report – month 11	**It was noted that there were higher incentives and rewards being offered to potential staff by other organisations which went against the system's agreed principles. This would be raised with the organisations responsible at Chief Executive level.**	Colin Scales	**GREEN**	June 2023: Discussions are taking place on this matter with a view to this being ceased.
06.04.23	27/23iii	Staff Survey	**Director of People to provide further information to clarify table four within the report.** **Director of People to contact the organisation supporting the staff survey to explore comparators on a regional or sub-regional basis as this would add more value opposed to community organisation to community organisation comparisons.**	Paula Woods	**GREEN**	May 2023: A Staff Survey Update Report is included on the agenda for the June Board. The Staff Survey table will illustrate Trust specific 'v' comparator data going forwards with regards to the 5% differentials in improved performance and areas of deterioration. The Trust's Deputy Director of Communication & Engagement will explore comparators for the 2023 Staff Survey and will also explore with Quality Health if we can benchmark ourselves against Acute Trusts this time around.

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	Due Date/BRAG Status	Comments/Further Action
					Completion Date	
06.04.23	27/23v	Statutory and Mandatory Training	**Director of People to undertake a cleanse of information to provide assurance that staff were undertaking the appropriate statutory and mandatory training as relevant to their roles**	Paula Woods	**GREEN**	May 2023: The training requirements as per NHS Business Group are allocated to all staff, and apart from Fraud Awareness and Dementia awareness they, are all statutory core requirements. The fraud awareness and dementia have been mandated by the Trust for all staff. Fraud Awareness came through Education Governance in 2021 from MIAA and has been agreed as a 3 year requirement. The dementia training is a once only- no renewal requirement. Via the Education, Learning & Development POD, we are currently working on a process for reviewing all mandated and role essential training requirements on a regular basis to ensure that all training that staff are required to complete remains up to date and relevant.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01/06/2023**
Agenda Item	**36/23**		
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
☒ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
☒ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
☒ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
☒ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	**01/06/2023**
Agenda Item	**36/23**		
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.

1.4   The BAF document has been updated to reflect the revised strategic objectives and tracks the progress of the BAF risks over the quarters of this and the previous year.

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 28 April. Two amends were recommended.

a) An amend under Assurances to make it clear that Internal Audit effectiveness is also an assurance.

b) The annual reports of the Committees of the Board were added to the assurance section.

This BAF remains at target.

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

The Quality & Safety Committee met on 20 April and noted that a thorough review has been completed on this BAF, therefore a minor amend should be added to in gaps in

control, paediatric audiology. No further changes were recommended, with no change to the risk rating.

2.3 **BAF3 – Managing demand and capacity**

The Quality & Safety Committee met on 20 April 2023 and noted that a thorough review has been completed on this BAF recently, therefore a minor amend should be added to in gaps in control, paediatric audiology, and district nurses. No further changes were recommended, with no change to the risk rating.

2.4 **BAF4 – Financial sustainability**

The Finance & Performance Committee met on 18 May 2023 and recommends the following changes:

    a) Rationale for current score, remove reference to Covid payments and note that 2022/23 budget achieved
    b) Update principal risk to show risk of deficit remains for 2023/24
    c) Remove 2019/20 audit in assurance section
    d) Add Key Financial audit with substantial assurance 2022/23

The Committee recommends the risk rating remains the same, at target.

2.5 **BAF5 – Staff engagement and morale**

The People Committee met on 10 May 2023 where the Committee recommended:

    a) An addition to Prevent Controls, 'agreement and implementation of the pay deal for AfC staff.
    b) An amendment to 'meetings with staff side' to update the frequency of them

No change to the current risk rating.

2.6 **BAF6 – Staffing levels**

The Quality & Safety Committee met on 20 April 2023 and did not ask for any changes to be made.

The People Committee met on 10 May 2023 and no changes were recommended.

Neither Committee recommended a change in the current risk rating.

2.7 **BAF7 – Strategy and organisational sustainability**

The Finance & Performance Committee met on 18 May 2023. The Committee had previously asked the Executive Directors to review this BAF and recommend changes. The following changes were suggested by the Executives and accepted by the Committee.

    a) The principal risk was updated to reflect the Trust's position within the Integrated Care System (ICS) and its work with other providers
    b) Rationale for current score updated to demonstrate the continuing relationships and partnerships at place and to record the Trust strategy, 'Communities Matter', has now been approved at the Board.
    c) Prevent controls were updated to demonstrate the additional projects and involvement the Trust is currently involved with.

The Executive team asked the Committee to consider reducing the risk rating for this BAF. This is because on the ongoing maturity with system working and the additional prevent

controls in place. The Committee agreed and recommends to the Board a reduction to the current risk rating from 12 (high) to 8 (medium), this brings this BAF to its target risk rating.

2.8 **BAF8 – Digital Services**

The Finance & Performance Committee met on 18 May 2023.

Some minor updates were recommended, such as

a) Reference to the Digital Strategy updated to reflect the current one.
b) MIAA audit, Cyber Security (moderate assurance) added to assurances, and
c) Information Commissioner's Office Audit 2019/20 removed.

The Committee had a thorough discussion on whether the current risk rating of on target should remain the same, noting some current challenges outlined in the DIGIT report. In conclusion the Committee felt these risks were being adequately mitigated but would like to see additional evidence within the DIGIT Chairs report going forward.

3. RECOMMENDATION

3.1 The Board is asked to approve the changes recommended by the Committees and note that four of the BAF risks (BAF1, BAF4, BAF7 and BAF8) are now currently at target.

Appendix A – Board assurance framework
Appendix B – BAF tracker

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK
LAST UPDATED 18 May 2023

STRATEGIC OBJECTIVES

- **Equity, Diversity and Inclusion** – We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
- **Health Equity** – We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
- **Partnerships** – We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
- **Quality** – We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
- **Resources** – We will ensure that we use our resources in a sustainable and effective way.
- **Staff** – We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

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: April 2023 Audit Committee Last reviewed: April 2023 Risk Ratings reviewed: April 2023	**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 fully implemented.	**Prevent Controls** • Trust Board • Governance structure approved by the Board, SFIs &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 • **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 • External independent Well Led review • Daily automated data reporting • Declarations of Interests Register • MIAA governance checklists • Annual Review of Effectiveness of Audit Committee • Annual Review of Effectiveness of Internal Audit & Anti-Fraud • Annual Review of Effectiveness of External Audit Service • Annual Reports received from Committees of the Board • 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) June 2023 – V0.1 Board Final

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

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: April 2023 Quality & Safety Committee Last reviewed: April 2023 Risk Ratings reviewed: April 2023	**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 multi-faceted risks such as a) challenges in relation to recovery, restoration, and service reset b) National recruitment challenges (inc. accessibility to specialist training) c) Geographical recruitment pressures d) Potential industrial action e) Seasonal pressures 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** 3075 : Dermatology – patient safety Less than 15 – combined District Nursing workforce risk	Quality & safety governance structure in place. Robust QIA process for all services Number of ongoing high risks Industrial action (Cross ref. with BAF2) Additional winter capacity	**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 • Daily Ops Huddle & Daily sit rep • Directorate Team Meetings **Detect Controls** • Quality & Safety Committee bimonthly meetings • Clinical & Internal Audit Programme • IQPR & quality dashboards • Quality Council • Performance 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 • Deep Dives at Committee • Ockenden Report to Committee • E-roster monitoring • Trust transformation programme (BOOST) • Quality Summits **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)
Staff compliance with mandatory and service specific training - training trajectory in place, monitoring related incidents System pressures – involvement in system pressure meetings and System Sustainability Group (SSG) Agency Cap – mitigating actions in place Paediatric Audiology

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

| 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: April 2023 Quality & Safety Committee last reviewed: April 2023 Risk Ratings reviewed: April 2023	**Managing demand & capacity** If the Trust is unable to manage the level of demand. 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** **2887:** Dermatology, waiting lists **3091:** Capacity in Risk & Patient Safety Team	Quality & Safety Committee Risk Management Council meets monthly. Performance Council meets monthly. Daily joint operations and nursing meetings. Managed risk with approval from the Board. Quality and safety under constant review to ensure no patient harm.	**Prevent Controls** • Quality & Safety Committee • Waiting list management via Performance council and Directorate Leadership Teams (DLTs) • Patient pathway management arrangements • System One PAS – Patient Administration System • RTT lists to track 6 week and 18-week access standards, national weekly submission • Executive management performance dashboard • 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 • Daily system pressure calls • Workforce Strategy in place / Workforce POD • Daily joint operations and nursing meetings **Assurances** • Audits monitored at each relevant Board Committee, exception reports to Audit Committee • Performance Council reports to Finance & Performance Committee • Deep dives at Committee • Winter Plans • Emergency Preparedness, Resilience and Response Plans (EPPR) • Quality Summits • Rapid Improvement Events • Absence Management Audit – Significant Assurance (2019/20)

Gaps in controls and assurance: (and mitigating actions)
 Dermatology – Action plans in place
District Nursing – demand and capacity
Paediatric Audiology

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

| BAF 4: Financial sustainability | TRUST OBJECTIVES:
• 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:

OPEN |

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Director of Finance Last reviewed: May 2023 Finance & Performance Committee last reviewed: May 2023 Risk Ratings reviewed: May 2023	**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 2023/24 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 Break even budget 2022/23 achieved.	**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 • Key Financial Systems (2020/21) and high and substantial assurance (2021/22 & 2022/23) • Board review of internal audit plan **External audit** • Audit review findings – Clean Unmodified Audit (2022/23) • Board review of external audit plan and annual accounts

Gaps in controls and assurance: (and mitigating actions)

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) June 2023 – V0.1 Board Final

| BAF 5:
Staff engagement and morale | TRUST OBJECTIVES:
• Equality, Diversity & Inclusion
• 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: May 2023 People Committee Last reviewed: May 2023 Risk Ratings reviewed: May 2023	**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 cost of living crisis. Impact on leadership and management practices, winter pressures, system incentives It may result in low staff morale, leading to poor outcomes and experience for large numbers of patients; less effective teamwork; reduced compliance with policies and standards; high levels of staff absence; and high staff turnover rates. **Risks on register 15 plus** No risks at this level	People Committee ensure governance and holds to account. Current risk rating reflects the Board acknowledges that, despite the controls and assurances in place, staff are currently fatigued; Restoration and recovery programmes / post covid effects Patient experience adversely affected (links to Q&S Committee) Uncertainty / Impact of national change programmes – Health & Care Act integration and collaboration Organisational structures and service redesigns and reorganisations	**Prevent Controls** • People Committee Organisational and local Staff engagement plan • Managers' Key brief/ communication, Time to Talk and CEO Q&A sessions • Local Negotiating Committee, Joint Negotiation & Consultative Committee • Occupational Health Service & Staff Health & Wellbeing Officer/Board Health & Wellbeing Guardian • Talent Management process and Succession Planning Tool • Revised Exit interview questionnaire / In house Resilience Training Programme • People Hub and POD Groups • Recruitment & Retention • Health & Wellbeing • Education & Professional development • Northwest Person-Centred approach to absence management • Bi-monthly meetings with Staff Side • Agreement and implementation of pay deal for AfC staff **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 . **Internal Audit MIAA Substantial Assurance** • Freedom to Speak Up (2020/21) • Attendance management Staff Engagement (2019/20) • Induction (2020/21) • Payroll (2022/23

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
Warrington Adults staff survey results – engagement ongoing
Pay deals under negotiation nationally

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

| 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: May 2022 Quality & Safety Committee Last review: April 2022 People Committee: May 2023 Risk Ratings reviewed: May 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. (Cross ref. with BAF2) 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)			

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

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

Lead Director/ Lead Committee	Principal risk	Rationale for current score	Prevent Controls & Assurances
Director of Finance Last reviewed: May 2023 Executive Team April 2023 F&P Committee Last reviewed: May 2023 Risk Ratings reviewed: May 2023	**Strategy & Organisational Sustainability** If the Trust fails to deliver on its strategy or fails to make the expected contribution by not meeting the needs of partners, commissioners or the IBC, it could lose its identity as a key system contributor and place partner. This may reduce the Trust's 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. **<u>Risks on register 15 plus</u>** No risks at this level	Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. Increased assurance from system relationships and partnerships Trust Strategy 2023 'Community Matters', now approved by Board with enabling strategies Trust System Oversight Framework (SOF) is segment 2 Enabling strategies	**Prevent Controls** • Trust Board Oversight – engagement and delivery of Health & Care Act & strategic milestones • Perf framework – enabling strategies - operation delivery plans • Execs carrying out SRO roles within system, eg aging well, starting well, workforce • • Regular Exec meetings with commissioners and other key stakeholders • Senor staff 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 • Joint working on a number of projects with commissioners and local authority * hospital e i.e. • General practice PCN • Engagement internally / externally • 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 • Implementing dental strategy with partners • Board development with Good Governance Institute and NHS Providers • National involvement in strategy for intermediate care **Assurances** • Mental Health, Community and Learning Disability Provider Collaborative member – Trust is host, including employing staff – C&M Health and Care provider collaborate including employing and hosting staff • Programme Director – Collaboration and Integration • Emerging integrated governance structures with partners • MOU in place where services are delivered in conjunction with other partners • Chief Executive's monthly reports providing an overview of engagement activity • Executive Directors hold regular meetings with all key partners and stakeholders • Adaptive reserve contribution

Gaps in controls and assurance: (and mitigating actions)
Implementation of revised system governance arrangements, to be finalised – ongoing maturity

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

| 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 2 (L) = **8, medium**
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: May 2023 F&P Committee Last reviewed: May 2023 Risk Ratings reviewed: May 2023	**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 the Digital Strategy • meet operational, regulatory, contractual & reporting requirements • embrace innovative and existing clinical service models • collaborate in system place-based developments • keep the Trust safe from Cyber-related threats **Risks on register 15 plus**	Cyber risks. 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 2022–25 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 Digital technology assessment criteria (DTAC) and Data Protection Impact Assessment (DPIA) routinely completed **Detect Controls** DIGIT and Digital Programmes Groups Participation and membership of ICS and Place based digital development groups High Severity Care Cert notifications from the National Cyber Security Centre **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 Password penetration test tools MIAA – Internal Audit Cyber Security – Moderate assurance (2022/23) **Audits – Substantial Assurance**: IT Threats & Vulnerability (2020/21) DSP Toolkit (2021/22)

Gaps in controls and assurance: (and mitigating actions) Digital Services team capacity

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final
Appendix 1: BAF Tracker

No.	Risk Title	Inherent Score			Target Score			Q2 Jul-Sep			Q3 Oct-Dec			Q4 Jan-Mar			Q1 Apr-Jun			Target Date	Change	Equity, Diversity & Inclusion	Health Equity	Partnerships	Quality	Resources	Staff
		C	L	S	C	L	S	C	L	S	C	L	S	C	L	S	C	L	S								
BAF 1	Failure to implement and maintain sound systems of corporate governance	4	4	16	4	2	8	4	2	8	4	2	8	4	2	8	4	2	8	TBC	→				✔	✔	
BAF 2	Failure to deliver safe & effective patient care	5	5	25	5	2	10	5	3	15	5	3	15	5	3	15	5	3	15	TBC	→		✔	✔	✔	✔	✔
BAF 3	Managing demand & capacity	4	4	16	4	2	8	4	4	16	4	4	16	4	4	16	4	4	16	TBC	→		✔	✔	✔	✔	✔
BAF 4	Financial sustainability	4	4	16	4	2	8	4	3	12	4	2	8	4	2	8	4	3	12	TBC	↓		✔	✔	✔		
BAF 5	Staff engagement and morale	4	4	16	4	1	4	4	3	12	4	4	16	4	4	16	4	3	12	TBC	↑	✔			✔	✔	✔
BAF 6	Staffing levels	4	5	20	5	2	10	5	3	15	5	3	15	5	3	15	5	3	15	TBC	→	✔	✔	✔	✔	✔	✔
BAF 7	Strategy & organisational sustainability	3	4	12	4	2	8	4	3	12	4	3	12	4	3	12	4	3	8	TBC	↑		✔	✔	✔	✔	✔
BAF 8	Digital services	4	4	16	4	2	8	4	3	12	4	3	12	4	2	8	4	3	8	TBC	→	✔	✔	✔	✔	✔	✔

Impact on Objectives

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

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

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

Board Assurance Framework (BAF) June 2023 – V0.1 Board Final

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		Directorate quarterly review		Board monthly review
Reporting	None			Relevant Board Committee	

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**		**Date**	**01/06/23**
Agenda Item	**37/23**			
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

- ☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
- ☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
- ☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
- ☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
- ☐ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
- ☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	1 June 2023
Agenda Item	37/23		
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 attended numerous meetings, namely: Race Inclusion Network on 4 April; National Chair Briefing from NHSE on 5 April; NHS Confederation National Chairs' meeting on 17 April; Cheshire & Merseyside Financial Plan Escalation meeting debrief on 28th April.

During March and April, Karen also attended two Time to Shine meetings and two North West System Leaders' calls.

In April, Karen attended two GGI webinars, one focusing on "Collaborative Governance" and one focusing on "System Partnerships and the Hewitt Report". On 19 May, Karen also attended a GGI webinar on "NEDs and Systems".

On 28 March, Karen was one of the speakers at the GGI webinar "Balancing the Books", on the challenges of managing NHS Finances for Trusts.

On 11 April, Karen accompanied the Director of Finance on a Time to Talk session with the Warrington Speech and Language Therapy Team, and on 8 May joined the Executive Management Team at an Eid Lunch which was hosted by our Dental Team at Oldham Integrated Care Centre.

Karen also met with Isla Wilson, Chair at Cheshire & Wirral Partnership on 18 May.

1.2 Non-Executive Director, Linda Chivers attended a number of meetings - the Trust Rest of England Governors meeting; Trust Council of Governors and Governors Development Session; Good Governance Institute Non-Executive Directors Development Session; monthly meetings with Mersey Internal Audit and also KPMG (external auditors) and had a follow up session with Audit Committee Governor Observers.

As part of the buddying arrangements, Linda met with Paula Woods, Director of People and Organisational Development.

1.3 Non-Executive Director, Tina Wilkins attended the following meetings:

- Rest of England Governors meeting on 4 April.
- Council of Governors and Governors Development session on 19 April.
- Voice of the Child meeting on 25 April.
- Private meeting with Audit Committee members and external audit on 27 April.
- Time to Shine meeting on 17 May.

Tina also attended the ICB facilitated Non-Executive Directors session in respect of People and Workforce on 31 March and on 20 April, the North West Non-Executive Director Network Event.

1.4 Non-Executive Director, Gail Briers attended the Warrington and Halton Governors meeting on 13 April, the private Audit Committee meeting with external auditors on 27 April and the Council of Governors meeting on 19 April. Gail accompanied the Chief Operating Officer on the IT Department Time to Talk session on 12 April and had a 1-1 meeting with the Chief Operating Officer as part of the buddying arrangements. Gail also had a 1-1 meeting with the Freedom to Speak Up Guardian on 17 May.

1.5 Non-Executive Director, Martyn Taylor attended numerous meetings during the month of April:
- Time to Shine – Speech and Language and School Immunisation Team on 4 April.
- Performance Council on 5 April.
- Governor meeting regarding new service visits programme on 12 April
- Warrington & Halton Governor Council meeting on 13 April
- Serious Incident Review Panel meeting on 18 April
- Safeguarding Trust Assurance Group meeting on 19 April

Martyn attended the Leader in Me event which took place on 21 April and also the Good Governance Institute Webinar on 25 April.

During the months of April and May, Martyn also had a number of 1-1 meetings with the following staff members:

- 10 April - Chief Executive
- 11 April – Lead Governor
- 12 April - Deputy Chief Nurse
- 2 May – Director for Safeguarding services re Safeguarding Trust Assurance Group
- 12 May – Programme Director of Collaboration & Integration re Strategy implementation
- 16 May – Lead Governor

1.6 Non-Executive Director, Abdul Siddique accompanied the Director of Finance on a Time to Talk session with the Warrington Family Nurse Partnership Team on 27 April.

On 4 May, Abdul attended The House of Lords Seacole conference, and said *"I was delighted to have represented Bridgewater at a recent conference in the House of Lords, to talk about bamer health inequalities and NHS board bamer representation. It was great to have Sir David Sloman NHS COO present and Baroness Thornton who sponsored the event and is spokeswoman for Equalities in the lords"*

2. EXECUTIVE UPDATES

2.1   On 27 March, the Chief Executive participated in the stakeholder panel interviews for the Warrington Borough Council Director of Adult Social Care interviews.

2.2   The Chief Executive met with Stephen Young, Chief Executive of Halton Borough Council to discuss the services being provided within the borough and joint working opportunities.

2.3   On 24 April the Chief Executive attended a virtual meeting of the Cheshire & Merseyside Integrated Care Board System Discharge to discuss the Cheshire sites.

2.4   **Executive and Senior Team Engagement**

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:

2.4.1 The Chief Executive met with the St Helens Audiology Team based at The Bridges Learning Centre in Widnes on 12 April.

2.4.2 On 11 April, on behalf of the Chief Executive, the Director of Finance met with the Warrington Speech and Language Team based at health services, Wolves, Warrington.

On the 27 April the Director of Finance met with the Warrington Family Nurse Partnership team at Great Sankey Neighbourhood Hub.

2.4.3 On 10 May, the Medical Director met with the District Nursing Team Runcorn West.

2.4.4 The Chief Operating Officer held a virtual session with the IT Service on 12 April.

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	Dame Elaine Inglesby
Aruna Hodgson	Martyn Taylor

2.5   **Board Sessions/Events**

2.5.1 A Leader in Me event took place on Friday, 21 April at Haydock Park Racecourse. The event was filled with energy and inspiration by motivational speaker Steve Head who provided those in attendance with some key tools and techniques they could apply to improve their working lives and the excellent care provided to patients. The afternoon session focused on the new 'Communities Matter' Strategy which was presented by the Chief Executive. This was followed by an update on the new approach being taken by the CQC, which was presented by the Deputy Chief Nurse.

2.5.2 On 9 May, the Executive Management Team were invited to join the Oldham Eid Lunch held at Oldham Integrated Care Centre, which was hosted by the Dental services team.

2.5.3 A Board Time-Out session took place on 11 May, which focused on the following key areas:

  ➢ Risk appetite
  ➢ Well led inspection report
  ➢ Patient Safety Incident Response Framework
  ➢ Buddying arrangements

2.5.4 A Drive Ability North West Event took place on 18 May at Haydock Park Racecourse to celebrate 30 years of the service. The event had a mix of presentations, speeches and demonstrations to showcase the service. Members of the Executive Team attended the session which was a success.

3.	EXTERNAL PUBLICATIONS AND REPORTS

3.1 Realising the potential of community-based multidisciplinary teams (Health Foundation briefing) -
This briefing summarises evidence from IAU evaluations of three MDTs and wider evidence to inform current efforts to develop integrated care in England. It reflects on what this evidence means for local leaders looking to implement MDTs, as well as for national leaders seeking to support these models of integrated care.

[Realising the potential of community-based multidisciplinary teams - The Health Foundation](#)

3.2 NHS Providers governance survey 2022

This survey was sent to company secretaries and others responsible for corporate governance in NHS trusts and foundation trusts in September and October 2022. It sought to explore respondents' views in relation to boards and the operation of board assurance committees and how the introduction of the statutory integrated care boards (ICBs) may have impacted trust boards. The results of this survey will be used to inform our governance policy and influencing work, and feed into our board development programmes. This briefing summarises the results of the 2022 survey, and where applicable, compares the results to previous years. Comparisons between trust types, regions, and between foundation trusts and trusts are available for each question.

[2022-governance-survey-full-report.pdf (nhsproviders.org)](#)

3.3 NHS Providers – Activity Tracker

This is a monthly tracker NHS Providers produce using activity data from NHS England.

NHS Activity Tracker 2023 (nhsproviders.org)

3.4 NHS response to COVID-19: Stepping down from NHS level 3 incident

On 18 May 2023 correspondence was received from Amanda Pritchard, NHS Chief Executive and Sir David Sloman, NHS Chief Operating Officer, to advise that the NHS is stepping down from the level 3 COVID-19 incident. The letter can be found in the link below.

PRN00498-nhs-response-to-covid-19-stepping-down-from-nhs-level-3-incident.pdf (england.nhs.uk)

4.	RECOMMENDATIONS

4.1 The Board is asked to note the report.

Integrated Quality and Performance Report

Information Team
Reporting Period: March 2023 (Month 12)

Contents

- **Section 1: Trust Overview**

- **Section 2: Operations – Responsive**

- **Section 3: Safe, High-Quality Care**

- **Section 4: People**

- **Section 5: Finance - Making Good Use of Resources**

Introduction

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

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

This month's report describes activity in March 2023.

Within this Report

1. KPI Amendments

KPI	Change	Rationale

2. Recommendations:

The Board are asked to:

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

Trust Overview
Executive Summary

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

Responsive (Operations)

There are 11 green indicators in month 12. There was one new red indicator pertaining to 'Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)', however this was outside of the control of the Trust

There have been some positive increases in performance most notably in the 18 week RTT and also the 28 day faster diagnosis standard. There is some challenges with the 6 week standard in audiology which are being managed within the service with support.

Cancellations, activity and referrals remain largely unchanged. The numbers of patients waiting for dental treatment is increasing, particularly in Greater Manchester West and for Paediatric GA activity.

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 38 green indicators in month 11. There are no new red indicators.

People

Four out of the five people indicators are red in month. There has been a considerable improvement in the rolling turnover in month which is due to the impact of the Oldham transfer impact now not impacting on the turnover calculation.

Making Good Use of Resources (Finance)

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

Operations

Executive Summary

Of the 19 Operations indicators which are reported; eight are red and eleven are green.

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

- Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral) – New red indicator

- Referrals to plan – Increase in month

- Cancellations by service – Decrease in month

- Cancellations by Patient – Increase in month

- Percentage of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway) – Significant improvement in month

- Warrington Audiology - Number of 6 weeks diagnostic breaches – increased from 5 to 9 breaches.

- Warrington Activity Variance – Increase in month

- Halton Activity Variance – Decrease in month

Overall, there is some improvement in operational performance which is pleasing, there is one indicator which has moved from red to green and this is in relation to the number of 6 week diagnostic breaches in Warrington Audiology.

Operations

Actions
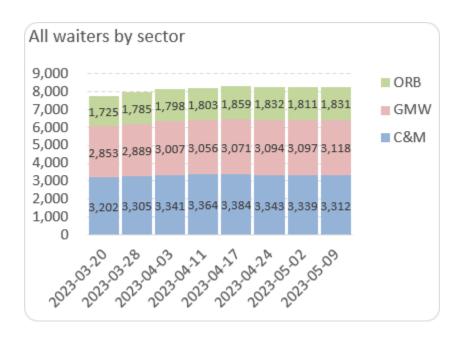
Indicator	Action	Target date	Responsible Committee
% of patients waiting under 18 weeks	Three services now showing breaches of the 18-week RTT – dermatology and community paediatrics, in Warrington and in Halton. Additional resources are already supporting the delivery of these services, but they will be monitored closely to ensure that the RTT is achieved as soon as possible.	October 2022 – Revised date for achievement of waiting times – NOT ACHIEVED Significant improvement in month – this is being closely monitored via the Directorate Leadership Teams and the Performance Council	Chief Operating Officer / Finance and Performance Committee

Operations
Trust Scorecard

Operations

Code	KPI Name	Target	Trend Line	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
OP01	KPIs / Achievements Locally agreed KPIs	100.00%														
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93.00%		93.97% (▼)	93.94% (▼)	94.03% (▲)	95.76% (▲)	93.19% (▼)	91.34% (▼)	93.93% (▲)	31.25% (▼)	92.34% (▲)	94.39% (▲)	98.84% (▲)	99.55% (▲)	98.16% (▼)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94.00%		100% (▲)	50% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	83.33% (▼)	100% (▲)	75% (▼)	100% (▲)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96.00%		100% (▲)	83.33% (▼)	100% (▲)	80% (▼)	100% (▲)	92.86% (▼)	100% (▲)	80% (▼)	100% (▲)	100% (►)	100% (►)	83.33% (▼)	100% (▲)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85.00%		86.67% (▼)	95.24% (▲)	96.97% (▲)	100% (▲)	85.71% (▼)	87.5% (▲)	92.31% (▲)	100% (▲)	100% (►)	100% (▲)	93.33% (▼)	87.5% (▼)	75% (▼)
OP22	28 day faster diagnosis	75.00%		60.21% (▲)	73.84% (▲)	66.5% (▼)	71.92% (▲)	72.73% (▲)	68.67% (▼)	75.19% (▲)	79.17% (▲)	73.02% (▼)	75.29% (▲)	75.95% (▲)	81.14% (▲)	91.01% (▲)
OP06	Referrals to plan	95.00%		76.51% (▼)	85.54% (▲)	94.12% (▲)	89.86% (▼)	87.27% (▼)	87.03% (▼)	84.88% (▼)	95.85% (▲)	90.53% (▼)	75.66% (▼)	91.08% (▲)	81.22% (▼)	85.83% (▲)
OP07	Cancellations by service	5.00%		9.18% (▼)	12.68% (▼)	11.58% (▲)	11.29% (▲)	12.43% (▼)	11.67% (▲)	12.56% (▼)	10.61% (▲)	10.56% (▲)	12.22% (▼)	10.89% (▲)	11.16% (▼)	10.77% (▲)
OP08	Cancellations by Patient	5.00%		5.18% (▼)	4.64% (▲)	4.5% (▲)	5.28% (▼)	6.32% (▼)	5.16% (▲)	5.3% (▼)	5.81% (▼)	5.66% (▲)	5.73% (▼)	5.39% (▲)	5.22% (▲)	5.79% (▼)
OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92.00%		60.01% (▼)	57.26% (▼)	61.03% (▲)	59.48% (▼)	59.05% (▼)	53.34% (▼)	43.21% (▼)	39.74% (▼)	35.29% (▼)	34.75% (▼)	39.76% (▲)	41.49% (▲)	57.99% (▲)
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		94.16% (▼)	93.96% (▼)	98.38% (▲)	96.6% (▼)	96.3% (▼)	98.66% (▲)	96.48% (▼)	92.66% (▼)	87.43% (▼)	82.48% (▼)	93.72% (▲)	96.01% (▲)	98.1% (▲)
OP12	Total time in A&E - 95th Percentile	4 Hrs		04:07 (▼)	04:17 (▼)	03:35 (▲)	03:54 (▼)	03:56 (▼)	03:32 (▲)	03:55 (▼)	04:31 (▼)	05:11 (▼)	06:06 (▼)	04:27 (▲)	03:57 (▲)	03:31 (▲)
OP13	A&E Time to treatment decision (median) <=60 mins	60 Mins		00:18 (▼)	00:04 (▲)	00:09 (▼)	00:11 (▼)	00:10 (▲)	00:09 (▲)	00:09 (▼)	00:10 (▼)	00:12 (▼)	00:14 (▼)	00:10 (▲)	00:08 (▲)	00:08 (►)
OP14	A&E Unplanned re-attendance rate <=5%	5%		0% (►)	0.09% (▼)	0% (▲)	0% (►)	0.03% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
OP15	A&E left without being seen <=5%	5%		0.13% (▼)	0.11% (▲)	0.41% (▼)	0.13% (▲)	0.28% (▼)	0.44% (▼)	0.23% (▲)	0.08% (▲)	0.27% (▼)	0.89% (▼)	0.13% (▲)	0.03% (▲)	0.09% (▼)
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches	0		2 (▼)	2 (►)	0 (▲)	5 (▼)	1 (▲)	0 (▲)	3 (▼)	2 (▲)	4 (▼)	4 (►)	1 (▲)	5 (▼)	9 (▼)
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score	95%		99.67% (▲)	99.68% (▲)	99.68% (►)	99.76% (▲)	99.8% (▲)	99.77% (▼)	95.36% (▼)	99.83% (▲)	99.83% (►)	99.82% (▼)	99.71% (▼)	99.71% (►)	99.73% (▲)
OP18	Halton Maternity Dashboard - Number of red rated areas	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
OP19	Warrington Activity Variance	3%		-23.17% (▲)	-24.03% (▼)	-20.85% (▲)	-19.14% (▲)	-16.68% (▲)	-17.26% (▼)	-17.81% (▼)	-16.77% (▲)	-16.37% (▲)	-17.02% (▼)	-16.95% (▲)	-17.1% (▼)	-17.28% (▼)
OP20	Halton Activity Variance	3%		-6.46% (▲)	15.26% (▼)	17.05% (▼)	14.07% (▲)	17.27% (▼)	17.39% (▼)	15.15% (▲)	13.85% (▲)	12.36% (▲)	11.08% (▲)	10.92% (▲)	10.36% (▲)	9.18% (▲)

Operations: Exception Reporting

Chart

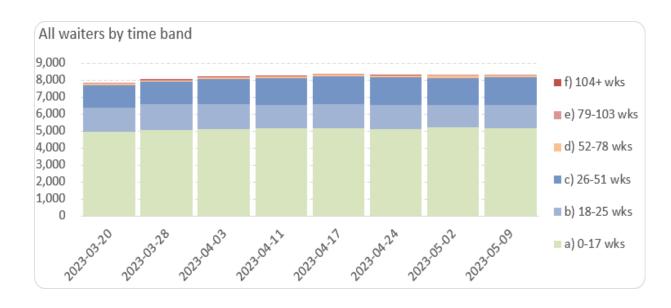All waiters by sector

Issue

Dental - Patients waiting by Sector

The number of waiters has increased by almost 500 patients since 20th March 2023. The most notable increase can be see in the Greater Manchester West Sector where number of patient waiting have increased from 2853 to 3118.

There have been smaller increases in Oldham, Rochdale and Bury and in Cheshire and Merseyside.

The number of waiters is closely monitored at the Directorate Leadership Team meetings and plans are in place to maximise capacity to deliver activity and a business case is being prepared to ask for additional funding from the ICS to support the delivery of some waiting list initiative sessions.

Operations: Exception Reporting

Chart

All waiters by time band

Legend:
- f) 104+ wks
- e) 79-103 wks
- d) 52-78 wks
- c) 26-51 wks
- b) 18-25 wks
- a) 0-17 wks

X-axis dates: 2023-03-20, 2023-03-28, 2023-04-03, 2023-04-11, 2023-04-17, 2023-04-24, 2023-05-02, 2023-05-09

Issue

Dental – Waiters by time band

There are no waiters over 104 weeks and there are only 4 patients waiting over 78 weeks. These 4 patients have been reviewed and are waiting for specific reasons.
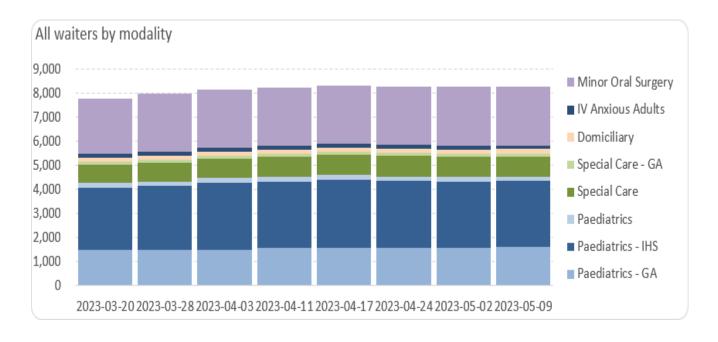
There is however an increasing number of patients who are waiting between 52 – 78 weeks who are being carefully monitored so that they do no fall into the 78 week plus categories.

As per the previous slide, this is being monitored by the Directorate Leadership Team and will be supported by the completion of the business case for additional funds.

Operations: Exception Reporting

Dental – Waiters by time band

Waiters by time band						
Snapshot date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
20/03/2023	4,947	1,444	1,314	73	2	0
28/03/2023	5,070	1,529	1,293	83	3	1
03/04/2023	5,109	1,481	1,458	93	4	1
11/04/2023	5,149	1,406	1,559	103	5	1
17/04/2023	5,161	1,432	1,598	120	3	0
24/04/2023	5,127	1,392	1,622	124	3	1
02/05/2023	5,226	1,279	1,625	115	2	0
09/05/2023	5,180	1,339	1,625	113	4	0

Operations: Exception Reporting

Chart

All waiters by modality

Legend:
- Minor Oral Surgery
- IV Anxious Adults
- Domiciliary
- Special Care - GA
- Special Care
- Paediatrics
- Paediatrics - IHS
- Paediatrics - GA

Issue

Dental - Patients waiting by treatment

The number of patients on all treatment modality has increased in all areas with the exception of IV Anxious Adults which has fallen by 3.

The most significant increases can be seen in Paediatric GA, Paediatric HIS and Minor Oral Surgery. These are challenging areas to address as theatre capacity is required for GA activity. More specialist training is required for HIS sedation and we only have a small number of minor oral surgeons.

Operations: Exception Reporting

Dental – Waiters by Modality

Snapshot date	Waiters by modality							
	Paediatrics - GA	Paediatrics - IHS	Paediatrics	Special Care	Special Care - GA	Domiciliary	IV Anxious Adults	Minor Oral Surgery
20/03/2023	1,467	2,609	178	775	112	148	166	2,325
28/03/2023	1,457	2,675	187	798	116	157	166	2,423
03/04/2023	1,489	2,783	184	827	123	171	161	2,408
11/04/2023	1,551	2,772	178	841	134	174	162	2,411
17/04/2023	1,575	2,815	190	841	132	171	165	2,425
24/04/2023	1,554	2,791	191	843	132	166	155	2,437
02/05/2023	1,569	2,744	191	836	136	167	159	2,445
09/05/2023	1,616	2,715	187	841	131	174	163	2,434
Change since 20/03/2023	149	106	9	66	19	26	-3	109

Quality
Executive Summary

There are 7 Quality indicators reporting as red and 38 green indicators in March 2023.

The 7 indicators which were red in March are as follows:

- % Of Incidents Low impact Level 1-2 - Improvement in month
- Information Governance – Improvement in month
- Safeguarding Adults Level 3 Training –Decrease in month
- Percentage of risks identified as High - Decrease in month
- Total Number of Community Falls– No change in Month
- Percentage of overall falls that are community falls– Decrease in performance
- Total Number of Unstageable Pressure Ulcers acquired in Bridgewater – Decrease in performance
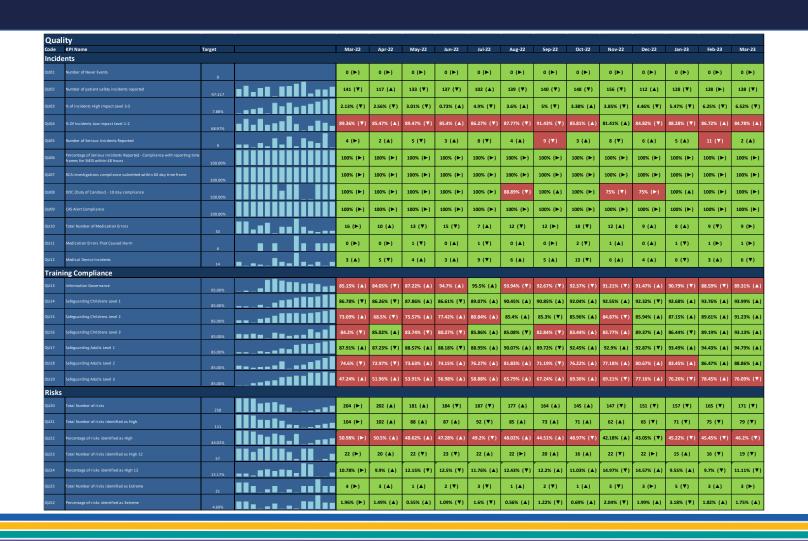
Quality

Actions:

Indicator	Action	Target date	Responsible Committee
Safeguarding Level 3 – Children's and Adults	• Staff to be supported to participate in training. • Additional sessions to be delivered as capacity permits • Education and Training team sharing regular lists of staff who are compliant and non compliant which is being reviewed at Directorate Level	• Children's Level 3 is now compliant Previous target was to have Adults Level 3 compliant by end of June 2022 **TARGET DATE EXTENDED TO 31st JULY 2023**	Associate Directors / Director of Nursing and Operational Managers

Quality: Exception Reporting

Trust Scorecard

Quality

Incidents

Code	KPI Name	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QU01	Number of Never Events	0	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU02	Number of patient safety incidents reported	97-217	141 (▼)	117 (▲)	133 (▼)	137 (▼)	102 (▲)	139 (▼)	140 (▼)	148 (▼)	156 (▼)	112 (▲)	128 (▼)	128 (►)	138 (▼)
QU03	% of incidents High impact Level 3-5	7.88%	2.13% (▼)	2.56% (▼)	3.01% (▼)	0.73% (▼)	4.9% (▲)	3.6% (▲)	5% (▼)	3.38% (▼)	3.85% (▼)	4.46% (▼)	5.47% (▼)	6.25% (▼)	6.52% (▼)
QU04	% Of Incidents Low impact Level 1-2	68.97%	89.36% (▼)	85.47% (▲)	89.47% (▼)	85.4% (▼)	86.27% (▼)	87.77% (▼)	91.43% (▼)	85.81% (▲)	81.41% (▼)	84.82% (▼)	88.28% (▼)	86.72% (▼)	84.78% (▲)
QU05	Number of Serious Incidents Reported	9	4 (►)	2 (▲)	5 (▼)	3 (▲)	8 (▼)	4 (▲)	9 (▼)	3 (▲)	8 (▼)	6 (▲)	5 (▼)	11 (▼)	2 (▲)
QU06	Percentage of Serious Incidents Reported - Compliance with reporting time frames for StEIS within 48 hours	100.00%	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU07	RCA investigations compliance submitted within 60 day time frame	100.00%	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU08	DOC (Duty of Candour) - 10 day compliance	100.00%	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	88.89% (▼)	100% (▲)	100% (►)	75% (▼)	75% (►)	100% (▲)	100% (►)	100% (►)
QU09	CAS Alert Compliance	100.00%	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU10	Total Number of Medication Errors	33	16 (►)	10 (▲)	13 (▼)	15 (▼)	7 (▲)	12 (▼)	12 (►)	18 (▼)	12 (▲)	9 (▲)	8 (▲)	9 (▼)	9 (►)
QU11	Medication Errors That Caused Harm	6	0 (►)	0 (►)	1 (▼)	0 (▲)	1 (▼)	0 (▲)	0 (►)	2 (▼)	1 (▲)	0 (▲)	1 (▼)	1 (►)	1 (►)
QU12	Medical Device Incidents	14	3 (▲)	5 (▼)	4 (▲)	3 (▲)	9 (▼)	6 (▲)	5 (▲)	13 (▼)	6 (▲)	4 (▲)	6 (▼)	3 (▲)	6 (▼)

Training Compliance

Code	KPI Name	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QU13	Information Governance	95.00%	85.15% (▲)	84.05% (▼)	87.22% (▲)	94.7% (▲)	95.5% (▲)	93.94% (▼)	92.67% (▼)	92.37% (▼)	91.21% (▼)	91.47% (▲)	90.79% (▼)	88.59% (▼)	89.31% (▲)
QU14	Safeguarding Childrens Level 1	85.00%	86.78% (▼)	86.26% (▼)	87.86% (▲)	86.61% (▼)	89.07% (▲)	90.45% (▲)	90.85% (▲)	92.04% (▲)	92.55% (▲)	92.32% (▼)	92.68% (▲)	93.76% (▲)	93.99% (▲)
QU15	Safeguarding Childrens Level 2	85.00%	73.09% (▼)	68.5% (▼)	75.57% (▲)	77.42% (▲)	80.84% (▲)	85.4% (▲)	85.3% (▼)	85.96% (▲)	84.87% (▼)	85.94% (▲)	87.15% (▲)	89.61% (▲)	91.23% (▲)
QU16	Safeguarding Childrens Level 3	85.00%	84.2% (▼)	85.02% (▲)	83.74% (▼)	80.27% (▼)	85.86% (▲)	85.08% (▼)	82.84% (▼)	83.44% (▲)	83.77% (▲)	89.37% (▲)	86.44% (▼)	89.19% (▲)	93.13% (▲)
QU17	Safeguarding Adults Level 1	85.00%	87.91% (▲)	87.23% (▼)	88.57% (▲)	88.18% (▼)	88.95% (▲)	90.07% (▲)	89.72% (▼)	92.45% (▲)	92.9% (▲)	92.87% (▲)	93.49% (▲)	94.43% (▲)	94.79% (▲)
QU18	Safeguarding Adults Level 2	85.00%	74.6% (▲)	72.97% (▼)	73.63% (▲)	74.15% (▲)	76.27% (▲)	81.83% (▲)	71.19% (▼)	76.22% (▲)	77.18% (▲)	80.67% (▲)	83.45% (▲)	86.47% (▲)	88.86% (▲)
QU19	Safeguarding Adults Level 3	85.00%	47.24% (▲)	51.96% (▲)	53.91% (▲)	56.98% (▲)	58.88% (▲)	65.79% (▲)	67.24% (▲)	69.36% (▲)	69.21% (▼)	77.16% (▼)	76.26% (▼)	78.45% (▲)	76.09% (▼)

Risks

Code	KPI Name	Target	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
QU20	Total Number of risks	258	204 (►)	202 (▲)	181 (▲)	184 (▼)	187 (▼)	177 (▲)	164 (▲)	145 (▲)	147 (▼)	151 (▲)	157 (▼)	165 (▼)	171 (▼)
QU21	Total Number of risks identified as High	111	104 (►)	102 (▲)	88 (▲)	87 (▲)	92 (▼)	85 (▲)	73 (▲)	71 (▲)	62 (▲)	65 (▼)	71 (▼)	75 (▼)	79 (▼)
QU22	Percentage of risks identified as High	44.02%	50.98% (►)	50.5% (▲)	48.62% (▲)	47.28% (▲)	49.2% (▼)	48.02% (▲)	44.51% (▲)	48.97% (▼)	42.18% (▲)	43.05% (▼)	45.22% (▼)	45.45% (▼)	46.2% (▼)
QU23	Total Number of risks identified as High 12	57	22 (►)	20 (▲)	22 (▼)	23 (▼)	22 (▲)	22 (►)	20 (▲)	16 (▲)	22 (▼)	22 (►)	15 (▲)	16 (▼)	19 (▼)
QU24	Percentage of risks identified as High 12	15.17%	10.78% (►)	9.9% (▲)	12.15% (▼)	12.5% (▼)	11.76% (▲)	12.43% (▼)	12.2% (▼)	11.03% (▲)	14.97% (▼)	14.57% (▲)	9.55% (▲)	9.7% (▼)	11.11% (▼)
QU25	Total Number of risks identified as Extreme	21	4 (►)	3 (▲)	1 (▲)	2 (▼)	3 (▼)	1 (▲)	2 (▼)	1 (▲)	3 (▼)	3 (►)	5 (▼)	3 (▲)	3 (►)
QU52	Percentage of risks identified as Extreme	4.69%	1.96% (►)	1.49% (▲)	0.55% (▲)	1.09% (▼)	1.6% (▼)	0.56% (▲)	1.22% (▼)	0.69% (▲)	2.04% (▼)	1.99% (▲)	3.18% (▼)	1.82% (▲)	1.75% (▼)

Quality: Exception Reporting

Trust Scorecard

Quality

Code	KPI Name	Target	Trend	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Falls (Bridgewater)																
QU26	Total Number of falls	23		18 (▼)	14 (▲)	15 (▼)	18 (▼)	9 (▲)	13 (▼)	13 (►)	18 (▼)	14 (▲)	14 (►)	20 (▼)	25 (▼)	21 (▲)
QU27	Total Number of falls identified as Catastrophic	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU28	Falls per 1,000 bed days - bed based	14		13.26 (▼)	11.45 (▲)	10.34 (▲)	16.29 (▼)	4.49 (▲)	9.42 (▼)	10.13 (▼)	14.61 (▼)	11.72 (▲)	11.39 (▲)	8.65 (▲)	11.63 (▼)	6.7 (▲)
QU29	Percentage of overall falls that are bed based	88.28%		77.78% (▼)	78.57% (▼)	73.33% (▲)	88.89% (▼)	44.44% (▲)	76.92% (▼)	76.92% (▼)	83.33% (▼)	85.71% (▼)	85.71% (►)	45% (▼)	44% (▲)	33.33% (▲)
QU30	Total Number of Community Falls	11		4 (▲)	3 (▲)	4 (▼)	2 (▲)	5 (▼)	3 (▲)	3 (►)	3 (►)	2 (▲)	2 (►)	11 (▼)	14 (▼)	14 (►)
QU31	Percentage of overall falls that are community falls	55.01%		22.22% (▲)	21.43% (▼)	26.67% (▼)	11.11% (▲)	55.56% (▼)	23.08% (▲)	23.08% (▲)	16.67% (▲)	14.29% (▲)	14.29% (►)	55% (▼)	56% (▼)	66.67% (▼)
Pressure Ulcers																
QU32	Total Number of Category 2 Pressure Ulcers acquired in Bridgewater	44		22 (▼)	18 (▲)	31 (▼)	14 (▲)	12 (▲)	30 (▼)	23 (▲)	14 (▲)	23 (▼)	19 (▲)	25 (▼)	23 (▲)	26 (▼)
QU33	Total Number of Category 3 Pressure Ulcers acquired in Bridgewater	5		2 (▼)	0 (▲)	0 (►)	0 (►)	2 (▼)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater	2		1 (▼)	0 (▲)	0 (►)	0 (►)	2 (▼)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU35	Total Number of Unstageable Pressure Ulcers acquired in Bridgewater	3		0 (►)	0 (►)	2 (▼)	2 (►)	3 (▼)	3 (►)	6 (▼)	4 (▲)	6 (▼)	5 (▲)	6 (▼)	5 (▲)	7 (▼)

Quality

Code	KPI Name	Target	Trend Line	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
Health Care Acquired Infections																
QU36	MRSA - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU37	C.Diff - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU38	Bacteraemia - Total Number of outbreaks	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
Harm Free Care																
QU40	VTE - Bed Based - % of patients risk assessed	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
Patient Experience																
QU41	Friends and Family Test	95.00%		98.96% (▲)	95.27% (▼)	99.03% (▲)	99.11% (▲)	99% (▼)	98.01% (▼)	98.97% (▲)	98.98% (▲)	98.06% (▼)	98.94% (▲)	99.03% (▲)	99.38% (▲)	98.97% (▼)
QU42	Number of Complaints	9		3 (▲)	4 (▼)	0 (▲)	5 (▼)	4 (▲)	5 (▼)	6 (▼)	6 (►)	6 (►)	2 (▲)	0 (▲)	6 (▼)	3 (▲)
QU44	Patient Experience - Dignity and Respect	95.00%		99.72% (▲)	98.97% (▼)	100% (▲)	100% (▲)	100% (►)	99.01% (▼)	100% (▲)	98.98% (▼)	98.97% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)
QU45	Patient Experience - Information / Communication	95.00%		98.58% (▲)	98.97% (▲)	99.03% (▲)	99.11% (▲)	99% (▼)	98.01% (▼)	98.97% (▼)	98.98% (▲)	98.97% (▼)	100% (▲)	100% (►)	100% (►)	98.97% (▼)
QU46	Patient Experience - Access/Waiting Time	95.00%		96.51% (▼)	97.94% (▲)	94.05% (▼)	93.96% (▼)	96% (▲)	95.03% (▼)	98.01% (▲)	97.03% (▼)	96% (▼)	95.98% (▼)	95.99% (▲)	96.02% (▲)	97.05% (▲)

People

Four out of five People indicators are shown as red in March 2023.

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

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

People

Actions

Indicator	Action	Target date	Responsible Committee

People

Trust Scorecard

People

Code	KPI Name	Target		Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23
PO01	count of new starters attending induction programme	95.00%		99.58% (▲)	99.26% (▼)	99.6% (▲)	99.54% (▼)	99.54% (▼)	99.4% (▼)	99.4% (▲)	99.47% (▲)	99.34% (▼)	99.74% (▲)	99.6% (▼)	99.8% (▲)	99.61% (▼)
PO02	rnover (rolling)	8.00%		27.69% (▼)	30.81% (▼)	31.35% (▼)	32.37% (▼)	32.62% (▼)	37.05% (▼)	33.57% (▲)	28.67% (▲)	28.47% (▲)	28.54% (▼)	27.91% (▲)	27.61% (▲)	13.25% (▲)
PO03	all Organisation Sickness rate (rolling)	4.80%		6.83% (▼)	6.01% (▲)	7.01% (▼)	7.02% (▼)	7.05% (▼)	6.99% (▲)	6.96% (▲)	6.88% (▲)	6.81% (▲)	6.75% (▲)	6.52% (▲)	6.41% (▲)	6.3% (▲)
PO04	s absence rate (Actual)	4.80%		6.98% (▼)	5.27% (▲)	7.02% (▼)	6.31% (▲)	7.16% (▼)	5.28% (▲)	5.77% (▼)	5.81% (▼)	6.1% (▼)	7.11% (▼)	6.19% (▲)	5.26% (▲)	5.5% (▼)
PO05	aff with a current PDR	85.00%		56.94% (▼)	56.35% (▼)	57% (▲)	58.96% (▲)	58.45% (▼)	63.59% (▲)	67.42% (▲)	63.71% (▼)	67.44% (▲)	66.09% (▼)	70.13% (▲)	72.57% (▲)	70.56% (▼)

Finance

Month Twelve Finance Report

Scope

1.1 The purpose of this paper is to update the Committee on the financial position of the Trust at the end of March 2023 (Month 12).
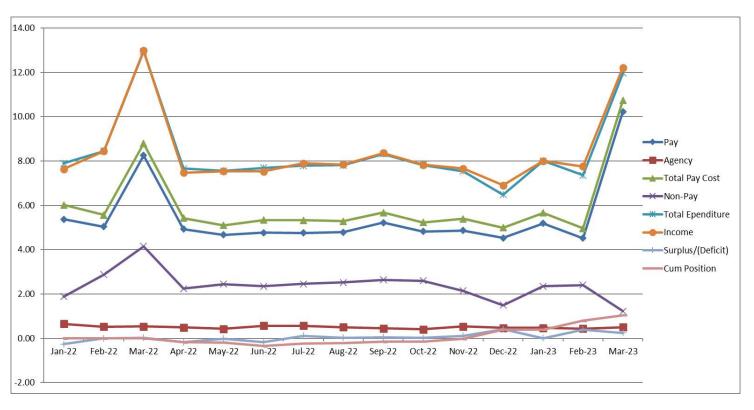
Summary Performance Month 12 2022-23	Month 12 Plan (£M)	Month 12 Actual (£M)	Month 12 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.47)	(12.21)	4.74	(89.96)	(97.00)	7.04	(89.96)	(97.00)
Expenditure - Pay	4.80	10.23	(5.43)	57.60	63.28	(5.68)	57.60	63.28
Expenditure - Agency	0.42	0.51	(0.09)	4.95	5.85	(0.90)	4.95	5.85
Expenditure - Non Pay	2.19	1.81	0.38	27.03	27.47	(0.43)	27.03	27.47
EBITDA	(0.06)	0.34	(0.41)	(0.37)	(0.41)	0.04	(0.37)	(0.41)
Financing	0.03	(0.04)	0.07	0.37	(0.11)	0.49	0.37	(0.11)
Normalised (Surplus)/Deficit	(0.03)	0.31	(0.34)	(0.00)	(0.52)	0.52	(0.00)	(0.52)
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)	0.31	(0.34)	(0.00)	(0.52)	0.52	(0.00)	(0.52)
Other Adjustments	0.00	(0.55)	0.55	0.00	(0.55)	0.55	0.00	(0.55)
Adjusted Net (Surplus)/Deficit	(0.03)	(0.24)	0.21	(0.00)	(1.07)	1.07	(0.00)	(1.07)
CIP	0.39	0.40	0.00	4.20	4.20	0.00	4.20	4.20
Capital	0.10	1.35	(1.25)	2.10	2.30	(0.20)	2.10	2.30
Cash	26.15	24.32	(1.83)	26.15	24.32	(1.83)	26.64	26.00
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

● Favourable Variance   ⚠ Adverse Variance

Finance

Key Headlines

Rolling Run Rates 2021/22 to 2022/23

Finance

CUMULATIVE PERFORMANCE AGAINST NHSE/I PLAN – £1m SURPLUS FOR THE YEAR.

The key headlines for month twelve are as follows:

- The Trust is reporting a final adjusted position surplus of £1.07m, ahead of the plan deficit of £0.03m.

- The Trust had a savings requirement of £4.20m (4.50%), split between £1.865m recurrent and £2.332m non recurrent largely driven by the requirement to reduce covid related spend.

- The Trust full year savings plan is £4.20m, which is reported as achieved.

- Income is £97.00m for the year - £7.04m above the plan, predominantly due to the additional funding for the pay award (including non consolidated) and notional pension income.

- Expenditure is £95.93m for the year – £5.97m above plan.

Finance

CUMULATIVE PERFORMANCE AGAINST NHSE/I PLAN – £1m SURPLUS FOR THE YEAR (continued)

- Pay is £63.28m for the year - £5.68m above plan due to the pay award and notional pension contributions.

- Agency spend of £5.85m for the year against a plan of £4.95m.

- Non pay expenditure is £27.47m for the year-to-date, against a plan of £27.03m.

- Capital charges are £0.49m below plan.

- Adjusted items (impairments & stock) are (£0.55m).

- Capital expenditure is £2.29m for the year, £0.19m above the original plan.

- Cash is £24.32m

Appendix

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

NHS Oversight Framework

File created on: 14/04/2023 12:30

Org Name Full	Aggregation Source	Indicator	Period Frequency	Period	Value	National Value	Target / Standard (not met if)	Change from previous period	3 period continuous change	Rank
	MH Provider	S035a: Overall CQC rating	Month	2023 02	- Requires Improvement					53/69
	MH Provider	S038a: Consistency of reporting patient safety incidents	Month	Apr 2022 - Sep 2022	100%		100%			1/71
	MH Provider	S059a: CQC well: led rating	Month	2023 02	- Requires Improvement					55/69
	MH Provider	S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	Annual; calendar year	2021	7.24/10					60/70
	MH Provider	S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	Annual; calendar year	2021	6.82%			↓		10/70
	MH Provider	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	Annual; calendar year	2021	13.9%			↑		31/70
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S063c: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from patients/service users, their relatives or other members of the public	Annual; calendar year	2021	20.8%			↑		12/70
	MH Provider	S067a: Leaver rate	Month	2022 12	10.1%	8.84%		↑		57/71
	MH Provider	S068a: Sickness absence rate	Month	2022 10	5.83%	5.69%		↑		37/71
	MH Provider	S069a: Staff survey engagement theme score	Annual; calendar year	2021	7.17/10			↓		27/70
	MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2021	7.41%		12%	↑		35/69
	MH Provider	S072a: Proportion of staff who agree that their organisation acts fairly with regard to career progression/promotion regardless of ethnic background, gender, religion, sexual orientation, disability or age	Annual; calendar year	2021	58.1%			↓		42/70
	MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2021	7.4/10					23/70
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2021	7.1/10					16/70

Org Type MHPRV

Rank Banding
- 🟩 Highest performing quartile
- 🟧 Interquartile range
- 🟥 Lowest performing quartile

Thank You

Committee Chair's Report

![NHS Bridgewater Community Healthcare NHS Foundation Trust]

Name of Committee/Group:	Quality and Safety Committee		Report to:	Board of Directors
Date of Meeting:	20 April 2023		Date of next meeting:	22 June 2023
Chair:	Gail Briers		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Gail Briers, Non-Executive Director and Committee Chair Abdul Siddique, Non-Executive Director Martyn Taylor, Non-Executive Director Ted Adams, Medical Director Sarah Brennan, Chief Operating Officer	**In attendance:** Jeanette Hogan, Deputy Chief Nurse (left the meeting between items 25/23 and 29/23) Susan Burton, Deputy Chief Nurse Sue Mackie, Director of Quality Governance Tania Strong, Head of HR Mark Charman, Assistant Director of Transformation Alan Lee, Head of Risk Management (to item 26/23) Rachel Hall, Head of Research (for items 36/23 to item 38/23iii) Suzanne Taylor, Clinical Audit Facilitator (for items 36/23 to item 38/23iii) Jan McCartney, Trust Secretary **Observers**: Christine Stankus, Public Governor, Rest of England	**Key Members not present**:	**Apologies received from:** Lynne Carter, Chief Nurse Elaine Inglesby, Non-Executive Director

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Deep Dive – Patient Safety Incident Response Framework (PSIRF)	2, 3	🟩	The Committee received a detailed report from the Head of Risk Management concerning the transfer from the NHS England Serious Incidents Framework to the new Patient Safety Incident Response Framework (PSIRF) and the changes and opportunities that the new system would bring as well as challenges. The new system would include compassionate engagement and involvement with those affected by patient safety incidents, the application of a range of system-based	The Committee welcomed the approach of PSIRF and supported a faster move forward with the implementation of this if it could be done safely with additional resources. The

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Committee Chair's Report

			approaches to learning from patient safety incidents, considered and proportionate responses to patient safety incidents and supportive oversight focused on strengthening response system functioning and improvement in standards of patient safety.

NHS England had produced a guide for organisations to follow in preparation for PSIRF. The Trust had been able to secure some project support both internally from the transformation team with part time support for the project management elements of PSIRF. The Trust had also been working with colleagues at the ICB and Warrington and Halton Hospitals concerning the system approach. Elements of the next phase of implementation were already in place. The Trust already has a well embedded process for the transparent reporting and management of incidents with training provisions around this in the organisation and it would be ensured by the risk team that all of those elements were in line with the ethos of PSIRF. It was highlighted that the NHS England guidance stated that organisations would be expected to transition to PSIRF within 12 months of publication of the document, meaning that the Trust would need to aim for a timescale of January 2024. A discussion took place concerning the potential for an accelerated implementation at an earlier point in time, recognising the benefits that PSIRF would bring in terms of freeing up clinical capacity with wider benefits and operational delivery of services and moving away from the existing system, balanced with capacity challenges in implementing the new system. Whilst some phases of implementation may take less time than expected this would not be clear until more detailed work had commenced.

The Committee considered the continuing use of the Ulysses system alongside the implementation of PSIRF. It was noted that should the Trust move away from Ulysses it would take some time for a procurement exercise to take place to secure a replacement system, around six to nine months. As an interim solution, Ulysses would be retained as it was considered that an alternative was not possible. It was acknowledged that there may be a requirement for the Committee to review information in more detail concerning any related risks. | Committee acknowledged a potential impact for the organisation as a learning organisation and reputationally should it be unable to meet the recommended implementation deadline, noting there was some flexibility.

The PSIRF project plan would be appended to each serious incident report going forwards to keep the Committee sighted on progress with implementation. |

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Committee Chair's Report

Serious Incidents Compliance Report	2, 3		During February and March 2023 there had been a total of 12 serious incidents reported. Two were in relation to category three pressure ulcers, one category four and seven unstageable pressure ulcers. There had also been one treatment delay relating to the Urgent Treatment Centre and one diagnostic incident related to audiology. She advised that there were 14 open incidents that were being investigated: nine for Warrington and five for Halton with none currently for Dental services. All incidents were continuing to be reported into the StIES system within 48 working hours. The Director of Quality Governance reported that there had been nine investigations completed during the period and the reports had been submitted to the ICB. All reports had continued to be submitted within the required timescales. Action plan meetings were also continuing to take place reviewing evidence against actions for serious incidents to gain assurance that learning was in place and any relevant changes in practice were being made.	The Committee noted the contents of the report and was assured that the systems and processes in place continued to effectively manage serious incidents reported within the Trust.
Summary Report for Risks Relating to Quality and Safety	2, 3		The Committee received a report which provided an overview of the corporate risks scoring 12 or above as reported through to the Risk Management Council in March 2023. The number of risks scoring 12 plus had reduced by one to 18, a reduction of one from January. There had been two new risks reported and three risks had passed the review dates but the reviews had taken place following the meeting. There had been 14 risks with a scoring of 12, two risks scoring 15 in relation to dermatology and capacity in the risk team and two risks scoring 16 in relation to dermatology and data security. The top risks within the organisation were in relation to demand and capacity within the risk team, dermatology, community neurology, palliative care and district nursing services.	It was noted that information had been presented to the Committee on a bi-monthly basis within the risk report and that reports going forwards must include information for each month to ensure that the necessary information was provided concerning any changes in the number of risks, either new or reducing risks.

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			Two new risks had been reported in the period: one in relation to the children's safeguarding team concerning demand and number of referrals which meant that work may not be completed in a timely way and result in delays to the screenings and: some governance issues in relation to the intermediate care services in Warrington where some processes had not been formalised for example via standard operating procedures. This was currently being looked at within the service. Concerning risk reduction, monitoring was in place to measure progress with target risks towards the target risk score. As at the end of March, there were 12 risks that had not reached their target risk date. There were four risks where the risk target dates had passed and were being reviewed and two risks with no target date identified. A target risk date would be assigned prior to the next Risk Management Council meeting. No risks were closed in the reporting period and all risks identified were considered to have either significant or moderate assurance.	The Committee were made aware that a risk in relation to Warrington District Nursing had been escalated to a scoring of 15 in relation to demand and capacity pressures. A number of immediate actions were in place following a recent quality summit. It was proposed that a deep dive be scheduled into district nursing risks. Reference was made to risks related to outdated policies The Committee requested a position statement on this to the next meeting which must include any impact of policies being out of date. The Committee received the report and was assured that the risks scoring 12 plus in relation to quality and safety were being effectively managed.
Patient Experience Report – Quarter Three	2,3		During the quarter there was approximately 8,000 people who had provided feedback on Trust services which was an increase from just over 7,000 in quarter two. From the friends and family test, there had been 95.7% of feedback describing patient experience as good or very good. There had been a 95% overall satisfaction rate, although there had	The Committee received the report and agreed that this was providing the requisite level of information.

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			been a small number of negative responses received from patients within the Halton borough concerning waiting times which reduced the overall scores. In terms of complaints, the Trust had received 2,000 in quarter three which was a reduction from just over 3,000 in quarter two. Work was ongoing in relation to the carer's plan to look at how the Trust could better support carers within the organisation. Work to capture information in relation to carers was now progressing following delays due to capacity, and it was hoped that this information would soon be available. Work was also continuing on lived experience across the Trust with a number of teams exploring different options to establish lived experience panels. There were already a number of those in place including the voice of the child forum. Within quarter three there had been 211 PALS contacts. There were 13 informal concerns raised which were all resolved without progressing to a formal complaint. There were 15 formal complaints, which was unchanged from quarter two. Six of those related to Halton borough and seven to Warrington. Four MP letters were received. The report also included some information on improvement initiatives that had taken place over the previous 12 months concerning services where complaints had been received and some examples of lessons learned over the quarter.	
IQPR – month 11	2, 3, 6		The Chief Operating Officer presented the report and highlighted that there were a number of new red rated indicators in month. She particularly noted the number of serious incidents reported which had increased to 10. An investigation had been conducted to look at why this had happened and this related to pressure ulcers: there had been some delays in the classification of pressure ulcers from the previous month (January). This then moved into February reporting and therefore the figure appeared higher. She explained that two of the incidents had been stepped down from being a serious incident and therefore the numbers	The Committee accepted the report as assurance that the quality indicators were being appropriately monitored.

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		█	had been overreported and the true figure was eight serious incidents in that month. She highlighted a new red rated indicator related to falls. The number of falls had increased from 20 in January to 25 in February and this was due to the increase in the number of falls in the community and the increased acuity of patients being managed in their own homes.	
Report from the Quality Council	2, 3	█	The Committee received the report setting out the key considerations from the Quality Council meeting held in March 2023: The quarter three research and audit report had been presented and demonstrated some delays in receiving updates on 2022/23 audit progression. Since this time all of the updates had now been received and there was good progression. The draft clinical audit plan for 2023/24 had also been presented. For Warrington and Halton there had been good progress around the record keeping audit, with a small number of small teams experiencing challenges in achieving compliance. A risk of note for Halton was highlighted concerning the continued lack of antenatal referrals into the 0-19 service which was impacting the services ability to offer and deliver against the health child programme. This had been escalated to the acute trust and the ICB. The Quality Council had requested an audit of the referrals received which would help to capture the impact around this. The Warrington report referenced capacity challenges across district nursing, community paediatric services, paediatric physiotherapy and neuro rehabilitation. All of those services had action plans in place to help build capacity and resilience. There had been a quality summit held in mid-April to focus on the district nursing service across both Warrington and Halton. The meeting had received the quarter three safeguarding report. Feedback had been provided from the ICB on the Halton report which had included a recognition of a reduced assurance around the children in care element of the service. This was in relation to the initial health assessment and compliance which was included on the risk register. The	The Committee received the report and accepted the update from the Quality Council.

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ICB acknowledged that many of the issues creating the problem were not within the control of the Trust. A regional meeting was planned to explore some of the issues around where children were placed out of borough. The children's safeguarding team had also been involved in two multi agency rapid reviews in respect of two child deaths and one highlighted the tenacity of a school nurse involved in one of the cases. The outcome of the second case was still awaited.

The highlights from the CQUIN report demonstrated some challenges with a CQUIN for district nursing particularly in Warrington. Work was ongoing to make improvements around this and achieve compliance.

A review had been undertaken concerning the lack of use of lone worker devices. Some of the feedback from staff had included the devices being too cumbersome and that some of the device alarms would accidentally be triggered. It was considered that some of the feedback could be historic with some of the devices having a negative reputation with staff. A trial had taken place of a new device in Halton borough since the Quality Council had met and the feedback was awaited, however anecdotal feedback had been positive. Once the feedback had been received a decision would then be made as to which device would be rolled out. An ongoing audit would be undertaken to ensure that there was assurance that the devices were being used. The risk around lone workers and the processes that staff use to support themselves were also under review from a risk register point of view. It was confirmed that that the audit being undertaken regarding the use of the devices would be against the policy in place and the actions that staff should be taking.

From the waiting list, validation and clinical harms report, it was noted that there had been a significant increase in the number of waiters that required validation. Up to 179 children had been identified on a waiting list for MDT in the Halton Child Development Centre. Work was ongoing around this with some of the cases requiring additional information from schools or parents prior to being able to be dealt with by MDT.

A report was received by the Quality Council from the medical device and procurement group with an escalation concerning the ordering of non-

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			approved devices. This had been shared with teams and the Director of Nursing for Warrington would be working with the Medical Device Safety Officer to resolve this issue. Learning was also raised and shared through the quality newsletter concerning the inappropriate use of a defibrillator.	
Paediatric Audiology Incident Update (item delegated to the Committee from the Board)	2, 3		The Committee received a report concerning the actions in place to manage and treat patients via the Trust's part of the joint paediatric audiology pathway in Warrington. There had been no pause to the delivery of the Trust's service, however it would be necessary to undertake a quality assurance assessment of the service to ensure that testing undertaken had been done in the right way. Work would be undertaken on this during May 2023 with a report produced to outline any concerns. Work would be undertaken to identify whether there had been any harms caused by any of the ABR testing, management of those patients or actions that the Trust had taken as a result. This would be completed as soon as possible. The level of harm would then be assessed, and the appropriate actions taken in relation to duty of candour. The incident had been included on the risk register however it was suggested that the scoring should be reviewed in terms of potential impact on patients, staff and any reputational damage and to reflect the actions that were in place. The Trust had also discussed the matter with the CQC.	**It was agreed that the Committee would seek the advice of the Board as to whether the Committee was required to undertake ongoing monitoring of this matter from a quality and safety perspective.** If it was not necessary for the Committee to receive a specific report going forwards, updates could also be provided via the risk report and the chair's report from the Quality Council.
Update on the Quality Accounts 2022/23	2,3		The submission date for the report to NHS England remained as 30 June. A number of sections were still outstanding which were being followed up and all sections would be thoroughly proof read before inclusion in the main report. The ICB presentation day would be 18 May with a draft of the report to be sent to the ICB one week prior. A draft copy of the report would be provided to Committee members around the beginning of May 2023 for review and virtual approval prior to the ICB	The Committee noted the update and would receive the final version of the report to its meeting in June 2023.

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Committee Chair's Report

			receiving the final version, which would then be provided to the Committee in June.	
Dermatology Update Report	2, 3		The Committee noted that the overall current position with the service was positive with a dermatology consultant in place to offer support on leadership for a day per week initially for three months. A cancer nurse specialist role had also been advertised. Whilst there were some remaining challenges, weekly meetings were taking place to discuss issues and the overall risk had been reduced from a score of 16 to 12. Positive indications of improvements across the service following the rapid improvement event were evident with the aim of continuing to maintain the service to its current standards of delivery.	The Committee noted the positive progress reported and was assured that the service was effectively managing current risks and making progress in the key areas which had been identified. It was recognised that there were still a number of risks within the service which were expected to reduce. The Committee would receive a further report and update in June 2023 which would include any changes in the risks and incidents.
CQC Update Report	2, 3		The Committee noted that there had been no notifications received from the CQC of their intention to undertake any reviews of the organisation. However work was being undertaken to review the Trust's approach and embedding of quality and all CQC domains and requirements.	The Committee noted the current position and would be kept updated.
Trust Improvement Plan Update	2, 3		The Assistant Director of Transformation reported that there were 10 service improvement plans currently on the programme with no new plans added within the current reporting cycle. One plan was completed; the MIAA quality spot checks re-audit. The Quality Council had approved that this plan could be removed from the programme as it was accepted as complete by the Council and the MIAA. Four plans were BOOST plans which were still in development. Four plans had demonstrated positive progress which related to North West Driveability, Community Equipment Stores, Carer's Strategy and insulin aggregated review. One plan, in relation to the dermatology service, was showing limited progress.	The Committee asked that appropriate narrative be included within the report where there were red rated actions to explain the reasons behind this.

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		■		The Committee received the report and was assured that the trust improvement plan was being reviewed on a monthly basis with progress on individual action plans being routinely monitored and exceptions being reported to the Quality Council.
Clinical Audit Plan		■	The Clinical Audit Facilitator presented the plan to the Committee to provide assurance concerning the process for developing and approving the 2023/24 document. She advised that this was refreshed on an annual basis and that the plan for the current year was based on priorities that had been agreed by the Directors of Nursing, Medical Director, and Dental Network. It also included re-audits of audits conducted in 2022/23 as well as any clinical interest audits, noting that all clinicians were encouraged to take part in quality improvement projects. She confirmed that the clinical audit plan was agreed at the Quality Council on 22 March 2023.	A discussion took place concerning the correct process for the monitoring of the plan which will be presented to the June Committee.
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.	
Risk Management Framework Update	2, 3	■	The Director of Quality Governance presented an overview of the framework which was first approved by the Board in 2018 and reviewed in February 2022. This detailed the Trust's arrangements for identifying and managing risks at all levels of the organisation.	The Committee received the framework and took assurance that the risk management framework was embedded within the Trust.
Research Strategy 2023-26	1	■	The Head of Research presented the final version of the research strategy which was supported by the Committee. It was also suggested that a presentation may be beneficial for the Trust's Council of Governors	The Head of Research and the Medical Director agreed to

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			concerning the amount of research undertaken by the organisation. It was noted that there had been considerable work undertaken on research by the Trust both within the organisation and externally.	review a paragraph within the document related to delivering and measuring against the Trust's overall strategy.
Infection, Prevention and Control	1		The Committee noted that this item was deferred to June 2023	
Board Assurance Framework (BAF)	2,3,6		It was agreed that following a recent thorough review, the BAF was up to date currently in terms of BAF2, 3 and quality and safety aspects of BAF6 and there were no changes to be made to the scorings. It was noted that there may be further changes to be made to the Board Assurance Framework following a dedicated Board session around risks with MIAA in May 2023.	**Paediatric audiology would need to be added to the gaps in control. The risk around district nursing would also need to be reflected on BAF2 and BAF3.**
Items for Deep Dive	1, 2, 3, 6		The Committee discussed Deep Dive subjects for upcoming meetings. A deep dive would be scheduled for the Professional Nurse Advocates and quality and safety aspects of the new CQC regime.	It was agreed that following earlier discussions, the Committee would receive a deep dive concerning district nursing risks in June 2023.
Items to be shared with the Board or other Committees	1		There were no other items to be shared or escalated.	
Risks Escalated: None from this meeting				

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BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	01/06/23
Agenda Item	39/23(i)		
Report Title	FINANCE REPORT – MONTH 1		
Executive Lead	Nick Gallagher – Executive Director of Finance		
Report Author	Rachel Hurst – Deputy Director of Finance		
Presented by	Nick Gallagher – Executive Director of Finance		
Action Required	☐ To Approve	☒ To Assure	☐ To Note

Executive Summary

To brief the Board on financial performance for month one:

- The Trust is reporting a deficit of £0.25m, against a plan position of breakeven.
- The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.
- The Trust in-month savings plan is £0.43m. Due to the early reporting of month one and the ongoing process of scheme identification, detailed performance against this plan will be reported in month two.
- Income is £7.75m for the month - £0.09m below the plan.
- Expenditure is £8.00m for the month – £0.15m above plan.
- Pay is £5.02m for the month - £0.18m below plan due to vacancies and the inclusion of 2% pay award in the plan that is yet to be paid.
- Agency spend of £0.38m for the month against a plan of £0.35m.
- Non pay expenditure is £2.69m for the month, against a plan of £2.25m.
- Capital charges are £0.13m below plan.
- Capital expenditure is £0m for the month, as per the plan.
- Cash is £26.03m.

Previously considered by:

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

Strategic Objectives

☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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**	**01 June 2023**
Agenda Item	**39/23(i)**		
Report Title	**FINANCE REPORT MONTH 1**		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial position as at Month One		

1. SCOPE

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

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

2. FINANCIAL POSITION AS AT MONTH ONE

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

Table 1 – Summary of financial performance

Summary Performance Month 01 2023-24	Month 1 Plan (£M)	Month 1 Actual (£M)	Month 1 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(7.84)	(7.75)	🔺 (0.09)	(7.84)	(7.75)	🔺 (0.09)	(94.17)	(94.17)
Expenditure - Pay	5.19	5.02	🟢 0.18	5.19	5.02	🟢 0.18	62.30	62.30
Expenditure - Agency	0.35	0.38	🔺 (0.03)	0.35	0.38	🔺 (0.03)	4.22	4.22
Expenditure - Non Pay	2.25	2.69	🔺 (0.43)	2.25	2.69	🔺 (0.43)	27.10	27.10
EBITDA	(0.04)	0.33	🔺 (0.38)	(0.04)	0.33	🔺 (0.38)	(0.55)	(0.55)
Financing	0.05	(0.09)	🟢 0.13	0.05	(0.09)	🟢 0.13	0.55	0.55
Normalised (Surplus)/Deficit	0.00	0.25	🔺 (0.25)	0.00	0.25	🔺 (0.25)	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	0.00	0.25	🔺 (0.25)	0.00	0.25	🔺 (0.25)	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	0.00	0.25	🔺 (0.25)	0.00	0.25	🔺 (0.25)	0.00	0.00
CIP	0.43	0.00	🔺 (0.43)	0.43	0.00	🔺 (0.43)	5.15	5.15
Capital	0.00	0.00	🟢 0.00	0.00	0.00	🟢 0.00	2.10	2.10
Cash	26.17	26.03	🔺 (0.14)	26.17	26.03	🔺 (0.14)	24.65	26.00
Use of Resources Metric	N/A	N/A		N/A	N/A		N/A	N/A

🟢 Favourable Variance   🔺 Adverse Variance
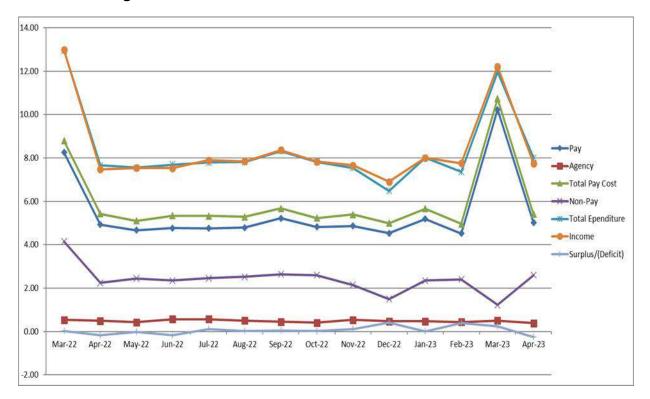
Table 2 - Rolling Run Rates 2022/23 to 2023/24

2.2 The Trust is reporting a deficit of £0.25 at month one (plan breakeven).

Income

- Income was adverse to plan by £0.09m in month one.

Pay

- Pay costs are below plan by £0.18m in month one primarily due to vacancies and the inclusion of 2% pay award in the plan that is yet to be paid.

Agency

- Although month on month agency expenditure continues to decrease, month one expenditure of £0.38m is above planned expenditure of £0.35m. £0.03m of the cumulative expenditure is COVID related.

The three services with the highest agency spend are:

- Dermatology – locum consultants.
- Halton District Nursing – high cost off framework agency use.
- Intermediate Care Bed Based (Padgate House) – high cost off framework agency use.

- Agency costs incurred in month one equated to 55.59 whole time equivalent staff.

- An Executive led workplan is being produced for 2023/24.

Non Pay

- During month one the Trust has spent £2.69m on non pay, £0.43m above plan.

The overspend on non pay is largely due to:

- Increasing spend on drugs (biologics).
- Continence products and equipment linked to increasing discharges.
- A rise in the acuity of those patients being discharged.

These overspends will be offset by income.

Financing Costs

- Additional interest received and an improved statement of financial position have contributed to reduced financing costs and a £0.13m variance favourable to plan.

2.3   Adjusting for year-end national accounting adjustments, all month one 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.

3.2   Some of this increase is driven by the 83% reduction in Covid funding for 2023/24.

3.3   This results in total savings for 2023/24 of £5.147m (5.2%) in line with ICB instruction.

3.4   The Trust plan for month one is £0.43m. Due to the early reporting of month one and the ongoing process of scheme identification, detailed performance against this plan will be reported in month two.

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.

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

5.1   Total capital expenditure as at 30th April was £0.01m against a plan of £nil.

5.2 Bids for 2023/24 capital have been received and the capital programme is currently oversubscribed by £1.32m. Scheme leads have been asked to complete a capital prioritisation template for discussion and at the next Capital Council meeting. Progress will be reported at the next meeting.

5.3 In April 2023 there was a net cash inflow of £1.71m with a closing cash balance of £26.03m.

5.4 Total debt as at 30th April is £9.10m excluding bad debt and credit note provisions, of which £4.32m relates to invoiced debt. Overall debt has decreased by £0.81m from March, overdue debt has increased by £0.64m.

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

	Target to be paid %	No of Invoices %	Value of Invoices %
Apr-23	95	99.7	99.9
Year to date performance	95	99.7	99.9

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

6. RECOMMENDATIONS

6.1 The Board is asked to:

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

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	Audit Committee		Report to:	Board of Directors
Date of Meeting:	27 April 2023		Date of next meeting:	18 May 2023 Specifically for review of final accounts, Annual Report and AGS Next full meeting 6 July 2023
Chair:	Linda Chivers, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers, Committee Chair Gail Briers, Non-Executive Director Abdul Siddique, Non-Executive Director Martyn Taylor, Non-Executive Director Tina Wilkins, Non-Executive Director	**In Attendance & Observers:** Sarah Brennan, Chief Operating Officer Susan Burton, Acting Deputy Chief Nurse Rachel Hurst, Deputy Director of Finance Eugene Lavan, Deputy Chief Operating Officer Samantha Scholes, Head of Corporate Governance Louise Thornton, Senior Financial Accountant Debbie Weir, Financial Controller Gary Baines, MIAA Audit Engagement Manager Adrian Poll, Senior Audit Manager, MIAA Phillip Leong, Anti-Fraud Specialist, MIAA James Boyle, Director, Public Sector Audit, KPMG **Observers** Bill Harrison, Governor Andrew Mortimer, Governor	**Key Members not present:**	**Apologies received from:** Dame Elaine Inglesby, Non-Executive Director Lynne Carter, Chief Nurse / Deputy Chief Executive Nick Gallagher, Director of Finance Jan McCartney, Trust Secretary John Blewett, Audit Manager, KPMG

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

Committee Chair's Report

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
e- Governance FTSU Policy	1		Feedback was provided by Audit Committee members to the proposed revised policy. This has now been considered and the policy will go through HR Policy Group for ratification of the amends and then back to Audit Committee for final approval.	Assurance received that although the revisions to the policy are delayed the Trust still has an effective FTSU policy in operation
Review of Committee Business Cycle	1		The Committee considered 2 written proposed changes along with a verbal update on the proposed inclusion of 2 compliance reports on the Clinical Audit programme, recently approved by Quality and Safety Committee. The changes were approved.	Assurance received.
Annual Audit Committee Report	1		The Committee considered the Annual report which gave an overview of the work of the committee during 2022/23 and were assured that the committee had met the requirements of its Terms of Reference. The content of the report will be included in the Annual Governance Statement. It was requested that the Corporate Governance team remind all attendees for all committees that if the Terms of Reference dictate that deputies should be nominated to attend in their absence this must be adhered to.	Assurance received.
Annual Reports from Board Committees	1		The Committee considered reports from each of the 4 Board Committees, Finance and Performance, Quality and Safety, People and Nominations and Remuneration which gave an overview of the work of each committee during 2022/23 and received assurance through each of	Assurance received

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			those committees that members were confident the Committees had fulfilled their Terms of Reference. The content of the reports will inform the Annual Governance Statement	
Review of BAF and Corporate Risk Register systems and processes	1		In addition to a review of BAF 1 the Committee sought and received assurance that the systems and processes of Risk Management were operating effectively across the Trust. It was agreed that these were working well and it was evident the BAF was a live document discussed at each of the Board Committees. It was noted that in the year 4 of the 8 BAFs had achieved their target risk score. For the remaining 4 it was accepted that the rational for current risk scores which were higher than target reflected the challenges and issues currently being faced by both the Trust and the NHS in general In relation to BAF1 one minor amend was made but there was no proposed change to the current risk score. In considering the assurance paper covering the Corporate Risk Register processes it was agreed that the paper now provided greater assurance. It was also noted that the recent MIAA audit on Risk Management had returned a High Assurance level which is an excellent result and the committee asked that all those involved in the Risk Management systems be congratulated.	Assurance received
Registers of Interests	1, 4		The Committee received updates on the annual declarations of interest from Directors, Governors and decision-making staff and agreed the registers could be published.	Assurance received that 100% compliance should be achieved but util this achieved on moderate assurance can be given

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NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

		🟧	It was noted that the move to completion of declarations for most staff using MS forms appeared to have increased submissions and eased the administration of the process. There remain a number of declarations outstanding and these are being followed up by the Corporate Governance team. The most significant area for non-declaration was Senior Dental Staff It was agreed that efforts to compile a schedule of declarations relating to Provider Collaborative would be made.	
Review of Losses, Special Payments and Waivers	1,4	🟩	Proposed bad debt write offs totalling £1210.70 were noted and assurance received that all possible recovery options had been exhausted. It was noted there had been 1 Special Payment of £6,365 in the quarter. The Committee were assured that due process had been followed for all 11 waivers, which were documented.	Assurance received
Review of Annual Accounts Progress	1,4	🟩	The Committee received an update on the submission of the draft accounts in line with the deadline of 27 April 2023	Assurance received
Review of Accounting Policies	1,4	🟩	The Committee approved a number of changes to the Trust's accounting policies for the 2022/23 financial year. Changes included: • Reference to Monitor replaced by NHS England • Update to Revenue from NHS contracts to reflect the financial framework in 2022/23 • Lease accounting policy rewritten to reflect the requirements of IFRS16 • Inclusion of a new policy on the initial application of IFRS16 • Updating provision rates to be used for 2022/23	Assurance received

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			KPMG confirmed that these follow the Group Accounting Manual but all policies will be reviewed as part of the final year end audit	
Review of Standing Financial Instructions (SFIs)	1,4		The Committee approved the recommended changes as a result of the annual review of the SFIs following detailed review across the Trust and scrutiny of the proposed changes by Committee members.	Assurance received
Review of the Scheme of Reservations and Delegations (SORD)	1,4		The Committee approved the recommended changes to the SORD following the annual review. Changes reflected updating of Job Titles, updating the Terms of reference for the Finance and Performance, Quality and Safety and People Committees.	Assurance received
IR35 Update	1,4		The Committee received a verbal update which closed down an outstanding action and gave assurance that the Trust's systems and processes in relation to IR35 were compliant with current legislation.	Assurance received
Mersey Internal Audit Internal Audit Plan 2023/2024	1		The Committee considered and approved the proposed final Internal audit Plan for 2023/2024. It was noted the proposed fee increase was a net 1.8% taking the Internal Audit Fee to £71,190 for the year which covers 210 days work. Thanks were given to MIAA for participating in the recent Governor Development session although it was noted attendance from Governors was very low.	Assurance received
Mersey Internal Audit Agency Progress Report	1,2,4 ,5,8		The Committee received assurance that the Internal Audit Programme was progressing to plan and had enabled a draft Head of Internal Audit Opinion to be provided at year end.	Assurance received The Assurance levels will be added to the appropriate BAFs

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			The Committee noted the completion of the following reviews since its last meetings and were delighted to note the levels of Assurance provided: • Cyber Security – Moderate Assurance • Mandatory Training and Appraisals – Moderate Assurance • Waiting List Management – Substantial Assurance • Safeguarding – Substantial Assurance • Payroll – Substantial Assurance • Key Financial Controls – High/Substantial Assurance • Risk Management – High Assurance Board Committees will be asked to monitor the implementation of agreed recommendations.	
MIAA Draft Head of Internal Audit Opinion	1		The Committee were pleased to note that the anticipated opinion is that of Substantial Assurance. MIAA confirmed this is not expected to change by the final submission date of 30 June 2023. MIAA also confirmed that the Trust was well placed against its peer group with what it termed as a robust Substantial Assurance Opinion.	Assurance Received.
MIAA Internal Audit Charter	1		The Committee approved the submitted Internal Audit Charter which is an annual requirement.	Assurance received
MIAA Anti-Fraud Plan 2023/2024	1,4		The Committee approved the final plan for 2023/2024. The fee for 2023/24 will increase by a proposed net 1.8% taking it to £30,510.	Assurance received

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Committee Chair's Report

MIAA Anti-Fraud Progress report	1,4		The Committee received the regular progress report. It was noted that as always this was a comprehensive report on the work undertaken.	Assurance received
MIAA Anti-Fraud Annual Report	1,4		The Committee received the annual anti-Fraud report for 2022/23 noting the Trust's compliance with the Functional Standards return.	Assurance received
External Audit progress report	1,4		Confirmation was received from KPMG that the year-end audit would commence week commencing 3 May and that they expected to meet the submission deadline date of 30 June.	Assurance received
External Audit Plan 2022/23	1,4		The Committee noted the final plan for the year-end audit which included the Value for Money Risk Assessment. A number of risks have been identified with none identified as significant. As a result of the introduction of IFRS16 Leases and the scale of the Trust's lease commitments there is an increased risk which will require additional testing along with increased testing on Payables, Accruals and Provisions as a result of a number of Prior Year recommendations made in 2021/22. The Committee were advised that this year the Trust has been selected as part of the segment of sampled components which means additional work may be required by KMPG as part of the Audit. This may result in an increase to the fee.	Assurance received
Review of the meeting	1		There was general agreement the meeting had been robust with a lot of ground covered.	
Risks Escalated: None from the meeting				
Members of the Audit Committee held a private meeting with KPMG after the meeting. There were no points raised that the Board need to be made aware of				

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Committee Chair's Report

Name of Committee/Group:	Audit Committee			Report to:	Board of Directors
Date of Meeting:	18 May 2023			Date of next meeting:	28 June 2023 Specifically for review of final accounts, Annual Report and AGS Next full meeting 6 July 2023
Chair:	Linda Chivers, Non-Executive Director			Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers, Committee Chair Gail Briers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director Abdul Siddique, Non-Executive Director Martyn Taylor, Non-Executive Director Tina Wilkins, Non-Executive Director	**In Attendance & Observers:** Sarah Brennan, Chief Operating Officer Susan Burton, Acting Deputy Chief Nurse Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance Jan McCartney, Trust Secretary Colin Scales, Chief Executive Officer Samantha Scholes, Head of Corporate Governance Louise Thornton, Senior Financial Accountant Debbie Weir, Financial Controller James Boyle, Director, Public Sector Audit, KPMG **Observers** Bill Harrison, Governor Andrew Mortimer, Governor	**Key Members not present:**		**Apologies received from:** Lynne Carter, Chief Nurse / Deputy Chief Executive Andrew Mortimer, Governor Observer Colleagues from MIAA were not required to attend this meeting given the Agenda items

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

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Committee Chair's Report

Review of Annual Accounts Progress	1,4		The Committee received an update on the progress being made on the External Audit which was into week 3. It was noted that the External Audit Team's attendance on site at times was significantly improving the effectiveness of the Audit. It was also noted that due to the increased scrutiny required of the Trust's application of IFRS16 there was additional evidence to be provided for testing.	Assurance received
2022/2023 Impairment Review of Property, Plant and Equipment	1,4		The Committee noted the standard report, which had also been considered at the Finance and Performance Committee. There were no untoward matters which required bringing to the attention of the Board. The key messages were: • The review has identified impairments totalling £0.08m and changes in useful economic lives for a number of assets owned. • The review has also identified 103 assets which are fully depreciated assets as at 31 March 2023 and need to be written off the fixed asset register. The assets have a total value of £2.768m for cost and accumulated depreciation (£nil net impact overall). • The Trust engaged District Valuation Services again this year to conduct a desktop valuation of the Trust's owned estate. The valuation identified a net increase in value of £0.040m. • Following the implementation of IFRS16, the Trust also requested the District Valuation Services to perform a revaluation of two Right of Use Assets; Warrington Wolves and Fleet House. The valuation identified an impairment of £0.398m.	Assurance received

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

Committee Chair's Report

Going Concern Assessment	1,4		The Committee received the recommendation that the Committee support the assessment that the Trust was operating on a "Going Concern" basis in relation to the preparation of the statutory accounts.	Assurance received
			This assessment had been made on the basis that:	Board to approve the acceptance of the adoption of the Going Concern basis for 2022/23
			• The Trust reported a surplus of £0.5m in 2022/23. However, this includes adjusting items such as impairments and the net impact of DHSC procured inventories. Excluding these items, the Trust's adjusted financial position for 2022/23 is a surplus of £1.07m.	
			• As a consequence of the Covid-19 pandemic, all NHS providers continued to be paid via block contract payments during 2022/23 with additional monies made available for COVID-19 and vaccination expenditure incurred plus a top up mechanism to support providers.	
			• In 2023/24 this has changed with a move back to contracts with commissioners, however top up funding is still in place but at a reduced value. A breakeven plan has been submitted to both NHS Cheshire and Merseyside ICB and NHS England (NHSE). The Board has approved the plan.	
			• The Trust continues to actively seek new business opportunities with Commissioners either through tendering opportunities being advertised or collaborative working and has successfully retained the Warrington 0 to 25 contract following a competitive tendering exercise.	
			• In the current climate the Trust does not view itself as an outlier in the NHS financial framework. Having considered the material uncertainties and the Trust's financial plans, the Directors have determined that it remains appropriate to prepare these accounts on a going concern basis.	

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			The Committee agreed to support the recommendation and put forward that the Board accept that the Trust continues to operate under a Going Concern Basis	
Review of the Draft Annual Accounts and Financial Statements	1,4		The Committee noted the draft accounts as submitted within the required timeframe. It was noted the accounts had also been considered by the Finance and Performance Committee and they remained subject to External Audit. There were no matters of concern to report to the Board.	Assurance received
Review of the Draft Annual Report and Annual Governance Statement	1,4		The Committee noted the work undertaken to date on producing the Draft Annual report and Annual Governance Statement. Both documents had already been reviewed by the Executive Management Team, Audit Committee, by e-governance, and KPMG, with a number of amendments and additions made. Colin Scales, Chief Executive Officer and Accountable Officer attended to confirm he was happy with the Governance arrangements in place across the Trust. Both the Annual Report and Annual Governance Statement continue to be subject to final revision and Audit but assurance was received that the Trust is on track to meet the submission deadline of 28 June 2023.	Assurance received
External Audit progress report	1,4		Confirmation was received from KPMG that the year-end audit was progressing well and that there was access to the Director of Finance and Audit Chair should any issues or concerns arise.	Assurance received
Review of the meeting	1		Governor, Bill Harrison, congratulated all the teams on the timely collation of all the complex documents.	
Risks Escalated: None from the meeting				

No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
Moderate assurance – potential moderate impact on quality, operational or financial performance	
Assured – no or minor impact on quality, operational or financial performance	

Committee Chair's Report

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

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

Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	Extraordinary Finance and Performance Committee		Report to:	Board of Directors
Date of Meeting:	5 May 2023		Date of next meeting:	18 May 2023
Chair:	Tina Wilkins		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Tina Wilkins, Non-Executive Director and Committee Chair Gail Briers, Non-Executive Director Sarah Brennan, Chief Operating Officer	**In Attendance** Jeanette Hogan, Deputy Chief Nurse Rachel Hurst, Deputy Director of Finance John Morris, Assistant Director of Estates Louise Thornton, Senior Financial Accountant Debbie Weir, Financial Controller Jan McCartney, Trust Secretary **Observers:** Andrew Mortimer, Public Governor, Warrington	**Key Members not present:**	**Apologies received from:** Martyn Taylor, Non-Executive Director Linda Chivers, Non-Executive Director Nick Gallagher, Director of Finance Lynne Carter, Chief Nurse

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Finance	4	🟩	Draft Annual Accounts 2022/23 The Committee noted that: • Adjusted financial position of £1.07m • Increase in finance income due to interest rate rises • New accounting standard IFRS 16 – Lease accounting – significant change to the accounts	The Committee noted the accounts The Committee noted that questions (and responses) would be collated into FAQs and circulated. The Committee recommended the draft accounts to the Audit Committee.

🟥	No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
🟧	Moderate assurance – potential moderate impact on quality, operational or financial performance	
🟩	Assured – no or minor impact on quality, operational or financial performance	

			• Reduction in overdue debt (receivables) • Healthy cash position	
Finance	4		Planning and Financial Arrangements - Presentation	The plan was submitted to the ICB on Wednesday 3 May and to NHS England on 4 May. The figures were broadly identical to those that were reported to the Board and a discussion had also taken place at the Executive Management Team meeting on 2 May. The plan remained as a break-even plan. This included circa £1.3m in income and expenditure for virtual wards which was a change from the plan previously presented to the Committee. The CIP was in line with ICS requirements and capital had been confirmed.
Governance	4,7,8		Review of meeting	The Committee thanked all involved in the production of the draft accounts for all of their work over the period.

Risks Escalated: None from the meeting

Actions delegated to other Committees:

Nothing delegated

No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
Moderate assurance – potential moderate impact on quality, operational or financial performance	
Assured – no or minor impact on quality, operational or financial performance	

Committee Chair's Report

![NHS Bridgewater Community Healthcare NHS Foundation Trust logo]

Name of Committee/Group:	Finance and Performance Committee		Report to:	Board of Directors
Date of Meeting:	18 May 2023		Date of next meeting:	20 July 2023
Chair:	Tina Wilkins		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Tina Wilkins, Non-Executive Director/Committee Chair Linda Chivers, Non-Executive Director Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Nick Gallagher, Director of Finance	**In Attendance** Rachel Hurst, Deputy Director of Finance Jeanette Hogan, Deputy Chief Nurse Eugene Lavan, Deputy Chief Operating Officer Dave Smith, Assistant Director of IT Mark Charman, Assistant Director of Transformation Gareth Pugh, Assistant Director of Finance Debbie Wier, Financial Controller Anita Buckley, Head of Information Jan McCartney, Trust Secretary **Observers:** Peter Hollett, Public Governor, Halton	**Key Members not present:**	**Apologies received from:** Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer John Morris, Assistant Director of Estates

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Finance	4	🟩	Month 1 finance report received and provided assurance. The Committee noted that: • Month 1 23/24 behind plan of breakeven	The Committee noted the financial position behind plan. The Committee noted CIP target.

🟥	No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
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🟩	Assured – no or minor impact on quality, operational or financial performance	

			• CIP behind plan • Maintenance of improvement in BPPC performance • Healthy cash position • Capital programme over subscribed	The Committee noted agency spend and for the top three spend areas and received confirmation that recruitment was underway. The Committee noted the capital position and the prioritisation process taking place. The Committee recommended the financial report to the Board.
Finance	4		Audit Update 2022/23 Impairment review of Plant, Property and Equipment (PPE)	No issues raised. DoF met with Audit Director. IFRS16 an area of significant work and review. The Committee noted the report.
Finance	4		Chair's report from CIP Council was received. This provided a final update to the programme for 2022/23 and the pipeline for 2023/24.	The Committee noted the report and the final position for 2022-23 including recurrent/non recurrent split. The updated pipeline for 2023/24 schemes was received by the Committee including best, worst and most likely scenarios. CIP Council will continue to work through and refine the schemes including development of PIDs and QIAs etc. The Committee requested that a report with more detail/themes etc come to the next Committee meeting. NEDs were also invited to attend the next CIP Council.
Finance	4		Service Line Reporting/National Cost Collection	The Committee noted the update.

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

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

Committee Chair's Report

Finance	4		Procurement Report	The Committee noted the achievement of the savings for 2022/23 and the workplan for 2023/24 and the reduction in waivers over the past year together with a focus on retrospective waivers going forward.
Performance	4,8		IQPR for month 12 was received by the Committee	The Committee noted the report. Over 18 week waits had reduced and there has been further improvement in the dermatology position since the report was written. Improvements in performance across all operational indicators. All cancer indicators were green and Widnes UTC performance has been steadily improving. There was an increase in the dental waiting list excluding Cheshire and Merseyside. Performance for the Duty of Candour indicator had returned to green. Action plans are in place to support RTT waiting lists. There are 4 patients showing with a waiting time of over 78 weeks in dental all of which will be cleared by 1st April. (These patients should have been seen by 1st April but haven't been and they have been reviewed and there are specific reasons for this which are patient specific..) The cohort of waiters between 52 to 78 weeks is being closely monitored and clinical harm reviews are being undertaken to ensure these patients do not exceed the 78-week mark.

🟥	No assurance – could have a significant impact on quality, operational or financial performance;
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Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust

Committee Chair's Report

		🟩		There are no other services with waiters of 78 weeks or more. Dermatology, community paediatrics in Warrington and Paediatric Speech and Language therapy in Warrington have waiters on or around the 52 week mark and there are action plans in place to reduce the waiting times.
Performance	4,8	🟩	The Chair's report from Performance Council for month 01 was received.	The Committee noted the report. The Committee commented that the report was much improved and the increased detail including performance hot spots provided assurance.
Performance	4.8	🟩	Waiting List Data Quality	The Committee received the report. This provided an update on the good work undertaken and the outcome of action plans now tasked to DLTs to further improve data quality.
Performance	4,8	🟧	Drive Ability North West	The Committee received the report. A further update was requested for the July meeting to include financial sustainability of the service.
Digital	8	🟧	Chair's report from DIGIT	The Committee received the report. It was reported that there was no substantive Clinical Nursing Information Officer in post however an interim has been appointed and is currently going through the relevant training required for this role. The workplan to support the delivery of the digital strategy over the next 12-18 months will be developed and reported back into DIGIT.

🟥 No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

		🟧		Procurement of the replacement extranet solution is underway. There was a request from the committee to ensure that Patient Safety Information Reporting Framework was included on DIGIT's agenda.
Estates	4	🟩	Estates Update	No update this month.
Audit	4	🟩		The Committee noted the report.
Risks	4	🟩		The Committee noted the report.
BAF	4,7,8	🟩	BAF 4	The Committee requested the removal of assurance: "Internal Audit reports – CIP - moderate assurance 2019/20 and the addition of Key Financial Systems - substantial assurance 2022/23 External Audit - Clean unmodified Audit to be updated from 2020/21 to 2021/22." Principal risk to be updated for 2023/24 Risk rating unchanged
			BAF 7	A number of changes were considered and recommended to the Board. Risk rating was discussed and reduced from 12 to 8.

🟥	No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
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Committee Chair's Report

		🟩	BAF 8	Minor updates for 2023/24
				No change to risk rating
Governance	4,7,8	🟩	Terms of Reference	Minor amendments to Terms of Reference agreed.
			Review of meeting	It was noted that the meeting was very long. As a result the next meeting will be scheduled for 3 hours and papers taken as read.

Risks Escalated: None from the meeting

Actions delegated to other Committees:

Nothing delegated

🟥 No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using
🟧 Moderate assurance – potential moderate impact on quality, operational or financial performance	the key to identify the level of assurance/risk to the Trust
🟩 Assured – no or minor impact on quality, operational or financial performance	

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**		**Date**	**01/06/23**
Agenda Item	**40/23**			
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

☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.

☐ **Resources -** We will ensure that we use our resources in a sustainable and effective way.

☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	01 June 23
Agenda Item	40/23		
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. PLACE UPDATE

1.1 **Warrington Together update**

The Warrington Together meetings have continued to progress as per the established governance framework with a clear and organised schedule of feedback from the 'wells' and the enabler groups into the Delivery Oversight Committee and onward to the Partnership Board.

1.2 It has been decided that the Warrington Together Partnership Board will be facilitated by an independent chair. Recruitment of the Chair will commence in July.

1.3 The Place Based Review for Warrington is taking place on 22nd May and all partners are represented on this meeting.

1.2 **One Halton update**

At the April 2023 One Halton Partnership Board, the discussion focused on developing and embedding the new governance arrangements, and associated priority workstreams. Both of which have been reviewed and updated to align with the Halton Health & Wellbeing Strategy.

1.3 A central component of this, and the focus, was on the Integrated Neighbourhood Model (INM) priority workstream, which is cross-cutting across the priority areas of Starting Well, Living Well and Ageing Well.

1.4 The Board reviewed and supported the case for change statement that had been developed:

When health and care organisations have a shared mission, work with their local citizens, and pool their ideas, energy, and resources to serve the public, the result is

often the delivery of outstanding quality and tailored, joined up care, which improves the experience for individuals and populations.

1.5   The Board reviewed and supported the vision:

Our vision for neighbourhood working is greater than just health and social care and moves beyond treating symptoms to addressing the underlying causes of poor health and wellbeing and supporting people to have a good life.

1.6   The Board also reviewed and supported a series of founding statements and principles, which included:
   ➤ Integrated community delivery across the public, private and third sectors
   ➤ Engagement with the communities and neighbourhoods being serviced to better understand what matters to local people, the problems and challenges they face
   ➤ An understanding of the local population and its needs on an individual and aggregate level
   ➤ Applying person-centred approaches and activating the population and communities, adopting a strengths and asset based approach
   ➤ Delivering services in a joined up, efficient and effective manner
   ➤ Focus on resources and assets available to and within a neighbourhood being used optimally to meet community needs

1.7   The Starting Well, Living Well and Ageing Well Senior Responsible Officers (SROs) are working with the Halton ICB team and partner members to identify the INM opportunities and proposed areas of focus for each of the three priority workstreams, individually and collectively.

1.8   An example of this will be the launch of Family Hubs in Halton. This clearly features as a priority in the Health & Wellbeing Strategy, with an integrated delivery approach central to the concept and design.

1.9   The Board will note the close alignment between this approach in Halton and our new strategy, objectives, and deliverables. Further assurance will be provided in due course with the alignment between the emerging workstreams in the Halton Adults and Children Directorate annual delivery plans, which describe our ambition and role in driving this forward and delivering integrated services and pathways.

2. Provider Collaborative

2.1   **Governance**

As updated in the previous Integrated & Collaboration Board paper, the Collaborative has been reviewing its governance arrangements, as a key element of the wider work on developing the value proposition and work programme.

2.2   Revisions to the governance arrangements include the launch of a new Board, increasing the members to include representation from the C&M Primary Care Advisory Group, Local Authority Chief Executive Group, CMAST Board and ICB Transformation Committee. The Board will be chaired by a Chair from one of the

Collaborative members, with two Non-Executive Directors also added to the membership.

2.3   The Board will report to both the Trust Boards of its 9 members, and the ICB.

2.4   Below the new Board, revisions have also been made to the former Management Group. This has been replaced by two new groups - a Strategy Transformation Group and an Operational Transformation Group.

2.5   Work is on-going to ensure all the necessary governance arrangements are aligned to the new and emerging structures.

2.5   **Recruitment**

The Collaborative has identified funding and is recruiting to four substantive posts to underpin and drive delivery of the workplan, with its members:

  ➢ Provider Collaborative Director – interviews taking place at the end of May 23
  ➢ Head of Programme Management – interviewed and appointed
  ➢ Programme Lead – out to advert
  ➢ Project Support Officer – interviewed and appointed

2.6   Bridgewater are the host employer for these posts. To assure the Board, the legal agreement regarding the shared risks of recruitment has been drawn up and this ensures that Bridgewater, as the host, are not solely liable for all of any potential future employment costs or redundancy.

2.7   **NEDs meeting**

As referenced above in the report, Non-Executive Directors (NEDs) from member organisations will have two seats on the Provider Collaborative Board, representing all NEDs and their collective voice.

2.8   The Collaborative is organising a session with NEDs from the 9 member organisations to discuss how NEDs engage within the collaborative and each other, and to ensure proportional representation.

2.9   At the time of writing this report, the date of the session is to be confirmed.

2.10   **Engagement with partners**

As part of the development of the Collaboratives Value Proposition and work programme and our engagement, a facilitated workshop with council CEOs, Directors of Adult Social Services (DASSs) and Place Directors from across C&M is being organised in June 23.

2.11   Finally, both Provider Collaboratives will be presenting their work programmes to the C&M ICB Board in June 23.

3. RECOMMENDATIONS

3.1   The Board are asked to note the contents of the report.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01 June 2023**
Agenda Item	**40/23ii**		
Report Title	**ICB Joint Forward Plans**		
Executive Lead	**Colin Scales – Chief Executive Officer**		
Report Author	**Rob Foster, Programme Director – Collaboration & Integration**		
Presented by	**Rob Foster, Programme Director – Collaboration & Integration**		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary
The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts to develop a Joint Forward Plan (JFP).

The purpose of JFP is to describe how each ICB and their partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs

This paper presents the Board with a draft version of the Cheshire & Merseyside (C&M) JFP.

The Board are asked to note the contents of this paper, review and feedback on the draft Cheshire & Merseyside Joint Forward Plan and endorse the document content, ahead of the planned publication date, set by NHS England, of 30th June 2023.

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

Strategic Objectives

☒ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☒ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☒ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☒ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.

☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.

☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	01 June 2023
Agenda Item	40/23ii		
Report Title	ICB Joint Forward Plans		
Report Author	Rob Foster, Programme Director – Collaboration & Integration		
Purpose	To present the draft Cheshire & Merseyside Joint Forward Plan and seek board feedback and endorsement.		
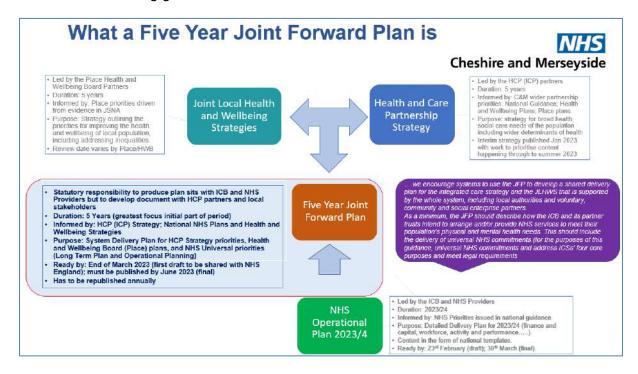
1. INTRODUCTION

1.1 The National Health Service Act 2006 (as amended by the Health and Care Act 2022) requires Integrated Care Boards (ICBs) and their partner trusts (the term used to refer to NHS trusts and foundation trusts throughout the document and this report) to develop a Joint Forward Plan (JFP).

1.2 The purpose of the JFP is to describe how each of the 42 ICBs and their partner trusts intend to arrange and/or provide NHS services to meet their population's physical and mental health needs. This should include the delivery of universal NHS commitments, address ICSs' four core purposes and meets legal requirements.

1.3 ICBs and their partner trusts have a duty to prepare a first JFP before the start of the financial year 2023/23 – i.e. by 1 April. For this first year, however, NHS England has specified that the date for publishing and sharing the final plan with NHS England, their integrated care partnerships (ICPs) and Health and Well-being Boards (HWBs), is 30 June 2023.

1.4 As part of this, ICBs and their partner trusts must consult with those for whom the ICB has core responsibility and anyone else they consider appropriate.

Cheshire & Merseyside (C&M) ICB

1.5 The C&M JFP has been developed following the three principles identified in the NHS England Guidance on developing the joint forward plan:

➢ Principle 1: Fully aligned with the wider system partnership's ambitions.
➢ Principle 2: Supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments.
➢ Principle 3: Delivery focused, including specific objectives, trajectories, and milestones as appropriate.

1.6 The C&M JFP recognises that the local system is on a journey and reflects that it will take time to fully embed different approaches fully, but the aim of the document is to

set a clear commitment to moving in this direction. The plan also recognises the variation in the level of detail within the plans being described in this document, which reflects the maturity of the respective programme plans.

1.7 The JFP will be refreshed annually in order to reflect developing plans, progress made, and provide opportunities for further engagement and collaboration in developing the plan.

2. CHESHIRE & MERSEYSIDE PLAN

2.1 The C&M Joint Forward Plan (JFP) contains the actions the ICB will take as an Integrated Care System (ICS) to deliver the priorities identified in:

➢ The Cheshire and Merseyside draft interim Health and Care Partnership Strategy
➢ The Joint Local Health and Wellbeing Strategies of the nine Place based Health and Wellbeing Boards
➢ The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24

2.2 This JFP builds on the draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

➢ Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
➢ Improving population health and healthcare.
➢ Enhancing productivity and value for money
➢ Helping to support broader social and economic development.

2.3 The ICB have identified priorities for Cheshire and Merseyside which match the ambitions in the draft interim Health Care Partnership Strategy. The key priorities identified are set out in the table below:

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans *	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme Supporting the safety of vulnerable Women and Children	2 2	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years) Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of Early detection of Cancer • Work towards MECC (Making Every Contact Count) • Encourage 'Healthy Behaviours' with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	1,2,3 2,3 2,3	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services Increased sign up to the NHS prevention Pledge Reduction in Smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active.
Enhancing productivity and value for money	• Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	1	Financial strategy and recovery plan in place by Sept 2023
Helping to support broader social and economic development	• Embed, and expand, our commitment to social value in all partner organisations • Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people • Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care	Develop as key Anchor Institutions and progress advancing at pace the associated initiatives. Embed and expand our commitment to Social Value • Developed focused work in schools around encouraging careers in Health and Social Care • Ensure a Health and Care workforce that is fit for the future. Achieve Net Zero for the NHS carbon Footprint by 2040	2 2 2 2	Grow the number of anchor framework signatories to 25 Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%) To be finalised in advance of the final publication in June 2023 Publish a Strategic Workforce Plan by March 2024 For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

← ***1. Delivery against NHS Operational plan and Long-Term Plan (See appendix 1)** →

← ***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)** →

← ***3. Core20PLUS5 (See appendix 3)** →

3. BRIDGEWATER STRATEGY ALIGNMENT

3.1 The table below presents a summary of a mapping exercise to show the alignment between the objectives set out the C&M JFP, and the objectives and deliverables described in our new Communities Matter organsiational strategy.

3.2 The exercise demonstrates alignment between the JFP and our strategy, with a further alignment and mapping exercise to be undertaken following the publication of the final C&M JFP at the end of June, and the finalisation of our Directorate and Corporate annual delivery plans.

3.3 The focus of the exercise will be to map the specific work programmes and projects being driven by our Directorates and services, with the C&M and place-based initiatives described in the JFP.

3.4 Through our partnership work with place, we have been involved in the development of the place-based plans and are committed to maintaining an aligned approach to ensure focus in our work programme.

BW Objectives	Objective deliverables	C&M objectives			
		Tackling Health Inequalities in outcomes, experiences and access	Improve population health and healthcare	Enhancing productivity and value for money	Helping to support broader social and economic development
QUALITY	D1) We will apply a systematic approach to the measurement of safety, patient experience, continuous learning, leadership and governance, ensuring accountability for improvement in line with the CQC quality statements.	Y	Y		
	D2) We will use Our Building On Our Strengths Together (BOOST) methodology to drive forward continuous quality improvements in the services we provide, led by our staff. This will be supported by access to learning, mentoring and training to improve the care delivered.	Y	Y	Y	
	D3) We will ensure patients and their families, including children and young people, are more involved in shaping our services, and the voice of the child, and their feedback will shape service transformation plans, alongside the views, insight and experience of our staff.	Y	Y		
	D4) We will learn through an open approach when things go well and when things go wrong, and we will continually strive to improve the care we provide to patients. Implementing the new NHS Patient Safety Strategy including the Patient Safety Incident Response Framework and Patient Safety Partners.	Y	Y		
	D5) We will support staff and services to recover from the impact of the pandemic and ensure that patients receive care in a timely way.	Y	Y		
HEALTH EQUITY	D6) We will implement the evidence-based, priority areas of focus from the NHS Prevention Pledge	Y	Y	Y	Y
	D7) We will work with partners in place to change the way our services are designed and delivered to ensure more equitable access, which will support improved outcomes and experience.	Y	Y		
	D8) We will influence, shape and support the delivery of Health and Wellbeing strategies in the places that we work.	Y	Y	Y	Y
	D9) We will further develop working relationships with all our health and care partners to identify high intensity users of services and support these patients to access the right services at the right time.		Y		
	D10) We will enhance our relationships with the voluntary sector and we will work in partnership with them to support the needs of our most vulnerable and at risk patients.	Y	Y		Y
PEOPLE	D11) We will maximise our workforce intelligence to fully understand our workforce profile to inform workforce planning utilising Population Centric Workforce Planning approaches.		Y	Y	
	D13) We will promote 'Grow your Own' initiatives with the local community to understand the potential future workforce and create job pipelines with colleges, local businesses and our strategic partners within each borough.			Y	Y
	D14) We will maximise utilisation of the apprenticeship levy to support the development of our workforce.			Y	Y
	D15) We will realise the added value to our workforce of our volunteers, third sector organisations and the armed forces.			Y	Y
	D16) We will create opportunities for working together with our community and other health and social care providers.		Y	Y	Y
	D17) We will create a culture where we are supportive of innovative roles – new ideas and innovative ways of working, upskilling and transforming services.		Y		
RESOURCES	D18) We will work in collaboration with staff, partners and communities to transform the way we provide services to generate efficiencies, which can be reinvested to improve the quality of care and improve outcomes in health equity.	Y	Y	Y	
	D19) We will enable excellent digital and data services to drive and deliver efficiency and optimisation.		Y	Y	
	D20) We will look to reduce carbon emissions and deliver the Trusts Green Plan.		Y	Y	Y
	D21) We will embed Anchor principles and look to procure locally where we can.	Y	Y	Y	Y
	D22) We will work with partners to maximise and right size our estates.			Y	
	D23) We will work with partners to operate within our financial allocations and maintain financial balance.			Y	
EQUITY, DIVERSITY & INCLUSION	D24) We will build a culture that champions diversity, equity and inclusion. Supporting and developing our people to provide compassionate and culturally competent care to our patients and each other.	Y	Y		
	D25) We will be proactive in anticipating the diversity of our patient needs and will respond to them to ensure we achieve the best outcomes.	Y	Y		
	D26) We will become an Anchor Institute in the community: We will take our social and environmental responsibility seriously, addressing the socioeconomic determinants of health.	Y	Y	Y	Y
	D27) We will improve the reach of our organisation and grow our standing in the community through local partnerships.				Y
PARTNERSHIPS	D28) We will continue work in close partnership with local General Practice, the Primary Care Networks and GP Federations to further enhance the quality and provision of services across our local communities.	Y	Y	Y	Y
	D29) We will work closely with all our partners and their staff to drive forward continuous quality improvements in the services we collectively provide.	Y	Y	Y	
	D30) We will work across our organisational boundaries with partners and their staff in place as we create future integrated care and service models.	Y	Y	Y	
	D31) We will work with partners to improve equity in health outcomes.	Y	Y		
	D32) We will work with our system partners to collaborate at scale to enable better care at place.	Y	Y	Y	

4. CONSULTATION

3.1 As part of the production process, the C&M ICB have engaged, with updates provided at the place-based partnership board and Health & Well Being Boards. A public survey was also run in March and April.

3.3 Draft versions of the JFP have been shared for comment with NHS Providers (including Primary Care Forum), Health and Care Partnership Membership, Health, and Wellbeing Board Membership (x9).

3.4 Between 22nd May and 30th June, the following activities are planned:

➢ The 9 Health and Wellbeing Boards are asked to review the JFP and provide a statement confirming if the JFP reflects the priorities from their respective strategy.
➢ NHS Providers are asked to review and "endorse" JFP document content.

3.5 Thereafter, feedback will be reflected, and a final document produced, with the ICB planning Board approval on 27th June, and publication on/by 30th June.

5. RECOMMENDATION

4.1 The Board are:
   a. Asked to note the contents of this paper.

   b. Review and feedback on the draft Cheshire & Merseyside Joint Forward Plan.

   c. Endorse the document content.

Cheshire and Merseyside

Joint Forward Plan

SUMMARY – DRAFT VERSION 1.5

1. About this document

We know that people's lives are better when organisations that provide health and care work together, particularly at the times when people need care most.

This document – our Joint Forward Plan (JFP) – describes how Cheshire and Merseyside Integrated Care Board (ICB), our partner NHS trusts and our wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

This Joint Forward Plan contains the actions we will take as an Integrated Care System (ICS) to deliver the priorities identified in:

- The Cheshire and Merseyside draft interim Health and Care Partnership Strategy

- The Joint Local Health and Wellbeing Strategies of our nine Place based Health and Wellbeing Boards

- The priorities outlined by NHS England in The NHS Long Term Plan and the national NHS Planning guidance for 2023-24 (Appendix 1)
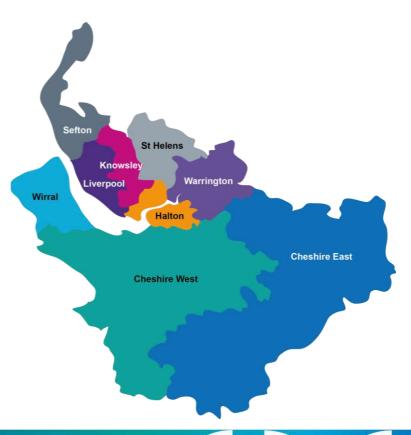
Our Joint Forward Plan aims to:

- improve the health and wellbeing of our population.

- improve the quality of services.

- make efficient and sustainable use of our resources.

We are committed to working on all three of these aims simultaneously to best meet our population's needs and to reduce inequalities in access and outcomes.

These aims also align to our statutory duties as an ICB. The details of these statutory duties can be **found here**.

Our Joint Forward Plan aligns with the recently published Hewitt Review (April 2023), which considers the future development of Integrated Care Systems in England. The review supports taking a 'whole system approach' to addressing wider determinants of health, and a shift of focus away from treating problems towards maintaining good health. These two themes align with our statutory duty and also our local commitment to integrate services to benefit our population.

Our approach to developing this Joint Forward Plan

The Cheshire and Merseyside Integrated Care Board was formally established in July 2022. We have already made significant progress, but we are still in a developmental phase and we have considerable work to do to further develop our plans and priorities. This Joint Forward Plan should be read in this context.

Whilst the responsibility to develop this plan sits with NHS Cheshire and Merseyside, and our NHS Providers, we have adopted a collaborative approach to developing this plan. We drew on the wide range of expertise, knowledge, and experience of our health and care professional leaders and partners to help us identify ways to improve integration and innovation. This will help us to deliver better outcomes for our population.

This 2023-2028 Cheshire and Merseyside Joint Forward Plan describes at a summary level the approach we are taking to tackle the current challenges we face in recovering access to services following the Covid 19 pandemic.

It also outlines a programme of radical transformation across our health and care system to address longstanding issues of inequalities in outcomes and financial sustainability.

This JFP builds on our draft interim Health Care Partnership Strategy. The strategy is built around four core strategic objectives:

- Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles).
- Improving population health and healthcare.
- Enhancing productivity and value for money
- Helping to support broader social and economic development.

These objectives support us to work towards achieving our vision and mission. The draft interim Health Care Partnership Strategy is broadly focused and contains many priorities. The HCP recognise the need to decide what to prioritise to enable progress to be made. Our residents provided feedback on the draft interim strategy during March and April 2023 which supported this view.

Figure 1: Cheshire and Merseyside Health Care Partnership Vision and Mission

Vision
We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer

Mission
We will prevent ill health and tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership

The HCP Strategy is currently in draft form and will be finalised later in 2023, in recognition of this ongoing work we have identified a number of priorities which contribute to making early progress against the ambitions outlined in the draft interim Strategy.

When the priorities in the HCP Strategy are finalised, we will refresh these priorities in our updated Joint Forward Plan, which will be published in March 2024.
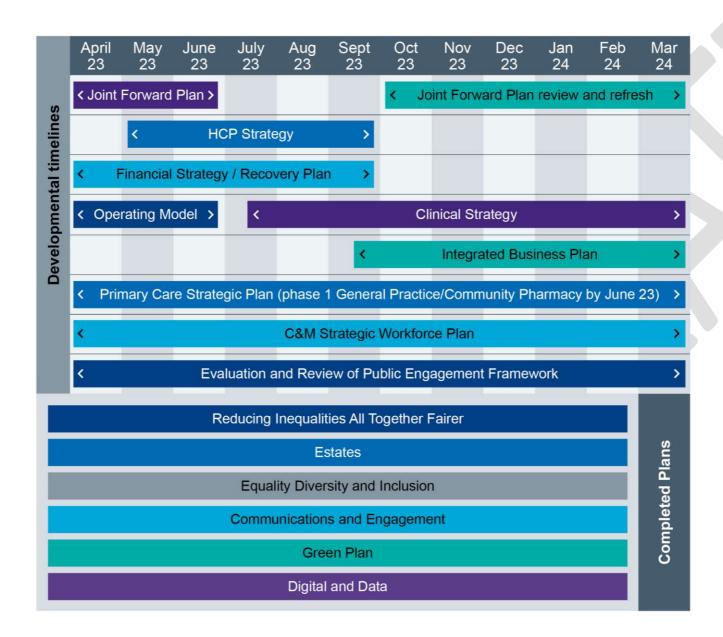
Figure 2: Cheshire and Merseyside Priorities

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans*	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme	2	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years)
		Supporting the safety of vulnerable Women and Children	2	Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of Early detection of Cancer • Work towards MECC (Making Every Contact Count) • Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	1,2,3	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services
			2,3	Increased sign up to the NHS prevention Pledge
			2,3	Reduction in Smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active.
Enhancing productivity and value for money	• Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and wellbeing services	Deliver our agreed financial plans for 23/24 whilst working towards a balanced financial position in future years	1	Financial strategy and recovery plan in place by Sept 2023
Helping to support broader social and economic development	• Embed, and expand, our commitment to social value in all partner organisations • Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people • Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care	Develop as key Anchor Institutions and progress advancing at pace the associated initiatives.	2	Grow the number of anchor framework signatories to 25
		Embed and expand our commitment to Social Value	2	Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%)
		• Developed focused work in schools around encouraging careers in Health and Social Care • Ensure a Health and Care workforce that is fit for the future.	2	To be finalised in advance of the final publication in June 2023 Publish a Strategic Workforce Plan by March 2024
		Achieve Net Zero for the NHS carbon Footprint by 2040	2	For the emissions we control directly (the NHS Carbon Footprint), net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

← ***1. Delivery against NHS Operational plan and Long Term Plan (See appendix 1)** →

← ***2. Delivery against the Marmot Beacon Indicators / All Together Fairer (See appendix 2)** →

← ***3. Core20PLUS5 (See appendix 3)** →

Whilst this summary document is relatively short, it is underpinned by significant activity across all of the priorities included in the table above. There are various links within this document which provide access to more detail about specific work programmes.

In developing this Joint Forward Plan, we recognise that we are in a developmental phase as an Integrated Care System and that there are some key pieces of planning and strategy work which we will need to align.

We intend to develop a fully integrated business plan during 2023/24 that will incorporate the key strategic plans we have either already developed or intend to develop during this year. These will be reflected in the next iteration of this Joint Forward Plan in March 2024.The table below shows our completed plans and outlines our developmental timeline for 2023/24.

Developmental timelines

	April 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
	‹ Joint Forward Plan ›						‹ Joint Forward Plan review and refresh ›					
		‹ HCP Strategy ›										
	‹ Financial Strategy / Recovery Plan ›											
	‹ Operating Model ›		‹ Clinical Strategy ›									
						‹ Integrated Business Plan ›						
	‹ Primary Care Strategic Plan (phase 1 General Practice/Community Pharmacy by June 23) ›											
	‹ C&M Strategic Workforce Plan ›											
	‹ Evaluation and Review of Public Engagement Framework ›											

Completed Plans

- Reducing Inequalities All Together Fairer
- Estates
- Equality Diversity and Inclusion
- Communications and Engagement
- Green Plan
- Digital and Data

2. How we work as partners for the benefit of our population

Cheshire and Merseyside is one of the largest Integrated Care Systems in England, with a large number of stakeholders working together to improve the health and care of our population.

The figure below illustrates how we are configured at a Cheshire and Merseyside level.

Some of the ways we come together in the Cheshire and Merseyside system are:

- The Cheshire and Merseyside Health and Care Partnership (HCP). This is a statutory joint committee between NHS Cheshire and Merseyside Integrated Care Board and our nine Local Authorities which also includes a wide range of partners from across the health and care system. This Board works together to support partnership working and is responsible for producing our Health and Care Partnership Strategy

- The NHS Cheshire and Merseyside Integrated Care Board. This is a statutory NHS organisation responsible for managing the NHS budget and arranging for the provision of health services whilst supporting the integration of NHS services with our partners.

- Our nine Place Based Partnerships. These work locally to support the integration of health and care services in support of local Joint Health and Wellbeing Strategies

Figure 3: Cheshire and Merseyside Integrated Care System

Through our Place based partnerships and the communities within them we are committed to the principle of subsidiarity. This means that we want to make decisions as locally as possible. Our Places and communities are the 'engine room' which drive change by designing and delivering services around the needs of the local population.

Complementary to this principle of subsidiarity, our large ICS provides opportunities to work at scale where appropriate. This enables us to share best practice and to work collectively to deliver

efficiencies and manage change. As an example, our two NHS Provider Collaboratives support our NHS providers to work together to deliver service improvement and enhance sustainability.

The picture below shows how we apply the principle of subsidiarity to decision making in our Places and the communities within them, whilst realising the benefits of working at scale in certain areas through our Health and Care Partnership, or ICB-wide programmes or through our two Provider Collaboratives.

Figure 4: Decision making and subsidiarity in Cheshire and Merseyside

Communications and Engagement

As system partners we are committed to engaging with people and communities. We know that harnessing the knowledge and experience of those who use and depend on the local health and care system can help improve outcomes and develop better, more effective services including removing or reducing existing barriers to access.

We are committed to working with those with lived experience to understand the impact of health inequalities and to support us in designing and implementing solutions to address these.

Our Green Plan

Climate change poses a threat to our health as well as our planet. Across Cheshire and Merseyside, we are committed to achieving net zero by 2040 (or earlier). The ICB and NHS Trusts and many Local authority partners have well established plans to achieve this.

Complementary to these local plans, NHS Cheshire and Merseyside has a strong system level Green Plan, and we work collaboratively as system partners to maximise the impact of our initiatives.

Our planet will continue to warm until circa 2060 we will continue climate adaptation / mitigation work to ensure we can continue to provide access to quality health and care for our population even as the climate changes. Including work to tackle air pollution, increased access to mental health services, coastal and other flooding, vector-borne diseases / prep for changing patterns of disease / sustained heat and high temperatures / impact on patients and on workforce, etc.

We will:

Reduce the emissions we control directly (the NHS Carbon Footprint), achieving net zero by 2040, with an ambition to reach an 80% reduction (from 1990 levels) by 2032.

Supporting wider social and economic development

Supporting social and economic development is one of our strategic objectives. We are working together on a plan for improving health including addressing wider determinants. Wider determinants, also known as social determinants, are a diverse range of social, economic, and environmental factors which impact on people's health.

We will:
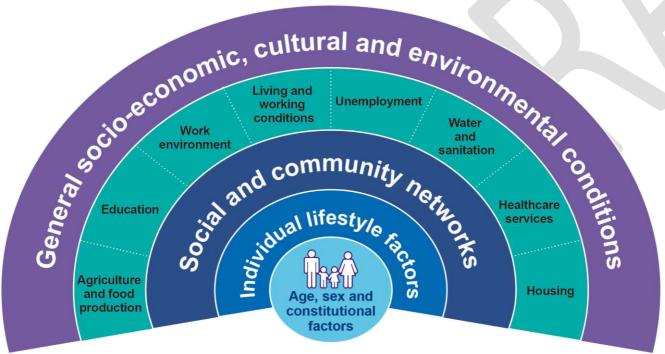
Increase the number of Anchor Framework signatories to 25 by the end of March 2024

And:

- Embed, and expand, our commitment to social value

- Develop as key Anchor Institutions within Cheshire and Merseyside

- Use an asset and strengths-based approach to planning

- Share data and insights, so resource can be targeted

- Ensure service, pathway and care model redesign is undertaken in collaboration

- Develop outcomes-focused funding models and contracts

- Support health and care professionals to think about care and support holistically

- Support a system-wide approach to embedding the minimum 10% social value weighting across all procurement processes (working towards 20%).

Figure 5: Wider social determinants of health and health inequalities, Dahlgren and Whitehead 1991

Safeguarding our population

Safeguarding is a shared responsibility across the health and care economy. Our teams work with colleagues from across the NHS, Local Authorities, the Police, and other partner agencies to drive improvements through local and regional partnership working to embed responsive safeguarding practice. This enables us to address national and local priorities and influence safe and effective care and commissioning.

Effective safeguarding at both system and organisational levels relies on systems that ensure safeguarding is integral to daily business.

We are committed to:

- Strengthening Collaboration and Communication
- Improving Training and Awareness
- Early Identification and Intervention
- Strengthening Partnership Working
- Enhancing Monitoring and Evaluation
- Empowering Service Users
- Promoting a Culture of Safeguarding

We will:

Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing Violence Against Women and Girls.

3. Our approach to improving Population Health

Our established Population Health Board oversees our Population Health programme of work. The aims of this are to improve health outcomes and reduce health inequalities by embedding a sustainable system-wide shift towards focusing on prevention and reducing health inequality. Our newly appointed Director of Population Health plays a key leadership role in this work.

Figure 6 provides a summary of the areas which our analysis tells us that our population experience worse outcomes when compared to the "England average", and where our people have told us their experience of accessing care does not meet their expectations.

We know that it is often the wider social determinants of health which are the cause of these poorer outcomes and this is why we are committed to addressing these wider determinants and to promote good health.

In line with the Hewitt Review recommendations, as an ICB we intend to increase year on year the proportion of our budget being spent on prevention. Over time we expect that this will improve the health of our population, whilst helping to address the variation and inequality in access and outcomes we see across Cheshire and Merseyside.

The following programmes describe how we are approaching this.

Figure 6: Population Health needs and cross cutting prevention themes in Cheshire and Merseyside

Strategic Intelligence

Strategic business intelligence is vital to underpin, inform and drive a coordinated and sustainable population health management approach across ICS programmes.

As outlined in our Digital and Data Strategy, we will build on our CIPHA and System P Programmes to enhance our strategic intelligence functionality. This will enable us to better identify areas for targeted interventions and monitor progress.

All Together Fairer

The primary objective of the draft interim Health Care Partnership Strategy is to reduce health inequalities, this commitment is at the heart of all of our programmes of work. This includes through our established All Together Fairer programme where we aim to improve population health and reduce population level inequalities in health, by focussing on the social determinants of health across Cheshire and Merseyside and supporting action at Place level. The All Together Fairer programme supports the eight Marmot principles, which are to:

1. Give every child the best start in life.
2. Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3. Create fair employment and good work for all.
4. Ensure a healthy standard of living for all.
5. Create and develop healthy and sustainable places and communities.
6. Strengthen the role and impact of ill health prevention.
7. Tackle racism, discrimination, and their outcomes.
8. Pursue environmental sustainability and health equity together.

An example is how we will work together to support our population to access safe, secure, and affordable housing.

We know that access to safe, secure, and affordable housing has a huge impact on the health of our population, and also that providing the right accommodation in the community supports people with a mental health condition or learning disability to access services in a more appropriate environment. A number of partners across our Health and Care Partnership provide excellent services which support our population to meet their housing needs.

Within the NHS many of our services such as community nursing services often involve visiting people at home. We can 'Make Every Contact Count' by using these interactions as opportunities to sign-post people to other local services which can help improve the environment they live in, impacting positively on their overall health and wellbeing.

We will measure the success of the All Together Fairer programme in the 2023-28 period against the 22 beacon indicators in the Marmot indicator set *(Appendix 2)*.

We will:

- **Increase the % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage**

- **Reduce hospital admissions as a result of self-harm (15-19 years)**

Core20PLUS5: System-wide action on healthcare inequalities

Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities. It identifies focus clinical areas requiring accelerated improvement. Making progress against these areas is a cross-cutting, system-wide responsibility, and delivery against priority clinical area objectives sits with respective ICS programmes and workstreams.

Our Population Health Programme strategic intelligence and system leadership will strengthen the oversight and monitoring of progress against the Core20PLUS5 clinical priorities *(Appendix 3).*

We will: Focus on delivery of the CORE20PLUS5 clinical priorities with an emphasis on:

- **Increasing the proportion of cancers diagnosed at an early stage (stage 1 or 2)**
- **Increasing the percentage of patients with hypertension treated to NICE guidance to 77% by March 2024**
- **Improving access, and equity of access, to Children and Young Peoples Mental Health services (0-17).**

System-wide action on Prevention and Making Every Contact Count

We are committed to working collaboratively as a system. As part of this commitment, we are embedding the philosophy of Making Every Contact Count. This is an approach to behaviour change that maximises the opportunity within routine health and care interactions for a brief discussion on health or wellbeing factors. This can support people in making positive changes to their physical and mental health and wellbeing.

We are also focusing on evidence-based and high impact interventions which include:

- Reducing smoking prevalence
- Reducing harm from Alcohol
- All Together Active Physical Activity Strategy
- Promoting Healthy Weight
- Increasing Health Checks
- Mental Wellbeing.

We will monitor our progress against key system objectives using an integrated framework that is currently being co-produced by system partners, and will incorporate key metrics in ICS, ICB and Marmot (All Together Fairer) dashboards.

We will:

- **Reduce smoking prevalence**
- **Reduce the % drinking above recommended levels**
- **Increase in the % who are physically active.**

NHS Prevention Pledge

Our providers are delivering against the 14 core commitments in the NHS Prevention Pledge. We are strengthening our focus on prevention, social value, and inequalities, embedding Making Every Contact Count (MECC) at scale, and supporting participating Trusts to achieve Anchor Institution charter status.

We are also exploring how we interpret the Pledge in a primary care setting, which involves considering how it may apply to colleagues such as GPs, dentists, optometrists, and pharmacists. This may provide further opportunities for partners to take early action to support health and wellbeing across a broader range of health and care settings.

We will:

Increase sign up to the NHS Prevention Pledge.

Vaccination and Immunisation

We plan to work with NHS England, UK Health Security Agency (UKHSA) and Place based commissioning teams to strengthen screening and immunisation uptake, and to reduce inequalities.

We will:

Work with partners to strengthen screening and Immunisation uptake and reduce inequalities.
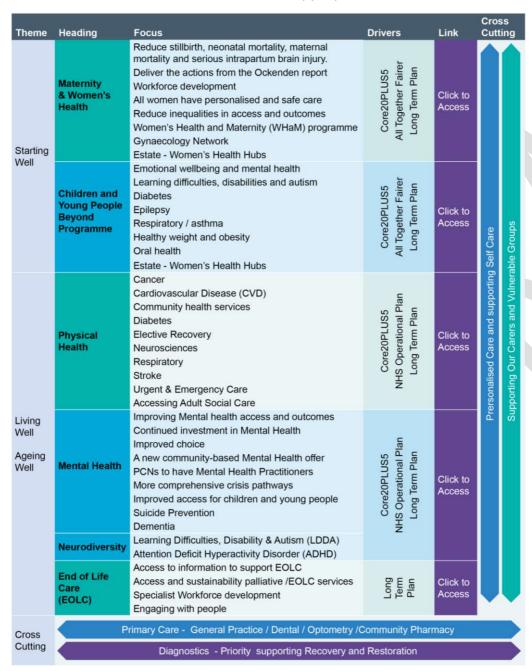
4. How we will improve our services and outcomes

We have adopted a life course approach to improving services and outcomes.

Starting Well – Living Well – Ageing Well

We are already working hard to improve services and outcomes for our residents through a wide range of programmes. The table below summarises our core areas of focus. Further details of our work can be accessed by clicking against the appropriate link.

Theme	Heading	Focus	Drivers	Link	Cross Cutting
Starting Well	Maternity & Women's Health	Reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury. Deliver the actions from the Ockenden report. Workforce development. All women have personalised and safe care. Reduce inequalities in access and outcomes. Women's Health and Maternity (WHaM) programme. Gynaecology Network. Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	Prersonalised Care and supporting Self Care / Supporting Our Carers and Vulnerable Groups
	Children and Young People Beyond Programme	Emotional wellbeing and mental health. Learning difficulties, disabilities and autism. Diabetes. Epilepsy. Respiratory / asthma. Healthy weight and obesity. Oral health. Estate - Women's Health Hubs	Core20PLUS5 All Together Fairer Long Term Plan	Click to Access	
Living Well / Ageing Well	Physical Health	Cancer. Cardiovascular Disease (CVD). Community health services. Diabetes. Elective Recovery. Neurosciences. Respiratory. Stroke. Urgent & Emergency Care. Accessing Adult Social Care	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Mental Health	Improving Mental health access and outcomes. Continued investment in Mental Health. Improved choice. A new community-based Mental Health offer. PCNs to have Mental Health Practitioners. More comprehensive crisis pathways. Improved access for children and young people. Suicide Prevention. Dementia	Core20PLUS5 NHS Operational Plan Long Term Plan	Click to Access	
	Neurodiversity	Learning Difficulties, Disability & Autism (LDDA). Attention Deficit Hyperactivity Disorder (ADHD)			
	End of Life Care (EOLC)	Access to information to support EOLC. Access and sustainability palliative /EOLC services. Specialist Workforce development. Engaging with people	Long Term Plan	Click to Access	
Cross Cutting		Primary Care - General Practice / Dental / Optometry /Community Pharmacy			
		Diagnostics - Priority supporting Recovery and Restoration			

5. Our Workforce

Our plans recognise the importance of investing in our workforce.

To achieve Cheshire and Merseyside Health and Care Partnership's strategic priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and Places.

In 2022/23 the Cheshire and Merseyside People Board, which has a broad membership across Cheshire and Merseyside stakeholders, agreed a set of ambitious Workforce Priorities for 2022-25 (see below).

Our system Workforce Strategy and the programme to support delivery of these priorities will be further developed during 2023/24.

Systemwide Strategic Workforce Planning to:	Creating New Opportunities across C&M to:	Promoting Health and Wellbeing to:	Maximising and valuing the skills of our staff to:	Creating a positive and inclusive culture to:
• Ensure a health and care workforce that is fit for the future • Smarter workforce planning linked to population health need • Creation of a 5-, 10- and 15-year integrated workforce plan • Developing a greater triangulation and monitoring between workforce / productivity / activity / finance.	• Grow our own future workforce • Increased focus on apprenticeships • Embed New Roles • Review barriers to recruitment • Work with the further and higher education sector • PCN Development • Greater links with social care and primary care • Ensuring an effective student experience.	• Ensure appropriate health and wellbeing support for all staff • Ensure good working environment • Focus on retention. • Preventing burnout • Ensuring appropriate supervision and preceptorship is available.	• Understand the impact of 5 generations working together/ changing expectation of the workforce • Developing career options at different stages of our lives and across health and social care • Responding to reviews / staff surveys and recommendations in a positive manner.	• Ensure proactive support of inclusion and diversity as a priority • Collaborative and inclusive system leadership • Understanding the barriers for staff / future employees • Development of learning and restorative practice.

Developing our culture and leadership

We plan to adopt, apply, and invest in the following areas to develop our culture, workforce, and ways of working as a system.

We will:

- **Ensure a Health and Care workforce that is fit for the future.**

  And:

- **Publish a Strategic Workforce Plan by March 2024**

- **Create new opportunities across health and care providers**

- **Promote health and wellbeing of all workforce**

- **Maximise and value the skills of our workforce**

- **Create a positive and inclusive culture**

- **Ensure digital upskilling for the whole workforce**

- **Further develop our partnerships with Health Education Institutes (HEI's), further education providers and school**

Cultural transformation

- Organisational and system redesign necessary for integration

- Competence and capability development to deliver integrated ways of working.

- Team cohesion to drive resource optimisation through sustainable collaboration.

- Growth mindset to stimulate systems leadership thinking and practice.

- A shared cultural identity values and behaviours premised on the principles of public service founded by the NHS Constitution, Equality Act and Nolan Principles

Talent management

- Talent management for effective capacity, demand and supply planning mapped to population health / market trends.

- Robust succession planning strategies for business-critical roles and hard to fill roles specifically.

- Reward and recognition strategies to ensure that success is rewarded and celebrated and improve staff engagement and retention.

Leadership development

- Resilient collective (systems) leadership evidenced in the continual enablement of integration for improved health and care integration.

- Compassionate and inclusive leadership cultures towards improving health inequalities.

- Culturally competent leadership to drive cultural competence in decision making for integration.

- Clinical leadership for integration towards health creation models of care

6. System development

Our Integrated Care System is geographically large and comprises a wide range of partners. This is reflected in how we apply our intention to distribute leadership to the most appropriate point in the system, which in many cases is as locally as possible.

In line with the concept of a "self-improving system" described in the Hewitt Review we intend to develop our capabilities and be ambitious in developing our leadership, workforce and improvement approaches alongside the plans already outlined in this document.

In early 2023/24 we will be delivering work to develop and embed an agreed operating model for our system, working alongside system partners. Part of this will involve considering how we can work more efficiently as a system to enable the integration of services across health, care and our wider partners and communities, within our Places and our communities to prosper whilst working collectively at a Cheshire and Merseyside level when it makes most sense to do so.

Clinical and Care Professional leadership

We have developed a Clinical and Care Leadership Framework which outlines how clinical and care leaders across Cheshire and Merseyside will be involved in key aspects of ICS decision making.

The framework was developed collaboratively with a wide range of clinical and care professionals and in partnership with the Innovation Agency. It will:

- Empower our leaders to work across traditional organisational boundaries

- Support specific groups of clinicians and care professionals to connect their particular areas of work to the ambitions of the ICS

- Create an environment where distributed leadership can thrive

- Maintain and develop the depth and breadth of clinical leadership we currently have, including development of our future leadership to be more reflective the diverse Cheshire and Merseyside population we serve

- Build on the expertise of existing clinical and care professional networks

- Enable clinical and care professionals to collaborate for improved health and care outcomes for people in Cheshire and Merseyside.

We will:

Develop a Cheshire and Merseyside Clinical Strategy by March 2024.
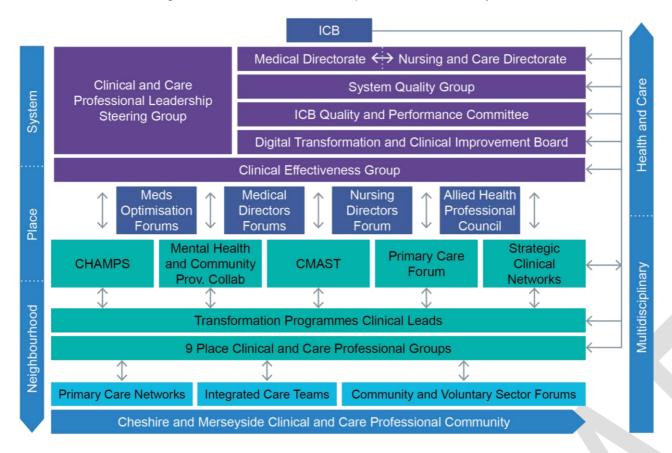
Figure 7: Clinical and Care Leadership in Cheshire and Merseyside

Quality Improvement

The government and public rightly expect Integrated Care Boards and their respective systems to ensure that the services we commission provide the highest standards of care. The development of our system quality strategy is being informed by the National Quality Board (NQB) guidance. The NQB publication 'Shared Commitment to Quality' provides a nationally agreed definition of quality and a vision for how quality can be effectively delivered through ICSs.

Quality Principles

We will work together as a system to improve quality and use the key principles for Quality Management, as set out by the NQB, in developing our approach to deliver care that is:

- Safe
- Effective
- A Positive Experience
- Responsive and Personalised
- Caring
- Well-led
- Sustainably Resourced
- Equitable

Our Provider Collaboratives

Effective collaboration and system working requires us to continually evolve, develop, improve and partner to further embed progress and capacity within the ICS and ultimately to provide more and better care to our residents and patients.

In Cheshire and Merseyside, we have two provider collaboratives:

- Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST)
- Mental Health, Community and Learning Disability and Community Provider Collaborative (MHLDC)

Our collaboratives are leading a range of work programmes which support delivery of the Cheshire and Merseyside HCP strategic priorities.

Our Cheshire and Merseyside Acute and Specialist Trusts Collaborative (CMAST) programmes and key areas of focus are listed below:

- Elective Recovery and Transformation
- Clinical Pathways
- Diagnostics
- Finance, Efficiency and Value
- Workforce

Our Mental Health Learning Disabilities and Community Provider Collaborative (MHLDC) is a joint working arrangement between the nine providers of community, mental health and learning disabilities services. The work programme priorities for 2023/24 are:

- Community urgent care:
  - Urgent community response teams
  - Intermediate care
  - Roll out of Urgent Treatment Centre specification
  - Virtual Wards
- Community services for children and young people
- Access to care, fragile services and community waiting times
- Population health and prevention
- Mental health transformation
- Workforce transformation

We will:

Work with our collaboratives on a range of work programmes which support delivery of the HCP strategic priorities.

Our VCFSE Transformation Programme

In Cheshire and Merseyside we are fortunate to have a strong and engaged Voluntary, Community, Faith, and Social Enterprise (VCFSE) sector across our nine Places. This is supported by established local infrastructure organisations providing skills, knowledge, and capacity to enable two-way communications and engagement between local neighbourhoods and the health and care system.

The new health and care structures which have recently been established provide an opportunity to transform services and make a lasting difference to patients and communities. VCFSE partners will play a vital role in transformation programmes with a focus on:

- Embedding VCFSE as key delivery partners
- Supporting investment in the VCFSE both financially and organisationally
- Building on VCFSE infrastructure and assets

We will:

Focus on embedding the VCFSE as a key delivery partner.

Our Places

Our nine Cheshire and Merseyside Places have been working collectively since before the formation of ICS in 2022, working through local partnership arrangements to deliver against the priorities in their local joint health and wellbeing strategies.

We have used a 'Place Development Assessment Framework' to support our Place Partnerships in their development, applying learning from other geographies. There are 4 key domains:

- Ambition and Vision
- Leadership and Culture
- Design and Delivery
- Governance

Place Partnerships have developed detailed plans to improve local services and outcomes.

We will:

As part of our Operating Model we will enable our nine Places to most effectively deliver functions and decision making at a local level.

Evolving our Commissioning and Corporate Services

We are developing a single suite of commissioning policies across Cheshire and Merseyside by March 2024, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

The Health and Care (2022) Act has created provisions for NHS England to delegate functions relating to the planning/commissioning of certain services to Integrated Care Boards. In April 2023 the ICB took on responsibility for dental, ophthalmic and pharmacy services, and we are planning for future delegation of Specialised Services from April 2024.

We have a number of programmes of work designed to support our system to improve consistency and value for money as its functions evolve. These include:

- Corporate infrastructure: we are reviewing the licenses and applications in use across our nine places, to improve consistency and realise operational and financial efficiencies.

- Commissioning support functions: we are reviewing all services currently provided to the ICB by Midlands and Lancashire Commissioning Support unit for consistency and value for money.

Research and Innovation

As described in our draft interim Health Care Partnership Strategy we have an ambitious vision for research in Cheshire and Merseyside. Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research to work closely with our stakeholders to develop the best performing research network in the country.

We are working closely as a system involving the CHAMPS public health collaborative, our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

We will:

- **Establish a Cheshire and Merseyside Research Development Hub**

- **Create a network of research champions across our system**

- **Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects**

- **Contribute to the development of a North West Secure Data Environment for research.**

Digital and Data

Cheshire and Merseyside ICS published its three year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board. We are committed to using digital and data to improve outcomes and services for our residents.

The strategy describes an ambition to improve the health and well-being of our region now and into the future by incorporating digital and data infrastructure, systems, and services throughout the pathways of care we provide.

This requires 'levelling up' our digital and data infrastructure to help address the significant inequalities so clearly faced by parts of our population and to ensure we successfully support all we serve.

We are committed to turning 'intelligence into action' by using increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to improve their health and care outcomes in an equitable way.

We will:

Work in partnerships to deliver the goals outlined in the Digital and Data Strategy, including making the Share2Care (shared care record) platform available in all NHS and Local Authority Adult Social Care providers, by March 2024.

Effective use of resources

In line with many other systems Cheshire and Merseyside faces significant financial challenges. As a system, we are spending more money on health and care services then we receive in income. We must take action to improve the long-term sustainability of the Cheshire and Merseyside health and care system by managing demand and transforming the way we use services, staff, and buildings.

As part of the Cheshire and Merseyside draft interim Health Care Partnership Strategy there is a commitment to developing a system-wide financial strategy during the first half of 2023-24 to:

- Determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Support health and care integration
- Identify key productivity and efficiency opportunities at both a Place and ICS footprint
- Outline system-wide estates and capital requirements and plans

As recommended in the Hewitt Review, we are focussed on ensuring we are getting best value from our investments and increasing the proportion of our ICB budgets allocated to prevention of ill health.

We will:

Agree a financial strategy and recovery plan by September 2023 which details how we will move to a sustainable system-wide financial position in Cheshire and Merseyside

Finance Efficiency and Value Plans

As part of our wider development of a system financial strategy, we have established an Efficiency at Scale programme. One of our provider collaboratives, CMAST, is hosting the programme on behalf of the ICB. The programme works across the NHS and links with partners from the wider system as appropriate.

The key areas of focus for the Efficiency at Scale programme are:

- Consolidating financial systems, approaches and capacity across organisations where appropriate, including financial ledgers.

- Delivering a structured procurement workplan to reduce influenceable spend across all providers.

- Building on existing medicines optimisation projects to deliver a more sustainable approach to pharmacy capacity and resourcing across Cheshire and Merseyside.

- Specific discrete workforce projects, for example a collaborative staff bank for Health Care Assistants.

This complements wider work on our financial strategy and recovery plan where system partners work to reduce costs, through ICB, Place, provider and partner led plans.

Capital plans

We have developed a Capital Plan which describes how we will use available capital funding to invest in our buildings and infrastructure. This is publicly available to view at: INSERT LINK TO CAPITAL PLAN

Our capital plans will be routinely shared with members of the Cheshire and Merseyside Health and Care Partnership and the nine Health and Wellbeing Boards in Cheshire and Merseyside.

We will continue working in partnership to deliver against our Capital plans.

Estates

Cheshire and Merseyside Health and Care Partnership's Estates Strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

- Fit for Purpose

- Maximising Utilisation

- Environmentally Sustainable

- Value for Money and Social Value

- Services and Buildings in the right place

- Flexibility

- Technology

- Working in Partnership

During the year we will be supporting our nine Place Partnerships and Primary Care Networks to ensure our focus areas translate into deliverable local plans.

All Age Continuing Health Care

The ICB is accountable for the fair and equitable commissioning of All Age Continuing Health Care (AACC) to support the assessed needs of our residents. We are accountable for the quality, safety and financial assurance of the continuing care provided.

We have recently reviewed the services we provide to people who receive Statutory funded continuing care. This review will have a range of benefits. It will improve the appropriateness of the care provided, meaning care is of higher quality. By providing more appropriate solutions, we also expect to improve the value for money of the services we provide meaning our funding can go further.

We will:

Complete the review and work with partners to establish an equitable model for delivery of services across Cheshire and Merseyside.

7. Our Place Plans

Click her to see our Place plans. (link to be added).

8. Glossary

An online glossary of terms has been developed by NHS Cheshire and Merseyside and can be accessed through this link:

cheshireandmerseyside.nhs.uk/get-involved/glossary/

9. Summary of Outcomes

In addition to the priorities outlined in Section 1 there are a range of additional outcomes the plans outlined in this document will deliver and can be accessed by clicking here (link to be added).

10. Links to our partners plans

Click here to find links to the strategic plans of our NHS Provider and Local Authority Partners. (link to be added).

Appendix 1 NHS Operational Plan and Long-Term Plan

Nation NHS Objectives

Area		Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality, and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
LTP and transformation	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

*ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published.

Appendix 2 Marmot 8 principles and 22 Beacon indicators

The tables below highlight the principles describing how we intend reducing inequalities and the indicators we will use to measure progress.

Marmot 8 principles	
1	Give every child the best start in life.
2	Enable all children, young people, and adults to maximise their capabilities and have control over their lives.
3	Create fair employment and good work for all.
4	Ensure a healthy standard of living for all.
5	Create and develop healthy and sustainable places and communities.
6	Strengthen the role and impact of ill-health prevention.
7	Tackle racism, discrimination, and their outcomes.
8	Pursue environmental sustainability and health equity together.

22 Beacon Indicators

	Life expectancy	Frequency	Level	Disagg.	Source
1	Life expectancy, female, male	Yearly	LSOA	IMD	ONS
2	Healthy life expectancy, female, male	Yearly	LA	IMD	ONS
	Give every child the best start in life				
3	Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)*	Yearly	LA	NA	DfE
4	Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception)	Yearly	LA	FSM status	DfE
	Enable all children, young people and adults to maximise their capabilities and have control over their lives				
5	Average Progress 8 score**	Yearly	LA	FSM status	DfE
6	Average Attainment 8 score**	Yearly	LA	FSM status	DfE
7	Hospital admissions as a result of self-harm (15-19 years)	Yearly	LA	NA	Fingertips, OHID
8	NEETS (18 to 24 years)	Yearly	LA	NA	ONS
9	Pupils who go on to achieve a level 2 qualification at 19	Yearly	LA	FSM status	DfE
	Create fair employment and good work for all				
10	Percentage unemployed (aged 16-64 years)	Yearly	LSOA	NA	LFS
11	Proportion of employed in permanent and non-permanent employment	Yearly	LA	NA	LFS
12	Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter***	-	-	-	NHS, local government
13	Percentage of employees earning below real living wage	Yearly	LA	NA	ONS
	Ensure a healthy standard of living for all				
14	Proportion of children in workless households	Yearly	LA	NA	ONS
15	Percentage of individuals in absolute poverty, after housing costs	Yearly	LA	NA	DWP
16	Percentage of households in fuel poverty	Yearly	LA	NA	Fingertips OHID
	Create and develop healthy and sustainable places and communities				
17	Households in temporary accommodation****	Yearly	LA	NA	MHCLG / DLUHC
	Strengthen the role and impact of ill health prevention				
18	Activity levels	Yearly	LA	IMD	Active lives survey
19	Percentage of loneliness	Yearly	LA	IMD	Active lives survey
	Tackle racism, discrimination and their outcomes				
20	Percentage of employees who are from ethnic minority background and band/level***	-	-	-	NHS, local government
	Pursue environmental sustainability and health equity together				
21	Percentage (£) spent in local supply chain through contracts***	-	-	-	NHS, local government
22	Cycling or walking for travel (3 to 5 times per week)~	Yearly	LA	IMD	Active lives survey

Children achieving a good level of development are those achieving at least the expected level within the following areas of learning: communication and language; physical development; personal, social and emotional development; literacy; and mathematics.
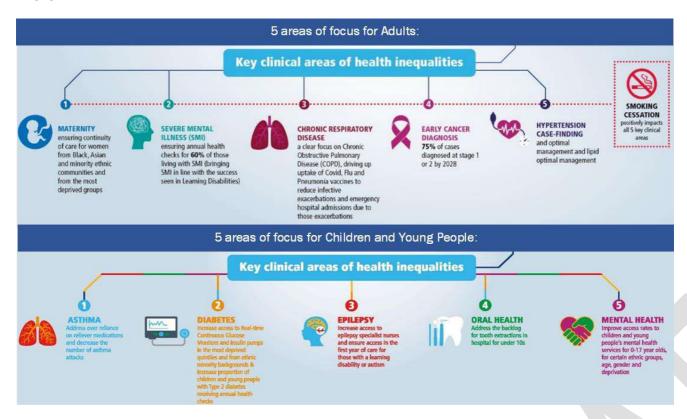
**Both the Progress 8 and Attainment 8 scores are proposed for inclusion. Progress 8 scores at local authority level demonstrate that schools with a negative average score require systematic intervention. Attainment 8 shows the percentage achievement of school-leavers and is a more sensitive measure of annual change within schools.*

***These indicators will require the NHS and local authorities to establish new data recording and collection methods. We have factored the social value indicators into the 2022/23 work programme to align with the rollout of the Anchor Institute Charter. It will also require definitions of "local" in both the local supply chain and employment. All contracts, direct and subcontracted, should be analysed and included. This should be reviewed after the first year of implementation. Collecting ethnicity data related to employment should also be reviewed after the first year of implementation.*

****To be used to demonstrate annual changes, interpretation to factor in population changes.*

~ *Active Lives Survey states the length of continuous activity is at least 10 minutes.*

Appendix 3 Core20PLUS5

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS		Date	01/06/23
Agenda Item	40/23iii			
Report Title	Communities Matter - Trust Strategy update			
Executive Lead	Colin Scales – Chief Executive Officer			
Report Author	Rob Foster, Programme Director – Collaboration & Integration			
Presented by	Rob Foster, Programme Director – Collaboration & Integration			
Action Required	☐ To Approve	☐ To Assure		☒ To Note

Executive Summary

The purpose of this report is to provide a regular update and assurance to the Trust Board on progress with the delivery of the new Communities Matter Trust Strategy.

Given the recent approval of the new strategy, this report provides an update on:

➢ The development of annual delivery plans
➢ Measuring and monitoring the delivery and impact of the new strategy

➢ Our engagement plans and approach

The report also provides an update on Quality Visits, a core aspect of our Quality objective, in supporting our focus on continuous improvement in patient outcomes, increasing patient satisfaction and staff experience.

Previously considered by:

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

Strategic Objectives

☒ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☒ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☒ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☒ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.

☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.

☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	01 June 2023
Agenda Item	40/23iii		
Report Title	<mark>Communities Matter - Trust Strategy update</mark>		
Report Author	Rob Foster, Programme Director – Collaboration & Integration		
Purpose	To provide a regular update and assurance to the Trust Board on progress with the delivery of the new Communities Matter Trust Strategy		

1. INTRODUCTION

1.1 The purpose of this report is to provide a regular update and assurance to the Trust Board on progress with the delivery of the new Communities Matter Trust Strategy.

1.2 Given the recent approval of the new strategy, this report provides an update on:

- ➤ The development of annual delivery plans
- ➤ Measuring and monitoring the delivery and impact of the new strategy
- ➤ Our engagement plans and approach

1.3 The report also provides an update on Quality Visits, a core aspect of our Quality objective, in supporting our focus on continuous improvement in patient outcomes, increasing patient satisfaction and staff experience.

2. Development of annual delivery plans

2.1 Working in partnership with the Transformation Team and Corporate Services, the four service Directorates (Dental, Childrens, Warrington adults, Halton adults) have developed annual delivery plans that describe the workstreams that will drive delivery of our new strategy, the objectives, and deliverables.

2.2 The Directorates are working together to ensure the plans balance common themes/initiatives where relevant, but equally focused on their respective needs and places.

2.3 The Transformation Team are working with the Directorate to develop SMART targets for workstreams, and a milestone tracker has been developed to monitor progress of the activities that drive delivery of the workstreams.

2.4 In parallel, the Transformation Team and Programme Director are working with the Corporate Services teams to ensure relevant corporate workstreams are aligned and included in the Directorate delivery plans, and a separate corporate delivery plan is being developed to capture all Trust-wide workstreams.

2.5   Leading the production of the materials, the Communications Team are development of a number of outputs, including:

➢ Branded/refreshed version of the corporate strategy.

➢ Corporate strategy Plan on a Page

➢ Corporate Strategy 'easy read' version

➢ Corporate Strategy 'easy read' version - languages/accessible

➢ Branded versions of each Directorate Delivery Plan

➢ Directorate Delivery Plans - Plan on a Page (*4)

➢ Directorate Delivery Plan 'easy read' versions

➢ Directorate Delivery Plan 'easy read' versions - languages/accessible

3. Measuring and monitoring

3.1   To ensure the organisation is able to effectively monitor and track progress and delivery of the strategy, new Strategy Dashboards and progress tracker are being developed, fully aligned and integrated with the current and emerging Performance Assurance Framework and Integrated Quality & Performance Report (IQPR).

3.2   The new Dashboards and tracker will focus on all metrics, deliverables, objectives, and our mission statement, across all Directorates. There will be 5 versions of the Dashboard – a summary view, and then a view for each Directorate.

3.3   All milestones and workstreams are being mapped to the relevant governance forum, meaning the monitoring of the delivery of the plethora of actions will take place day to day, as BAU. The updates, monitoring and assurance will therefore be driven through the existing, organisational governance infrastructure, aligned to the BAF reporting framework and IQPR.

3.4   The Dashboards and tracker will provide a snapshot summary, focusing exclusively on the strategy.

3.5   Dovetailing our measuring with our engagement approach, a blend of quantitative and qualitative measures will be used. This includes a focus on stakeholder surveys, feedback, and insights to help us assess and assure ourselves on our approach and impact. This will be described further in the engagement section below.

3.6   The first version of the new Strategy Dashboards and Performance Report will be presented to the Trust Board in August 23.

4. Engagement

4.1   Section 8 of our new Communities Matter strategy, sets out our engagement ambitions, where we identify four main stakeholders:

> ➤ Staff
> ➤ Patients (and carers)
> ➤ Public
> ➤ Partners

4.2 The Bridgewater Engagement Group (BEG) recently launched an assessment of our engagement plans, structures, resources, and governance underpinning the four stakeholder groups, to identify their alignment and respective readiness to fully deliver the engagement ambitions we describe in Communities Matter.

4.3 This will enable us to identify any gaps or potential risks to delivery, and to consider solutions and mitigations, appreciating short-term and longer-term timescales, ensuring we have clear delivery plans, resources, and governance for each stakeholder group.

4.4 As part of our engagement approach, we will be presenting our strategy and delivery plans to respective place and system partners, and we'll use these opportunities to promote our ambition for joined up, collaborative, community engagement moving forward.

4.5 As referenced in the section above, we will also be engaging with our stakeholders to co-produce metrics/measures to help assess and assure on delivery and impact of our strategy. These insights will be included alongside quantitative metrics to present a more holistic view.

4.6 The table below shows where stakeholder feedback will be used to assess progress against our new mission statement and objectives.

TARGETS	Staff	Patient	Public	Partner
Mission - We will improve health, health equity, wellbeing and prosperity across local communities, by providing person-centred care in collaboration with our partners	✓	✓	✓	✓
Quality - We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.	✓	✓		
Health equity - We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.			✓	✓
Staff - We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.	✓			
Resources - We will ensure that we use our resources in a sustainable and effective way.				
Equity, Diversity and Inclusion - We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.	✓	✓		
Partnerships - We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.				✓

4.7 In our new strategy, we have committed to adopting a strengths-based approach to our engagement. As such, our approach will largely be based on accessing and using existing meetings, forums, and channels to seek this feedback.

4.8 Where required, we will introduce new methods, including launching a partner survey, and will look to utilise available technologies to ensure we introduce efficient processes.

5. Quality visits

5.1 As referenced above, each Strategy update board report will also include any developments and updates that are relevant and/or critical to the delivery of our strategy and objectives, that aren't included in other Board reports but are vital in the delivery of our strategy.

5.2 The focus in this report is on Quality visits.

Background

Quality assurance visits are undertaken within the Trust to gain assurance and promote the quality and safety of services we deliver by:

Improving quality, patient experience and safety.

Supporting team leaders and managers to articulate how they deliver care; identify (and celebrate) what works well and where improvements are needed.

Quality visits also help the Trust prepare for inspections by the Care Quality Commission (CQC) which could happen at any time.

5.3 The overall aim is to answer the 5 key questions associated with CQC regulatory and compliance framework for the fundamental standards:

➢ Are the services **safe**?
➢ Are the services **effective**?
➢ Are the services **caring**?
➢ Are the services **responsive to people's needs**?
➢ Are the services **well-led**?

5.4 The quality visits provide a comprehensive overview of the team's performance, identifies trends in the data, and enables shared learning. The visits were coordinated by the quality team, with each service within the Trust Quality visits within the Trust were put on hold during COVID-19 pandemic.

5.5 **Recent Developments**

Following the CQC introduction of a new single assessment framework in July 2022, the Trust have reviewed the approach in line with the "we" quality statements, with engagement with staff at the recent Leader in me event on 21st April.

Senior leaders within the trust (clinical and operational) have met to agree an approach to implementing the new framework, with the Directors of Nursing providing support to operational managers via the Directorate quality meetings and quality matrons visiting and supporting teams with the trust self-assessment framework. The aim is to reintroduce quality visits in quarter 2 23/24.

5.6 As a next step the Trust has committed to developing an accreditation framework which will identify a set of metrics against which to measure quality of care and is central to demonstrating improvement. Accreditation will bring together key measures of nursing and clinical care into one overarching structured framework to enable a comprehensive assessment of the quality of care at team and service level to drive continuous improvement in patient outcomes and increase patient satisfaction and staff experience.

6.   Recommendations

6.1   The Board are asked to note and support the contents of this report.

Committee Chair's Report

NHS
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Name of Committee/Group:	People Committee	Report to:	Board of Directors
Date of Meeting:	10 May 2023	Date of next meeting:	12 July 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 Linda Chivers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director Paula Woods, Director of People & Organisational Development Dr Ted Adams, Medical Director In attendance Jo Waldron, Deputy Director of People and Organisational Development Mike Baker, Deputy Director of Communications and Engagement Tania Strong, Interim Head of Human Resources Adie Richards, Education and Professional Development Lead Ruth Besford, Equality and Inclusion Manager Denise Bradley, Unison Bridgewater Branch Secretary and Staff Side Chair Jeanette Hogan, Deputy Chief Nurse attending on behalf of Lynne Carter, Chief Nurse Jan McCartney, Trust Secretary Razia Nadir, Knowledge and Library Services Manager Helen Young, Freedom to Speak Up Guardian Eugene Lavan, attending on behalf of Sarah Brennan left at 12 pm to chair another meeting **Observers** Christine Stankus, Governor Observer	Quorate (Yes/No):	Yes
		Key Members not present:	Member: Lynne Carter, Deputy Chief Executive and Chief Nurse Member: Sarah Brennan, Chief Operating Officer Attendee: Kathryn Sharkey, Head of Workforce Attendee: Helen Hollett, Head of Leadership and Organisational Development Observer: Sarah Power, Governor Observer

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

Committee Chair's Report

	Rachel Game, Governor Observer Melissa Brown, OD Practitioner Elaine Richards, HR Business Partner – Warrington Adults		

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
UPDATED PEOPLE COMMITTEE BUSINESS CYCLE - **EDI CONSIDERATIONS**	BAF 5 and 6		The updates People Committee Business Cycle with revised reporting for EDI, was presented by Ruth Besford, Equality and Inclusion Manager. This report provided members with a draft equality reporting schedule for the Committee's business cycle for 2023/24. This review has been undertaken following changes made nationally to reporting for Workforce Race and Disability Equality Standards, and Equality Delivery System reports; and following queries raised previously regarding reporting dates for Gender Pay Gap report and action plan.	The Committee approved the changes to the business cycle proposed.
RISK REPORT UPDATES • **HR** • **OD/EPD** **COMMUNICATION**	BAF 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 (RMC). **HR Risk Report** During the reporting period there are a total of 2 risks detailed on the HR Risk Register, both of which were scored below 12 as at 3rd April 2023.	The Committee noted the content of the reports and were assured that the risks were being managed appropriately.

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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			Risk No: 3059 - Ongoing Industrial/Strike Action linked to National Pay award. Risk level reduced during the period of consultation with members relating to the government pay offer whilst agreements were in place to pause industrial action with those Unions covered by Agenda for Change terms and conditions. A risk score of 9 is reflective of the risk status as at 3rd April. As of 17.04.23 risk score returned to 3x4 = 12 to reflect the reinstatement of planned industrial action by the RCN between 30th April – 1st May inclusive. Control measures continue to be applied. No derogations agreed. Notification submitted to the RCN regarding increased rates of pay for those staff prepared to work to fulfil minimum staffing levels in priority 1 services. UTC closed due to an inability to safely staff the service. - Industrial Action Planning meeting established including Sitrep requirements. - Strike Committee established between on strike days. - Local Incident Team established on site at Europa Point on strike days. - Clinical Support Hub Established for any clinical related queries established and will be on site at Europa Point. - On call arrangements being enhanced. - Action Cards created for staff to follow. - Manager's Guide and Staff FAQs have been cascaded.	

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			- Continuous staff, patient and partners communications. Additionally, by way of providing the most up to date information, the Committee were informed of our awareness of the RCN's intention to re-ballot, although we have had no formal notification of dates via the RCN. Additionally we have had formal notification from the BMA to advise of their intention to ballot their members from 15th May 2023 – 27th June 2023. **Educational and Professional Development (EPD) and Organisational Development (OD) Risk Report** During the reporting period there is 1 risk detailed on the EPD and OD Risk Register: • Reduction in Mandatory Training compliance as a consequence of the pandemic response. This risk was created following the recommendation of the RMC to merge the two previous risks and create one overall mandatory training compliance corporate risk, covering all reported core statutory and mandatory training titles together. It was recognised by the RMC that areas of low compliance within individual services should be recognised and managed locally. It was agreed that service specific risks should logged and assessed to address these areas as required.	

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Committee Chair's Report

NHS
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			Communications Risk Report	
			During the reporting period there is 1 risk detailed on the Communications Risk Register:	
			• Bridgewater staff intranet – continuity of service	
			Following the last presentation to People Committee in January, the risk remains unaltered although work is happening behind the scenes between the Communications Team, IT Team and Procurement Team in the potential of working with a preferred digital supplier.	
			As a new extranet will need to be procured and built, an estimated date would be anything up to 20 weeks. This would extend the current thought of completing the task in Quarter 1 in the 2023/24 financial year. It is likely that any completion would now extend to later summer 2023.	
			Dedicated Communications Team resource, using the current establishment, is focusing on this Extranet task so progression can continue.	
IQPR – PEOPLE INDICATORS	BAF 5 and 6 WLR 9 PP 1-7		The IQPR people indicators report was presented by Jo Waldron, Deputy Director of People and Organisational Development for month 8. Four of the five People Indicators were reporting as red – the exception being Induction which is reporting green. Four of the indicators however PDRs, Sickness (actual and rolling) and Turnover still remain adrift from the Trust targets.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings.

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			Overall Turnover in month 9 is at 27.91% which includes those who have transferred out of the Trust by way of TUPE; however Voluntary turnover is at month 9 is at 14.95% which has decreased from 15.20% in month 8. When compared with similar local Trusts, who haven't been impacted as significantly by the transfer of services, we are not a significant outlier.

Themes from Exit Interviews and On-boarding surveys were presented in the report.

Turnover data along with Exit Interviews and Onboarding surveys, in relation to Trust wide themes, are included in the data provided at the Recruitment and Retention POD and Trust wide actions across all of the POD's aim to address our Retention actions in line with the NHS Nursing and Midwifery Retention Toolkit and our Engagement with the ICB Retention Lead. The Committee are familiar with the work being undertaken in the PODs via the regular POD report.

Additionally, this data is provided at a Directorate level to the DLTs so that local action planning can take place via the Staff Survey Action Plans. These plans are monitored through Performance Council.

A discussion took place in relation to incentives and our ability to potentially offer additional incentives where possible. The Director and People noted that there are local Trusts who are offering incentives outside of Terms and Conditions, which is at odds with how the ICB have asked for consistency in offer by way of supporting a systems approach | |

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			to Retention. This has been discussed at a system level and the challenges Trusts face who are in fact adhering to a system wide approach. It was noted that our commitment is in addressing the issues that we can directly impact on such as better career progression opportunities, flexible working, health and wellbeing etc as per the work of the POD's and DLT's. Papers presented later in the agenda outlined the actions being taken to address those other indicators that remain below the Trust target.	
DIRECTOR'S UPDATE REPORT	BAF 5 and 6 WLR as highlighted in the report PP as highlighted in the report		The Director's Update Report was presented by Paula Woods, Director of People and OD, for information and assurance purposes. The report provides high level 'people' updates at national, regional, and local levels. The following areas were tabled in the report with key areas highlighted to the Committee by Paula Woods, paying attention to any developments since the writing of the report by way of verbal updates: The Director's update report covered the following: - Industrial Acton Update - NHS England People Updates, including International HR Day - National People KPI and Customer Feedback Framework - National People Policies – Development Programme	The Committee noted the report and its comprehensive contents. Further updates on the workstreams will be provided in future meetings as they progress.

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Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
		■	- North West Wellbeing & Sickness Absence Policy – Early Adopter Update - Cheshire & Merseyside Resilience Hub Update - NHS Cheshire & Merseyside Workforce Event – 31st March - Cheshire & Merseyside HR Directors Update - Warrington Together: Workforce & OD Enabling Group Update - Our Just & Learning Culture – showcasing our progress - North West Agency Cap Compliance - North West publicising of our PODs as best practice - People Operational Delivery Council Proposal – amalgamation of PODs - IQPR People Indicators – Rates and Targets Review - Council of Governors Meeting – People Directorate Overview - Leader in Me Feedback – 21st of April - Reciprocal Mentoring for Inclusion Programme Update - North West BAME Assembly Letter to Chairs and CEOs - Children's Services: 0-19 (25) Tender and Bidding Process – Formal Award of Contract - Staff Relocation Consultation	

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
NATIONAL STAFF OPINION SURVEY – ACTION PLAN UPDATES	BAF 5 and 6 PP 1-7		The National Staff Opinion Survey – action plan updates was presented by Eugene Lavan, Deputy Chief Operating Officer for information and assurance purposes. Overall, the Trust received pleasing scores across the survey results, however there were challenges identified in some of the Directorates. There are individual factors for each of the Directorates which may have potentially affected the staff survey results and there are also the more general challenges to all staff of working in the NHS. The paper recognised that the approach utilised has enabled actions to be taken forward but there is learning which now needs to be embedded that will help progress this further. Following the staff survey in 2021, action plans were developed by each Directorate to address the areas where it was identified that more focus and targeted support was required to address the deficits identified by staff in the feedback. The plans were put in place and reviewed in a monthly basis at Performance Council where a discussion took place on delivery against the plans and any areas of positive progress. This is the first time in which this approach has been used and co-ordinated by the Directorate Leadership Teams which the support of the Communications Team and then reviewed at Performance Council. Across the Directorates there is clear improvement in the staff survey scores most notably in:	The Committee noted the content of the report and the governance arrangements in relation to action planning.

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Committee Chair's Report

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			- Halton Adults - Warrington Childrens - Dental East - Dental West There are still challenges most notably in: - Dental Central - Warrington Adults - Halton Childrens - St Helens Childrens The individual Directorates have reviewed the actions undertaken and the effectiveness of these and details were provided to the Committee. The report highlighted some the challenges faced during the staff survey action plan delivery period: - Impact of the pandemic on staff, feelings of exhaustion and the challenges of continuing to work in very stressful situations. - In Dental, there was a significant Clinical and Operational Management Restructure. - In Warrington Adults challenges in relation to recruitment of senior operational management roles and district nursing posts. - In Halton Adults, the interim Associate Director finished her contract, and a permanent appointment was made.	

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			- In the Children's Directorate, the Warrington 0-19s service was made aware that it was subject to a procurement process. The report highlighted some of the learning identified: - Robust involvement of staff in shaping the action plans. - Visibility of senior managers and Executive Team - Learning to celebrate success. - DLTs need to work more closely to ensure cross learning from things that have gone well. - Developing confidence in Operational Managers to support better flexible working - The importance of Team meetings. The Committee noted the positive links between the actions identified and the links to the work of the POD's. It was discussed how the results and the overall People Indicators suggested that some Directorates had more challenges than others i.e. Warrington Adults in particular was discussed. The Deputy Chief Operating Officer highlighted that better cross Directorate learning is needed to ensure best practice sharing. Jeanette Hogan, Deputy Chief Nurse highlighted the work being taken forward in relation to Quality Visits, particularly in District Nursing.	
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET OF 4.8%	BAF 5 and 6		The Review of Sickness Absence against Trust Target report was presented by Jo Waldron, Deputy Director of People and	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.

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Committee Chair's Report

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	WLR 8 PP 4		Organisational Development for information and assurance purposes. Trust sickness absence for the period 01 April 2022 to 31 March 2023 was 6.30% compared to 01 April 2021 to 31 March 2022 (6.83%). Over the 12-month period, rolling sickness absence rates increased month on month from April to August 2022 but decreased month on month from September 2022 to February 2023 Rolling Sickness increased in February 2023 (6.41%) and decreased to 6.30% in March 2023. Actual sickness absence % rate has fluctuated month on month over the 12-month period; however has decreased to 5.50% in March which is the lowest we have seen since August 2022. Stress continues to be our highest reason for absence. We are seeing a steady increase in the uptake and recording of stress risk assessments with more targeted support from the HR Team in Directorates, which is monitored at DLT's and Performance Council. Training is being rolled out by our Health and Safety Specialist who is also looking at how we can make the Stress Risk Assessment form more user friendly. Our Performance Team are looking at the opportunity for us to make it electronic for better recording and monitoring.	
EMPLOYEE RELATIONS REPORT INCLUDING FREEDOM TO SPEAK UP REPORT	BAF 5 and 6 PP 3		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 report was noted by the Committee.

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		🟩	The report details numbers of ER Cases, numbers of Freedom to Speak Up (FTSU) cases and as per our Just and Learning Journey the report 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. As per the request at the Committee in May, the report also detailed the Employee Relations cases by Ethnicity. Minority representation equates to 16% of cases pertaining to conduct, although the low numbers of cases can skew this percentage. The Workforce Race Equality Standard (WRES) tracks details of the ethnicity of employees involved in disciplinary cases for the period April – March in each tax year and is due for submission to Board later this year. Over the rolling 12-month period, a total of 18 employee relations cases have been opened. Following the adoption of the Just Culture '4 step' approach (going forward labelled as the 'informal' procedure), the number of cases where this has been adopted is 9 in total. **Freedom to Speak Up (FTSU)** Speaking Up activity in 2022/23 has increased by 77% which is positive, however overall numbers remain low. A Lead Freedom to Speak Up Guardian was appointed in January 2023 and will continue to grow the FTSU agenda.	The Committee asked that the next report presented includes a breakdown of cases by Directorate.

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		🟩	According to the 2022 Staff Survey, there has been a negative differential in the experiences of staff speaking up in relation to clinical versus non-clinical concerns. The report detailed the following: - An overview of developments including current mechanisms for 'Speaking Up' - Activity undertaken during 2022/2023 - Data in relation to the number and type of cases raised via 'Speaking Up' processes. - Details of the national staff survey results relevant to 'Speaking Up'. The Committee asked that the next report presented includes a breakdown of cases by Directorate. Tania Strong, Head of HR advised that she would endeavour to provide this, providing the information was not person identifiable.	
SYSTEM STAFFING IMPLEMENTATION UPDATE	BAF 5 and 6	🟩	The System Staffing Implementation Update report was presented by Jo Waldron, Deputy Director of People and Organisational Development for information and assurance purposes. The E-Rostering system is now live within all teams. Dental Services went live in April 2023.	The Committee noted the reports and were assured on the progress and plans.

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			Services have identified the benefits of the system via feedback sessions with the E Roster Team which are essentially better planning ability, better oversight of staffing to support cross cover and the ability to process information in one system, saving time and resource. E Scheduling –Allocate and EMIS have confirmed the interface between the systems and work has commenced. To support the interface of the systems and the introduction of E Community within the Halton District Nursing Team a series of training meetings started on the 6th of February 2023. The E Community product team from Allocate came into the organisation on the 4th of May 2023 to start the testing on the interface of the systems. Following the implementation of the system and now all services are live the future paper to the committee will be reviewed with the Deputy Director of Nursing.	
HR POLICIES AND PROCEDURES	BAF 5 PP 1,3,4 and 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. The last policy update presented to People Committee was in March 2023. There have been no policies scheduled for refresh since January 2023 and so HR Policy Group meetings have been stood down. A summary of progress of policies updated on in January People Committee is detailed below:	The Committee noted the content of the report.

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			• **Freedom to Speak Up in the NHS Policy** – Further consultation required to include Audit Committee via HRPG. The revised policy will be re-presented to JNCC members in June for their final approval and replaced on the intranet immediately after. The policy will be next reviewed in June 2026. • **Staff Carer Support Policy** - Decision required as to whether the policy is to be a standalone policy or an addendum to the Special Leave Policy. Paula Woods is to present the policy to EMT in May and then feedback the agreed action to the Policy Author for reflection into the policy. The revised policy will then go back to the Staff Carers Group for discussion, HRPG and JNCC for final approval. At this stage dates are still to be agreed. • **Underpayment/Overpayment Policy –** Further discussion required with staff-side to agree wording in the policy where overpayments/underpayments are due to manager error, as opposed to employee. Agreed that Paula Woods and Denise Bradley would in partnership, review the wording/the process and agree a mutually acceptable way forward. Narrative will be agreed and fed in to the policy by the Policy Author, and then the policy would be represented to HRPG for discussion and then back to June JNCC for sign off.	

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Committee Chair's Report

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COMMUNICATIONS UPDATE	BAF 5 PP 1-7		The Communications Update paper was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. **General Communication to Note** - Industrial Action. - New Extranet to replace the Hub. - NHS Staff Survey Action Planning. **Internal and External Communication** - Trust Strategy. - Leader in Me event. - Recruitment. - Dental – Altrincham Hub. - Paediatric Neurodevelopment Assessment Pathway. - Drive Ability North West – 30th Birthday Celebration. - Civility and Respect Campaign. - Bridgewater Health & Wellbeing rebrand. To further promote the health and wellbeing offering here at Bridgewater **Partnership Update** - System engagement. We have joined the now combined One Halton and Warrington Together partnership call - Provider Collaborative. **Horizon Planning** - Changes to the team. - Industrial Action.	The Committee noted the reports and were assured on the progress and plans.

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			- Bridgewater 'Thank You' Awards. Planning will soon start for the 2023 'Thank You' Awards as nominations will need to open in the coming weeks. - Community Health and Wellbeing Workers. - Recruitment. - NHS75. Greater focus will start to filter through from NHS England over the next few weeks as the NHS celebrates its 75th birthday in July.	
DELIVERY OF OCCUPATIONAL HEALTH SERVICES (ANNUAL UPDATE INCLUDING PROGRESS ON PROCUREMENT)	BAF 5 and BAF 6 PP 4 WLR 8		The Delivery of Occupational Health Services – Annual Report was presented by Tania Strong, Interim Head of HR for information and assurance purposes. The Trust's Occupational Health Services are provided externally by People Asset Management (PAM) - they were awarded the contract and commenced provision of the Trust's Occupational Health offer on 1st April 2021. PAM offer a fully consolidated Occupational Health Service including: - Occupational health appointments via management referral - Support and advice for musculoskeletal issues - Physiotherapy - Pre-employment screening - Vaccinations and health surveillance for staff - Needlestick injury support - Stress management support - Ergonomics advice	The Committee noted the reports and were assured on the progress and plans for contract renewal.

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			- PAM Assist (Employee Assistance Programme) – a 24 hour / 7 days per week confidential helpline providing advice and support on a range of issues including bereavement, divorce, addiction and stress. - Counselling and cognitive behavioural therapy The contract is scheduled for review in April 2023. In May 2022, PAM introduced a 5% cost increase, which was levied across the full range of services. Further clarification was sought on the rationale for the cost increases and provided to the procurement team. At present procurement colleagues are currently drafting a recommendations paper for the Trust to consider regarding the two year extension. Contract provision is monitored via monthly contract review meetings which includes attendance from the Procurement Team. A suit of KPIs forms part of the contract for services. In conjunction with the issuing of a new contract for the Occupational Health Service, the suit of KPIs attached to the contract will be refreshed. The refresh is in response to the capabilities of the MIOHIO referral management system operated by PAM. Payment for services is via a 'pay as you go' expenditure rather than via block contract. In order to ensure reduction of waste, DNAs and late cancellations (within 48 hrs) are monitored and analysed by the HR Business Partners and any themes or concerns escalated to the Divisional Leadership Teams to address.	

■ No assurance – could have a significant impact on quality, operational or financial performance;	Please complete to highlight the key discussion points of the meeting using the key to identify the level of assurance/risk to the Trust
■ Moderate assurance – potential moderate impact on quality, operational or financial performance	
■ Assured – no or minor impact on quality, operational or financial performance	

Committee Chair's Report

NHS Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			The report received by the Committee detailed the activity across the contract. The overview of annual activity for provision of the current contract is good and the HR team continue to focus on data driven improvements, and work with PAM to drive data reporting improvements in 2023/24.	
EQUALITY, DIVERSITY & INCLUSON – *no items for May as per Business Cycle*			No items as per business cycle	
ORGANISATIONAL DEVELOPMENT UPDATES:	BAF 5 and 6 PP 4 and 5		Three reports were presented for information and assurance purposes – PPDR & Mandatory and Statutory Training Compliance and the Talent Management and Succession Planning and Staff Engagement and Recognition Annual Report.	PPDR, S&MT compliance is being actively monitored and staff have been asked to ensure full compliance by 31st July 2023.
PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE	BAF 5 and 6 WLR7 and 8 PP 1, 4 and 5		The PDR and Statutory and Mandatory Training Compliance Report was presented by Adie Richards, Education and Professional Development Lead for information and assurance purposes. Month 12 compliance with Mandatory Training shows 19 requirements at green, 3 at amber and 1 at red. PPDR compliance at Month 9 stands at 70.56%. Updated communications have been cascaded via Team Brief and internal meetings to ensure full compliance by 31st July 2023. The focus on communications is ensuring that we	The Committee noted the reports and were assured on the progress and plans, as above. Positive compliance trends were noted. Next report to include compliance rates by Directorate.

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🟧	Moderate assurance – potential moderate impact on quality, operational or financial performance
🟩	Assured – no or minor impact on quality, operational or financial performance

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Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			create the right environment for staff to complete their mandatory training, through protecting time in E-Roster and ensuring that compliance with mandatory training is given as much attention as seeing patients. Consideration is being given to a set of principles for the managing and handling non-compliance post 31st July 2023, however only where staff have been given every opportunity to ensure compliance. At Risk Management Council (RMC) in February, it was recognised by the Council that there are limitations in this solely being a Corporate risk and there was a recognition of the support that is provided by the EPD team. It was agreed that areas of low compliance within individual services should be recognised and managed locally, and service specific risks should be raised and assessed to address these areas as required. The Committee asked for compliance rates by Directorate for the next meeting.	
KNOWLEDGE AND LIBRARY SERVICE ANNUAL REPORT	BAF 5 and 6 PP 1, 4 and 5		The Knowledge and Library Service Annual Report was presented by Razia Nazir, Library Services Manager for information and assurance purposes. The Library and Knowledge Service (LKS) aims to ensure community-based staff, learners in practice, associated Trust partnerships and students working across Bridgewater have a	The Committee noted the reports and were assured on the progress and plans.

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🟩	Assured – no or minor impact on quality, operational or financial performance

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

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			consistent experience of accessing library expertise and resources.	
			LKS user activity presented shows the service saw increased user activity in 2022-23 as a result of the post pandemic rise in learners and a higher number of apprenticeships across the Trust.	
			The Quality and Improvement Outcomes Framework (QIOF) aims ensure that for Trusts in receipt of funding through the NHS Education Contract, that there is a proactive, high-quality knowledge and library service that is available to all staff and learners. Bridgewater were assessed in 2020/21 and the report detailed the national picture for the assessed period of 2020-2021. The Bridgewater LKS QIOF validation report was presented and reflected the national pictures placing most services at levels 1 and 2 across the six assessed.	
			The NHSE have acknowledged that the period of self-assessment was during unprecedented pressures on the NHS therefore is not representative of a 'typical' year. Also, Bridgewater LKS was also either under-staffed or unstaffed during this period. Action plans are in place and some areas have already seen significant progress.	
			2022-23 has been a difficult year for service provision due to staffing with a limited service offer since September 2022. Currently the LKS is staffed by a full-time Knowledge & Library Manager. The 0.5 FTE Librarian left the Trust in September 2022, and the post is vacant. The Library Services Manager	

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Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			advised the Committee that she will be reviewing the job description to encourage a better candidate pool. The Committee noted some historic cases studies in the report that pre-dated the pandemic. It was agreed that once the service is fully staffed that more recent and relevant case studies should be undertaken.	
APPRENTICESHIP SCHEME AND LEVY	BAF 5 PP 1-7		The Apprenticeship Scheme and Levy Report was presented by Jo Waldron, Deputy Director of People and Organisational Development for information and assurance purposes. - There are currently 65 employees registered as apprentices across the Organisation. - Additionally, the Trust have approximately 40 further planned apprenticeships starts in Q1 and Q2 of 2023/24. - Of the 105 existing and planned apprenticeships, 36% were or will be directly recruited into apprenticeship positions. - 5.06% of all new starters in 2022/23 were directly recruited as apprentices. - The Trust have reported a figure of 2.59% against the 2.3% Public Sector Apprenticeship Target, which reflects the percentage of apprenticeship starts (both new hires and existing employees who started an apprenticeship) in 22022/23 as a proportion of Trust's total headcount.	The Committee noted the report and recognised the significant work and progress with the Apprenticeship agenda.

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

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			- Of the 105 existing and planned apprenticeships, approximately 66% are or will be undertaking programmes that are clinical in nature, many leading to professional registration, with either the NMC or the HCPC. In 2022/23 the Trust spent £234,364 on Apprenticeship training, an increase of £76,848 from the previous financial year. The total Apprenticeship Levy expiry for 2022/23 was £43,672.56 significantly lower than all previous years since its introduction. Since November 2022 the Trust has sustained zero expiry month on month and projects that this will remain at zero moving forward due to significantly increased spend and utilisation of funds.	
MIAA INTERNAL AUDIT UPDATE - **MANDATORY TRAINING AND APPRAISALS REVIEW** - **PAYROLL FEEDER SYSTEM REVIEW**	BAF 5 and 6 PP 1 and 5		The Mandatory Training and Appraisals Review and Payroll Feeder System Review were presented by Jo Waldron, Deputy Director of People and Organisational Development. **Mandatory Training and Appraisals Review** - The Trust received Moderate Assurance - Lots of areas of good practice identified. - Areas of improvement related to compliance rates, which the Committee are well informed on and Quality Assurance processes. - Deputy Director of People and Organisational Development highlighted the plans in place to address the quality controls	The Committee noted the reports and were assured on the progress and plans.

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■	Assured – no or minor impact on quality, operational or financial performance

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

Committee Chair's Report

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			Payroll Feeder System Review - The Trust received Substantial Assurance - Significant areas of good practice - Key actions are in relation to the management and handling of late submission of forms - Committee members highlighted the plans in please to address	
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	BAF 5 and 6		It was suggested by Jan McCartney, Trust Secretary that a full review of the BAF will be taking place at the Board Development session on 11th May 2023	Update of BAF to be concluded following the Board session on 11th May 2023.
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 5 and 6		None	N/a
REVIEW OF MEETNG ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			Christine Stankus, Lead Governor reviewed the meeting as positive and informative. There is good discussion and support from the Non-Executive Directors. Lots of positive work taking place.	
Risks Escalated			None.	

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Moderate assurance – potential moderate impact on quality, operational or financial performance	
Assured – no or minor impact on quality, operational or financial performance	

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**		**Date**	**01/06/23**
Agenda Item	**41/23ii**			
Report Title	**UPDATE ON INDUSTRIAL ACTION AND PAY DEAL**			
Executive Lead	**Paula Woods - Director of People and Organisational Development**			
Report Authors	Eugene Lavan – Deputy Chief Operating Officer Paula Woods - Director of People and Organisational Development			
Presented by	Mike Baker – Deputy Director of Communication & Engagement			
Action Required	☐ **To Approve**	☒ **To Assure**		☒ **To Note**
Executive Summary				

The Trust was advised on the 18th of April that RCN industrial action (IA) would take place from 8pm on Sunday the 30th of April to 8am Tuesday the 2nd of May. This encompassed overnight hours and a bank holiday Monday. Originally IA was planned to continue up to 8pm on Tuesday but this was changed following a successful legal challenge.

The Trust's Industrial Action Task and Finish group was mobilised to plan and co-ordinate our response to the IA.

All services were included in the strike action - there were no derogated services.
The Local Incident Team (LIT) was mobilised to support our staff working and those on the picket line.

Four out of five of our previously derogated services (District Nursing, UCR, IV therapy, Padgate House) were staffed to minimum agreed levels. One service, the Urgent Treatment Centre (UTC), could not be staffed safely and was therefore closed.

The Trust cancelled 215 appointments, and 48 shifts were not filled due to strike action.
The Trust Board and staff were kept up to date with the development via our well established communication channels.

Staff were supported leading up to, during, and after the period of industrial action.
Leaders in the Trust attended services to speak to staff and offer face-to-face support.
On-call arrangements were robust and clearly communicated and understood.

On the 2nd of May, the NHS Staff Council convened and formally signed off the pay deal which the majority of Agenda for Change Trade Unions accepted. Those who did not accept were Unite and the RCN. Agenda for Change colleagues will receive additional payments in relation to last year and a minimum 5 per cent uplift for this financial year. This pay deal does not include doctors or dentists.

Pay deal implementation is set for June and staff are being kept fully briefed as to the requirements for processing, along with an option to receive the lump sum amounts by way of monthly instalments.

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

Strategic Objectives
☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☐ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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**

Title of Meeting	**BOARD OF DIRECTORS**	Date	**1ˢᵗ June 2023**
Agenda Item	**41/23ii**		
Report Title	**INDUSTRIAL ACTION UPDATE AND PAY DEAL**		
Report Authors	Eugene Lavan - Deputy Chief Operating Officer Paula Woods – Director of People and Organisational Development		
Purpose	To update the Board on the Trust's planning and response to the RCN strike action on 30ᵗʰ April and 1ˢᵗ May 2023 respectively. To update the Board on the industrial action ballots that are currently taking place at the Trust (the RCN and the BMA). To update on the Agenda for Change pay deal and its implementation.		

1. OVERVIEW

1.1   On the 18ᵗʰ of April, the Trust was informed by the RCN that their members (and our employees) were authorised to take discontinuous industrial action (IA). The days of industrial action were Sunday 30ᵗʰ of April from 20.00pm to Tuesday 2ⁿᵈ of May to 08.00am. This encompassed overnight hours and a bank holiday Monday.

1.2   The industrial action was in the form of strike action. We received a list of 408 RCN members who could participate in the strike.

1.3   The Industrial Action Task & Finish (T&F) group was mobilised to manage the Trust's response to minimise the impact of the industrial action on our patients, our staff and the wider health and care system.

2. SERVICE AND WORKFORCE ASSESSMENT

2.1   The strike action affected our Adult Services in Warrington and Halton and Children's Community Nursing Team (CCNT) in Warrington. Dental services were mainly unaffected. We were notified that the RCN's terms of reference for this Industrial Action was across all services and included proposed strike action in those previously derogated services (priority 1 services). Therefore, there were no services eligible to be derogated in this industrial action.

3. GOVERNANCE

3.1   Following the RCN and Unison strikes, the Industrial Action Task & Finish Group has

continued to meet on a weekly basis. In addition, daily meetings took place from 17th April up to 28th April.

3.2   The T&F Group membership includes Senior Operations staff, Nursing, Human Resources, EPRR and Communications representatives.

4. SELF-ASSESSMENT CHECKLIST

4.1   As per previous strike days, the ICB issued a self-assessment checklist to support organisations in their planning and operational readiness for planned industrial action. The checklist covered: engagement with unions, planning, command and control, mitigations and capabilities, clinical priority areas, estimated workforce and activity impacts, staff, patient, and public communications and staff health and wellbeing.

5. ENGAGEMENT WITH UNIONS

5.1   Prior to and during this industrial action there was limited engagement with the RCN, despite the Trust's attempts to make contact. This position was also experienced by other Trusts, as confirmed by various feedback from Trust employees following ICB led Nursing and HR updates.

5.2   The picket line was confirmed to be at the Wolves Stadium between 10am and 2pm on Monday 1st of May. Unlike last time, there were no requests for facilities etc.

6. COMMAND AND CONTROL

6.1   A Local Incident Team (LIT) was established comprising of the Trust's EPRR Lead, Associate Directors (Operations), the Deputy Director of People & OD, the Deputy COO and Deputy Chief Nurse. A control room (the Boardroom at Europa Point) was identified by the LIT. The LIT also provided support to our staff on the picket line, which was important learning from the first RCN industrial action.

6.2   Two SITREPs (situation reporting) required completion during the strike period and for seven days after the industrial action – Workforce and Activity (cancellations).

7. SERVICE AND WORKFORCE ASSESSMENT

7.1   The original planned strike action included Tuesday the 2nd of May. However, this was subsequently deemed to be unlawful and removed from the planned dates.   This meant that none of our elective services would be impacted and therefore no planned clinic appointments were cancelled for these services.

7.2   The affected services therefore were our previously derogated services:

Table 1 - List of Previously Derogated Services (Priority 1 Services)

1. UTC, Widnes
2. District Nursing Day Service, Halton
3. District Nursing Out of Hours Service, Halton
4. District Nursing Day Service, Warrington
5. Out of Hours Services Service, Warrington
6. Rapid Community Response Service (UCR Halton and Warrington)
7. IV Therapy (OPAT), Warrington and Halton
8. Padgate House, Warrington

7.3   Based on initial conversations with staff on their striking intentions, our initial assessment was that we would be able to provide:

- A minimum service to our UCR teams, IV Therapy and Padgate House
- No service in the UTC
- An unsafe day time service on Monday for critical patients ("life and limb")
- No service for out of hours on Sunday and Monday for critical patients

As at the 21st of April, across all our previously derogated services there was a shortfall of 72 shifts.

7.4   A paper with recommendations to mitigate these risks to our patients and staff was discussed on the 25th of April. EMT approved a pay offer to staff who had either previously been rostered or agreed to work during the industrial action. The approved pay offer was to pay staff for a double shift, plus enhancements for working weekends/bank holidays. The administration of this was supported by the Trust's Workforce and E-roster Teams.

7.5   The staffing rota was updated once the offer was made to staff. On the 27th of April the number of unfilled shifts had reduced to 28 (from 72).   The Trust was now able to staff all services to the minimum standards required, except for the UTC.

7.6   At the same time as the pay offer was being shared with staff, a local System call was set up to explore the potential to staff the UTC and avoid closure (our local Systems were also being briefed via the daily System calls). Despite the offer of additional GP support, there would still be no Advanced Nurse Practitioners on duty in the UTC and it was decided that the GPs would be better deployed into the Runcorn UTC. The decision was taken to close the UTC on Monday the 1st of May and close it at 8pm on Sunday the 30th of April.

7.7   Meanwhile, at a national level, the RCN announced on Friday the 28th of April that they had agreed a process for the submission of "safety critical mitigations". This allowed Trusts to agree minimum staffing levels with the RCN (as per previous arrangements with "derogated" services). The Trust submitted safety critical mitigations for the UTC and District Nursing.

7.8   Both our submissions were approved by the RCN. However, despite this,

staff are not mandated to attend for work if they chose not to. Unfortunately, we were not able to identify staff to be enable us to keep the UTC open on the 1st of May.

8. STAFF, PATIENT, AND PUBLIC COMMUNICATIONS

8.1 Staff have been kept regularly updated via the Bridgewater Bulletin and Team Brief on the preparations for industrial action. The Communications Team also prepared the use of social media channels to communicate with the public regarding services and their availability on strike days. The local health and care systems and ICB were also updated on a regular basis.

8.2 In keeping with our compassionate leadership principles, we ensured that staff were very clear that we understood that the dispute was with the Government and not with the Trust as such. Messages communicated to staff acknowledged and reinforced that we understood that their decision to strike had not been taken lightly, particularly as any action taken would be unpaid.

9. STAFF HEALTH AND WELLBEING

9.1 Health and wellbeing support was planned to be made available before, during and after the strike. Managers were supported to engage in open and supportive Health and Wellbeing conversations with their Teams. Staff were offered the opportunity to talk to an alternative Manager, or their HR representative if they felt they needed additional support. Information in relation to all our Health & Wellbeing offers is on the Health Hub pages of the Bridgewater HUB/Intranet. The People Directorate's Teams were also on hand to provide support and signpost staff wherever necessary. Staff were also supported to work from alternative bases if they did not wish to cross the picket line to attend work.

10. WORKFORCE AND ACTIVITY SIT REPS

10.1 **Activity** - across Warrington and Halton Boroughs, 215 patient appointments were cancelled in District Nursing over the strike weekend.

10.2 **Workforce** - On Sunday evening and overnight, there were 13 shifts that were unfilled due to strike action and on Monday there were 35 shifts.

11.1   The Trust was notified of two ballots for industrial action as per the British

11. FURTHER BALLOTS AND THE POTENTIAL FOR FURTHER INDUSTRIAL ACTION

Medical Association and the Royal College of Nursing. The BMA are balloting 9 of its members, whilst the RCN is balloting approximately 400 members.

11.2   The ballot for the BMA runs from the 15th of May to the 27th of June.

11.3   The RCN's ballot runs from the 23rd of May until 11.59am on the 23rd of June.

11.4   The Board will be kept up to date on ballot outcomes in the usual way and our well established mechanisms for the planning of such action will continue as will our support for those staff affected by any further industrial action.

12. PAY DEAL UPDATE

12.1   The Trust's Board and staff have been kept up to date on the pay offer and deal as accepted by the majority of Agenda for Change Trade Unions, as announced by the NHS Staff Council who formally met on the 2nd of May.

12.2   The following communication went out to staff to outline the pay principles and implementation timeframes, along with choices to have the non-consolidated pay, put through salaries in instalments.

📢 IMPORTANT: Pay Award Update

We are now in receipt of important information about the forthcoming pay award.

Please make sure you read this communication carefully. Managers and Team Leaders are asked to make sure this information is cascaded to your teams, including those who may be absent from work, as some colleagues will need to take action.

As a quick reminder, Bridgewater Agenda for Change (AfC) colleagues will receive additional payments in relation to last year and a minimum 5 per cent uplift for this financial year. This follows a recent NHS Staff Council meeting with the Government last month.

Eligible staff can expect to receive the additional payment and pay rates (including back pay to 1 April 2023) as part of their pay in June.

Important: All staff are encouraged to familiarise themselves with the Frequently Asked Questions (FAQs) which can be found on the NHS Employers website as follows:

→ **NHS pay offer - Frequently Asked Questions**

Important: Colleagues have the option to request payment of the two non-consolidated amounts to be made in instalments.

As a result, staff have two options only:

- **OPTION 1 – One lump sum (no action required)**

- **OPTION 2 – Ten equal instalments - June 2023 to March 2024 (action required)**

So we can correctly pay those colleagues who wish to spread their non-consolidated payment equally over ten months, a form must be completed by each individual staff member who wishes to take up the offer of split payments (OPTION 2):

⊡ **AfC Non-Consolidated Payments in Instalments Opt In Form**

This form must be completed and submitted by 11.59pm on Wednesday 31st May 2023 in order for the payment to be made in multiple instalments. We are unable to process any late forms in relation to the pay offer or any other forms in relation to pay received after this deadline.

Important: If you are happy to receive the full payment as one lump sum (June pay), no action is needed. You do not need to fill in the form as this will be paid automatically in line with the Pay Offer.

12.3   The Trust's Workforce Team have been supporting staff to ensure that all payroll forms are processed on time.

12.4   The payments will be made in June salaries and will be backdated accordingly.

13. RECOMMENDATIONS

13.1   The Trust Board are asked to:

- Note the planning, engagement, risk assessment and implementation of our industrial action response to the RCN strike action.
- Note the actions taken to mitigate the impact of strike action to enable the Trust to continue to deliver minimum service levels in four of our previously derogated (priority one) services.
- Note the decision to close the UTC for the duration of the industrial action.
- Note the further ballots being conducted at the Trust by the BMA and the RCN.
- Note the pay award/deal developments and plans for June implementation.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01/06/23**
Agenda Item	**41/23iii**		
Report Title	**STATUTORY AND MANDATORY TRAINING AND PPDR – ACTION PLANS**		
Executive Lead	Paula Woods, Director of People and Organisational Development		
Report Author	Paula Woods, Director of People and Organisational Development		
Presented by	Mike Baker, Deputy Director of Communications and Engagement		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

As reported at April Board, throughout the previous year, the Trust has been focused on ensuring the appropriate compliance with Statutory and Mandatory Training and PPDR compliance.

Section three outlines the mandatory training compliance rates over the previous five months, with the latest data presented for month 1 (April 23). Month 12 data was presented to the People Committee on the 10th of May 2023, as per the latest information available at the time of reporting.

The paper presented to Board in April 2023 detailed the communications and support put in place across the Trust to ensure compliance.

Despite the support put in place, compliance levels still remain below target in a number of high-risk modules and as a result further communications, as outlined in Section four, have taken place across the Trust to ensure full compliance.

Consideration is being given to a set of principles for the managing and handling of non-compliance post 31st July 2023, which the Board are sighted on and will receive a further update.

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

Strategic Objectives

☒ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☒ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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**	**01 June 2023**
Agenda Item	**41/23iii**		
Report Title	**STATUTORY AND MANDATORY TRAINING AND PPDR – ACTION PLANS**		
Report Author	Jo Waldron, Deputy Director of People and Organisational Development		
Purpose	To provide an update on the compliance with mandatory training and PPDRs within the Trust along with details of the planned actions to address non-compliance		

1. SCOPE

1.1 This paper provides an update on the compliance with mandatory training and PPDRs within the Trust and details of the planned actions to address non-compliance.

2. INTRODUCTION

2.1 As reported at April Board, throughout the previous year, the Trust has been focused on ensuring the appropriate compliance with Statutory and Mandatory Training and PPDR compliance.

2.2 This reports outlines our current progress against the targets for PPDR and Statutory and Mandatory Training rates along with the action planning and communication approaches across the Trust to ensure full compliance by 31st July 2023.

3. COMPLIANCE RATES AS AT MONTH 1 (April 23)

3.1 The below table provide a summary of the current position in relation to Trust wide Statutory and Mandatory training and PPDR compliance rates.

3.2 The target for MT compliance is 85% with the exception of Data Security Awareness which remains at a nationally mandated target of 95%.

3.3 The below table shows progress over the previous five months against the core Mandatory Training Modules and PPDR Compliance rates.

MT Subject	Compliance Target %	Dec 2022 %age	Jan 2023 %age	Feb 2023 %age	March 2023 %age	April 2023 %age
PPDR *	85	66.09	70.13	72.57	70.56	71.62
Corporate Induction	95	99.74	99.60	99.80	99.61	99.36
Complaints Handling	85	86.72	88.5	89.76	88.98	86.74
Conflict Resolution*	85	92.53	93.13	93.90	93.90	93.76
Dementia awareness	85	94.25	94.91	94.88	95.33	95.24
Equality, Diversity & Human Rights	85	92.93	93.06	93.57	93.71	93.37
Fire Safety	85	90.81	91.21	91.73	92.48	92.28
Health Safety & Welfare	85	92.33	92.60	93.24	93.19	93.50
Infection Control level 1	85	92.72	91.56	92.67	93.33	91.73
Infection Control level 2	85	88.69	88.72	88.77	90.91	89.51
Data Security Awareness	95	91.47	90.79	88.59	89.31	88.86
Moving & Handling Level 1	85	91.61	92.20	93.04	93.39	93.11
Moving and Handling Level 2 (new addition)	85	77.80	78.25	79.87	80.66	81.94
Prevent: Basic Awareness	85	93.39	93.79	94.88	95.27	94.53
Prevent: WRAP 3	85	91.69	92.17	92.94	93.38	93.39
Safeguarding Children Level 1	85	92.32	92.68	93.76	93.99	92.69
Safeguarding Children Level 2	85	85.94	87.15	89.61	91.23	89.97
Safeguarding Children Level 3	85	89.37	86.44	89.19	93.13	93.84
Safeguarding Adults Level 1	85	92.87	93.49	94.43	94.79	93.57

MT Subject	Compliance Target %	Dec 2022 %age	Jan 2023 %age	Feb 2023 %age	March 2023 %age	April 2023 %age
Safeguarding Adults Level 2	85	80.67	83.45	86.47	88.86	88.79
Safeguarding Adults Level 3	85	77.16	76.26	78.45	76.09	79.72
Resuscitation Level 1	85	79.59	80.99	82.93	85.30	84.41
Resuscitation Level 2	85	85.49	85.02	85.90	88.35	86.98

3.4   Whilst compliance rates, overall, have continued to improve month on month, some modules are still adrift of the Trust target.

4. SUPPORT, MEASUREMENT AND COMMUNICATION

4.1 A Mandatory Training and PPDR Compliance Delivery Plan was agreed at Executive Management Team and Senior Leadership Team in July 2022, with a commitment to focus on a set of specific trajectories on the completion of specific modules based on the associated risk of non-compliance.

4.2 Overall compliance percentages improved significantly; however some do still remain below target despite the continued communication, regular reporting and additional support from the EPD team.

4.3 As a result, updated communications have been cascaded via Team Brief and internal meetings to ensure staff at all levels are aware of the required full compliance by 31st July 2023.

4.4 The focus on communications is ensuring that we create the right environment for staff to complete their mandatory training, through protecting time in E-Roster and ensuring that compliance with mandatory training is given as much attention as seeing patients.

4.5 Consideration has been given to a set of principles for the managing and handling non-compliance post 31st July 2023. The Board are sighted on these and will receive an update on progress.

4.6 At Risk Management Council (RMC) in February, it was recognised by the Council that there are limitations in this solely being a Corporate risk and there was a recognition of the support that is provided by the EPD Team. It was agreed that areas of low compliance within individual services should be recognised and managed locally, and service specific risks should be raised and assessed to address these areas as required.

4.7 Statutory and Mandatory Training compliance is monitored closely at DLTs and Performance Council and is reported as a standing item report at People Committee.

4.8 Statutory and Mandatory Training compliance is logged on BAF 5.

5. RECOMMENDATION

5.1 It is recommended that the Board note the content of this report by way of assurance on the Trust's plans for ensuring compliance with Statutory and Mandatory Training compliance targets.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01/06/23**
Agenda Item	**41/23iv**		
Report Title	**NHS STAFF SURVEY - UPDATE**		
Executive Lead	Paula Woods – Director of People and Organisational Development		
Report Author	Mike Baker – Deputy Director of Communications and Engagement		
Presented by	Mike Baker – Deputy Director of Communications and Engagement		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Executive Summary
At April 2023 Board, an update was given to members about the NHS Staff Survey results. This report was well-received by members. Following a post-report discussion, Board members raised the question as to whether additional information could be brought back to Board on how the Trust compared to previous years and not just how it compared to the Community Trust comparator average. This report gives a further update to Board members on how key staff survey questions have fared over the past few years in answer to the discussion raised. This is highlighted in a high-level graphic showcasing areas of significant (above or below 5%) comparator differences between 2021 and 2022. An in-depth breakdown of all questions from the past few years are included as an appendix to the report. The report also explains an additional question asked at the April 2023 Board about the comparator group that Bridgewater sits within. The Trust Board is asked to note this report.

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

Strategic Objectives
☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.	
☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.	
☐ **Resources -** We will ensure that we use our resources in a sustainable and effective way.	
☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.	

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	01 June 2023
Agenda Item	41/23iv		
Report Title	**NHS STAFF SURVEY – UPDATE**		
Report Author	Mike Baker – Deputy Director of Communications and Engagement		
Purpose	This report responds to additional questions asked at the April 2023 Board about the 2022 NHS Staff Survey results.		

1. SCOPE

1.1 The NHS has a couple of key important listening channels to hear and respond to Employee Voice. These are:

    a. The annual NHS Staff Survey
    b. The National Quarterly Pulse Survey

1.2 These surveys give us a great opportunity to hear what matters to our NHS people and make positive steps to improving our experience of work.

1.3 The annual NHS Staff Survey is one of the largest workforce surveys in the world and is carried out every year to improve staff experiences across the NHS.

1.4 In 2021, the questions were aligned with the NHS People Promise to track progress against its' ambition to make the NHS the workplace we all want it to be.

1.5 The fieldwork for the 2022 NHS Staff Survey was carried out between September and November 2022.

1.6 The response rate for Bridgewater was 56% (828 respondents). This was the best ever return rate for Bridgewater, although the median response rate against other Community Trusts was 57%.

1.7 The chosen survey mode for Bridgewater was via an 'online' survey.

1.8 There were 16 Community Trusts benchmarked in the results. 24,650 surveys were completed within this benchmarked group.

2. INTRODUCTION

2.1 The results of the 2022 NHS Staff Survey were delivered to Trust Board in April 2023.

2.2 **Figure 1** has been inserted back into this report to act as a quick reminder and overview. It displays how the Trust has scored for this survey period against other Community Trusts. The graphic also illustrates how the organisation benchmarks from a NHS North West geography and a regional Cheshire and Merseyside ICS geography.

2.3 **Figure 1**

People Promise Element / Theme	BCHFT 2022 score	Community Trust Average	Trust results v's Community Trust Average	North West Average	Trust results v's North West Average	C&M ICS Average	Trust results v's CM ICS Average
We are compassionate and inclusive	7.6	7.6	0	7.2	0.4	7.3	0.3
We are recognised and rewarded	6.1	6.4	-0.3	5.8	0.3	6	0.1
We each have a voice that counts	7.1	7.1	0	6.7	0.4	6.8	0.3
We are safe and healthy	6.3	6.3	0	6	0.3	6.1	0.2
We are always learning	5.3	5.9	-0.3	5.2	0.1	5.1	0.2
We work flexibly	6.4	6.7	-0.3	6.1	0.3	6.1	0.3
We are a team	7	7.1	-0.1	6.7	0.3	6.7	0.3
Staff engagement	7.2	7.2	0	6.8	0.4	6.9	0.3
Morale	6.1	6.1	0	5.8	0.3	5.8	0.3

2.4 The comprehensive NHS Staff Survey report outlining the results was received well by Board members at the April 2023 meeting. There was however a constructive discussion after the delivery of the report on how the Trust compared to previous years and not just how it compared to the community trust comparator average for the question responses.

2.5 This report gives a further update to Board members on how key staff survey questions have fared over the past few years in answer to the discussion raised.

2.6 The report also explains an additional question asked at the April 2023 Board about the comparator group the organisation sits within.

3. QUESTION RESPONSE - SIGNIFICANT TRUST DIFFERENCES - 2021 V 2022

3.1 **Figure 2** drills down into some of the questions that are asked within the NHS Staff Survey and highlights areas of significant (above or below 5%) comparator differences between 2021 and 2022.

3.2 There are several strong green category indicators highlighted. There are however, three areas that have been flagged as red. These mainly relate to levels of pay and health and wellbeing.

3.3 **Figure 2.**

		THEME (based on People Promise)	2021 Results	2022 Results	2021 v 2022 Results
YOUR JOB					
3h (previously 4f)	I have adequate materials, supplies and equipment to do my work.	Morale & P4:1 Health and safety climate	61%	66%	5%
3i (previously 4g)	There are enough staff at this organisation for me to do my job properly.	Morale & P4:1 Health and safety climate	30%	35%	5%
4c (previously 5g)	My level of pay.	Promise 2: We are recognised and rewarded	38%	29%	-9%
6b	My organisation is committed to helping me balance my work and home life	P6.1: Support for work-life balance	49%	55%	6%
YOUR HEALTH, WELLBEING AND SAFETY AT WORK					
11c	During the last 12 months have you felt unwell as a result of work related stress?	P4:3 Negative experiences	55%	62%	7%
12b	How often, if at all, do you feel burnt out because of your work	P4:2 Burnout	31%	37%	6%
13d (previously 12d)	The last time you experienced physical violence at work, did you or a colleague report it?	P4:1 Health and safety climate	61%	66%	5%
16c02	On what grounds have you experienced discrimination? Gender (No).		82%	91%	9%
16c06	On what grounds have you experienced discrimination? Age (No).		78%	87%	9%
20 (previously 18)	I think that my organisation respects individual differences (e.g. cultures, working styles,	P1.3: Diversity and equality	72%	77%	5%

	backgrounds, ideas etc)				
YOUR PERSONAL DEVELOPMENT					
21a (previously 19a)	In the last 12 months, have you had an appraisal, annual review, development review, or knowledge and skills framework (KSF) development review	P5.2: Appraisals	**72%**	**79%**	**7%**
22e (previously 20e)	I am able to access the right learning and development opportunities when I need to	P5.1: Development	**55%**	**61%**	**6%**

3.4 For completeness, all NHS Staff Survey question responses since 2019 can be found as **Appendix 1** at the end of this report.

4. QUESTION RESPONSE – COMPARATOR GROUPS

4.1 Knowing the organisation is only compared to 16 other Community Trusts in England when it comes to the NHS Staff Survey comparator results, a question was raised at the April 2023 Board meeting as to whether this could be investigated.

4.2 The Bridgewater Deputy Director of Communications and Engagement is a member of the Staff Survey Advisory Group (SSAG).

4.3 As we await clarification from SSAG, the Deputy Director of Communications and Engagement is not confident that the benchmark group (that Bridgewater sits under) will be able to change as all other solus Community Trusts also sit in this category. The NHS Staff Survey is also seen as an official statistic. The benchmark category of 'acute and Community Trust' or 'mental health and Community Trust' are for NHS providers that are clearly defined as having that mix of services within their portfolio.

4.4 One additional question raised to SSAG however is about the early embargoed data that comes into the organisation prior to national release. **Figure 1** (earlier in this report) shows that Bridgewater flagged red in four themes when compared to the Community Trusts comparator.

4.5 Greater data was subsequently released when the NHS Staff Survey embargo lifted nationally. This included benchmark data in which the Trust could compare itself at Integrated Care Board (ICB) level and NHS regional level. As **Figure 1** highlights, the Trust flagged green in all themes across the Cheshire and Merseyside ICB and NHS

North West region. If this additional data was available under embargo, like it is for the trust comparator data, this would have made the reporting and communicating of the staff survey much more proactive in nature.

4.6   Once clarification comes back into the organisation in the two matters raised in this section, it will be fed to Board so the action request can be completed and closed.

5.   RECOMMENDATION

5.1   Board is asked to note Section 3, Figure 2 of this report in answer to the question raised at the last meeting. Appendix 1 also has the complete oversight of NHS Staff Survey questions with annual compassion.

5.2   Board is asked to note the update in section 4, mindful that clarification is still outstanding.

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
YOUR JOB							
1	Do you have face-to-face contact with patients / service users as part of your job?						
2a	I look forward to going to work.	Staff Engagement	57%	61%	59%	61%	2%
2b	I am enthusiastic about my job.	Staff Engagement	74%	75%	73%	74%	1%
2c	Time passes quickly when I am working.	Staff Engagement	80%	81%	81%	80%	-1%
3a	I always know what my work responsibilities are.	Morale & P3.1: Autonomy and control	84%	82%	83%	85%	2%
3b	I am trusted to do my job.	P3.1: Autonomy and control	92%	89%	91%	92%	1%
3c	There are frequent opportunities for me to show initiative in my role.	Staff Engagement & P3.1: Autonomy and control	72%	73%	74%	73%	-1%
3d (previously 4b)	I am able to make suggestions to improve the work of my	Staff Engagement & P3.1: Autonomy and control	79%	78%	75%	77%	2%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	team / department.						
3e (previously 4c)	I am involved in deciding on changes introduced that affect my work area / team / department.	Morale & P3.1: Autonomy and control	58%	58%	54%	58%	4%
3f (previously 4d)	I am able to make improvements happen in my area of work.	Staff Engagement & P3.1: Autonomy and control	62%	62%	58%	60%	2%
3g (previously 4e)	I am able to meet all the conflicting demands on my time at work.	Morale & P4:1 Health and safety climate	40%	43%	44%	45%	1%
3h (previously 4f)	I have adequate materials, supplies and equipment to do my work.	Morale & P4:1 Health and safety climate	41%	59%	61%	66%	5%
3i (previously 4g)	There are enough staff at this organisation for me to do my job properly.	Morale & P4:1 Health and safety climate	28%	38%	30%	35%	5%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
4a (previously 5a)	The recognition I get for good work.	Promise 2: We are recognised and rewarded	60%	58%	57%	57%	0%
4b (previously 5f)	The extent to which my organisation values my work.	Promise 2: We are recognised and rewarded	45%	47%	46%	47%	1%
4c (previously 5g)	My level of pay.	Promise 2: We are recognised and rewarded	41%	41%	38%	29%	-9%
4d (previously 5h)	The opportunities for flexible working patterns.	P6.2: Flexible working	59%	64%	59%	60%	1%
5a (previously 6a)	I have unrealistic time pressures.	Morale & P4:1 Health and safety climate	24%	26%	28%	31%	3%
5b (previously 6b)	I have a choice in deciding how to do my work.	Morale & P3.1: Autonomy and control	65%	66%	64%	62%	-2%
5c (previously 6c)	Relationships at work are strained.	Morale	51%	49%	49%	53%	4%
6a (previously 7b)	I feel that my role makes a difference to patients / service users.	P1.1: Compassionate culture	87%	90%	88%	88%	0%
6b	My organisation is committed to helping me	P6.1: Support for work-life balance	N/A	N/A	49%	55%	6%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	balance my work and home life						
6c	I achieve a good balance between my work life and my home life	P6.1: Support for work-life balance	N/A	N/A	58%	59%	1%
6d	I can approach my immediate manager to talk openly about flexible working	P6.1: Support for work-life balance	N/A	N/A	74%	74%	0%
YOUR TEAM							
7a (previously 4h)	The team I work in has a set of shared objectives.	P7.1: Team working	76%	74%	74%	77%	3%
7b (previously 4i)	The team I work in often meets to discuss the team's effectiveness.	P7.1: Team working	73%	65%	69%	72%	3%
7c (previous 4j)	I receive the respect I deserve from my colleagues at work.	Morale & P7.1: Team working	82%	75%	78%	81%	3%
7d	Team members understand each other's roles	P7.1: Team working	N/A	N/A	77%	80%	3%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
7e	I enjoy working with the colleagues in my team	P7.1: Team working	N/A	N/A	87%	87%	0%
7f	My team has enough freedom in how to do its work	P7.1: Team working	N/A	N/A	61%	62%	1%
7g	In my team disagreements are dealt with constructively	P7.1: Team working	N/A	N/A	63%	61%	-2%
7h	I feel valued by my team	P1.4: Inclusion	N/A	N/A	76%	75%	-1%
7i	I feel a strong personal attachment to my team	P1.4: Inclusion	N/A	N/A	71%	75%	4%
PEOPLE IN YOUR ORGANISATION							
8a	Teams within this organisation work well together to achieve their objectives	P7.1: Team working	N/A	N/A	55%	56%	1%
8b	The people I work with are understanding and kind to one another	P1.4: Inclusion	N/A	N/A	80%	81%	1%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
8c	The people I work with are polite and treat each other with respect	P1.4: Inclusion	N/A	N/A	81%	81%	0%
8d	The people I work with show appreciation to one another	Promise 2: We are recognised and rewarded	N/A	N/A	76%	76%	0%
YOUR MANAGERS							
9a (previously 8a)	My immediate manager encourages me at work.	Morale & P7.2: Line management	74%	70%	74%	74%	0%
9b (previously 8c)	My immediate manager gives me clear feedback on my work.	P7.2: Line management	67%	59%	66%	63%	-3%
9c (previously 8d)	My immediate manager asks for my opinion before making decisions that affect my work.	P7.2: Line management	61%	58%	62%	61%	-1%
9d (previously 8f)	My immediate manager takes a positive interest in my health and well-being.	P7.2: Line management	75%	73%	73%	74%	1%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
9e (previously 8g)	My immediate manager values my work.	Promise 2: We are recognised and rewarded	76%	73%	76%	75%	-1%
9f	My immediate manager works together with me to come to an understanding of problems (Agree/Strongly agree)	P1.2: Compassionate leadership	N/A	N/A	72%	70%	-2%
9g	My immediate manager is interested in listening to me when I describe challenges I face	P1.2: Compassionate leadership	N/A	N/A	73%	73%	0%
9h	My immediate manager cares about my concerns	P1.2: Compassionate leadership	N/A	N/A	74%	73%	-1%
9i	My immediate manager takes effective action to help me with any problems I face	P1.2: Compassionate leadership	N/A	N/A	70%	69%	-1%
YOUR HEALTH, WELL-BEING AND SAFETY AT WORK							

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
10a	How many hours a week are you contracted to work?						
10b	On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?		82%	84%	84%	82%	-2%
10c	On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?		43%	42%	41%	45%	4%
11a	My organisation takes positive action on health and wellbeing	P4:1 Health and safety climate	N/A	N/A	64%	65%	1%
11b	In the last 12 months have you experienced musculoskeletal	P4:3 Negative experiences	77%	71%	76%	78%	2%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	problems (MSK) as a result of work activities?						
11c	During the last 12 months have you felt unwell as a result of work related stress?	P4:3 Negative experiences	60%	56%	55%	62%	7%
11d	In the last three months have you ever come to work despite not feeling well enough to perform your duties?	P4:3 Negative experiences	53%	54%	47%	46%	-1%
11e	Have you felt pressure from your manager to come to work?		N/A	80%	84%	83%	-1%
12a	How often, if at all, do you find your work emotionally exhausting	P4:2 Burnout	N/A	N/A	22%	26%	4%
12b	How often, if at all, do you feel burnt out because of your work	P4:2 Burnout	N/A	N/A	31%	37%	6%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
12c	How often, if at all, does your work frustrate you	P4:2 Burnout	N/A	N/A	24%	24%	0%
12d	How often, if at all, are you exhausted at the thought of another day / shift at work	P4:2 Burnout	N/A	N/A	43%	46%	3%
12e	How often, if at all, do you feel worn out at the end of the working day/shift	P4:2 Burnout	N/A	N/A	21%	22%	1%
12f	How often, if at all, do you feel that every working hour is tiring for you	P4:2 Burnout	N/A	N/A	57%	58%	1%
12g	How often, if at all, do you not have enough energy for family and friends during leisure time?	P4:2 Burnout	N/A	N/A	37%	39%	2%
13a (previously 12a)	In the last 12 months how many times have you personally experienced	P4:3 Negative experiences	94%	97%	95%	94%	-1%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	physical violence at work from Patients / service users, their relatives or other members of the public						
13b (previously 12b)	In the last 12 months how many times have you personally experienced physical violence at work from managers	P4:3 Negative experiences	100%	100%	100%	100%	0%
13c (previously 12c)	In the last 12 months how many times have you personally experienced physical violence at work from other colleagues	P4:3 Negative experiences	99%	100%	100%	100%	0%
13d (previously 12d)	The last time you experienced physical violence at work, did you or	P4:1 Health and safety climate	69%	74%	61%	66%	5%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	a colleague report it?						
14a (previously 13a)	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from Patients / service users, their relatives or other members of the public	P4:3 Negative experiences	77%	81%	80%	78%	-2%
14b (previously 13b)	In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers	P4:3 Negative experiences	89%	91%	93%	92%	-1%
14c (previously 13c)	In the last 12 months how many times have you personally experienced harassment, bullying or	P4:3 Negative experiences	86%	87%	86%	86%	0%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	abuse at work from other colleagues						
14d (previously 13d)	The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	P4:1 Health and safety climate	56%	52%	50%	51%	1%
15 (previously 14)	Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	P1.3: Diversity and equality	58%	58%	58%	61%	3%
16a (previously 15a)	In the last 12 months have you personally experienced discrimination at work from Patients / service users,	P1.3: Diversity and equality	97%	98%	99%	98%	-1%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	their relatives or other members of the public						
16b (previously 15b)	In the last 12 months have you personally experienced discrimination at work from Manager / team leader or other colleagues	P1.3: Diversity and equality	94%	95%	96%	96%	0%
16c01 (previously Q16)	On what grounds have you experienced discrimination? Ethnic background				82%	80%	-2%
16c02	On what grounds have you experienced discrimination? Gender (No).				82%	91%	9%
16c03	On what grounds have you experienced discrimination? Religion (No).				96%	93%	-3%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
16c04	On what grounds have you experienced discrimination? Sexual orientation (No).				98%	98%	0%
16c05	On what grounds have you experienced discrimination? Disability (No).				91%	87%	-4%
16c06	On what grounds have you experienced discrimination? Age (No).				78%	87%	9%
16c07	On what grounds have you experienced discrimination? Other (No).				58%	56%	-2%
17	In the last month have you seen any errors, near misses, or incidents that could have hurt staff and/or					82%	

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	patients/service users (No).						
18a	My organisation treats staff who are involved in an error, near miss or incident fairly (Agree/Strongly agree).					64%	
18b	My organisation encourages us to report errors, near misses or incidents (Agree/Strongly agree).					92%	
18c	When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again (Agree/Strongly agree).					74%	
18d	We are given feedback about changes made in response to reported errors,					66%	

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	near misses and incidents (Agree/Strongly agree).						
19a (previously 17a)	I would feel secure raising concerns about unsafe clinical practice.	P3.2: Raising concerns	70%	75%	84%	80%	-4%
19b (previously 17b)	I am confident that my organisation would address my concern.	P3.2: Raising concerns	58%	64%	72%	70%	-2%
20 (previously 18)	I think that my organisation respects individual differences (e.g. cultures, working styles, backgrounds, ideas etc)	P1.3: Diversity and equality	N/A	N/A	72%	77%	5%
YOUR PERSONAL DEVELOPMENT							
21a (previously 19a)	In the last 12 months, have you had an appraisal, annual review, development review, or	P5.2: Appraisals	N/A	N/A	72%	79%	7%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	knowledge and skills framework (KSF) development review						
21b (previously 19b)	It helped me to improve how I do my job	P5.2: Appraisals	N/A	N/A	19%	22%	3%
21c (previously 19c)	It helped me agree clear objectives for my work	P5.2: Appraisals	N/A	N/A	31%	32%	1%
21d (previously 19d)	It left me feeling that my work is valued by my organisation	P5.2: Appraisals	N/A	N/A	31%	33%	2%
22a (previously 20a)	The organisation offers me challenging work	P5.1: Development	N/A	N/A	68%	71%	3%
22b (previously 20b)	There are opportunities for me to develop my career in this organisation	P5.1: Development	N/A	N/A	42%	45%	3%
22c (previously 20c)	I have opportunities to improve my knowledge and skills	P5.1: Development	N/A	N/A	65%	68%	3%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
22d (previously 20d)	I feel supported to develop my potential	P5.1: Development	N/A	N/A	50%	52%	2%
22e (previously 20e)	I am able to access the right learning and development opportunities when I need to	P5.1: Development	N/A	N/A	55%	61%	6%
YOUR ORGANISATION							
23a (previously 21a)	Care of patients / service users is my organisation's top priority.	Staff Engagement & P1.1: Compassionate culture	72%	77%	79%	79%	0%
23b (previously 21b)	My organisation acts on concerns raised by patients / service users.	Staff Engagement & P1.1: Compassionate culture	72%	77%	81%	79%	-2%
23c (previously 21c)	I would recommend my organisation as a place to work.	Staff Engagement & P1.1: Compassionate culture	51%	59%	57%	57%	0%
23d (previously 21d)	If a friend or relative needed treatment I would be happy with the standard of care provided	Staff Engagement & P1.1: Compassionate culture	69%	79%	78%	80%	2%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
	by this organisation.						
23e (previously 21e)	I feel safe to speak up about anything that concerns me in this organisation	P3.2: Raising concerns	N/A	67%	70%	69%	-1%
23f (previously 21f)	If I spoke up about something that concerned me I am confident my organisation would address my concern	P3.2: Raising concerns	N/A	N/A	57%	58%	1%
24a (previously 22a)	I often think about leaving this organisation.	Morale	41%	48%	45%	47%	2%
24b (previously 22b)	I will probably look for a job at a new organisation in the next 12 months.	Morale	46%	57%	52%	55%	3%
24c (previously 22c)	As soon as I can find another job, I will leave this organisation.	Morale	52%	63%	60%	62%	2%

APPENDIX 1

		THEME (based on People Promise)	2019 Results %	2020 Results %	2021 Results %	2022 Results %	2021 v 2022 Results
22d (previously 19d)	If you are considering leaving your current job, what would be your most likely destination?						

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01/06/23**
Agenda Item	**42123v**		
Report Title	**FREEDOM TO SPEAK UP – ANNUAL REPORT & SELF ASSESSMENT UPDATE**		
Executive Lead	Lynne Carter, Chief Nurse/Deputy CEO		
Report Author	Tania Strong, Freedom to Speak Up Guardian/Head of HR		
Presented by	Tania Strong, Freedom to Speak Up Guardian/Head of HR		
Action Required	☐ **To Approve**	☒ **To Assure**	☒ **To Note**

Executive Summary

The Freedom to Speak Up (FTSU) Annual Report is a summary of the FTSU activity during 2022/23.

The report provides an overview of developments including current mechanisms for speaking up, data returns to the National Guardians Office, and the national 2022 staff survey results.

Speaking Up activity in 2022/23 has increased by 77% which is positive, however overall numbers remain low.

A Lead Freedom to Speak Up Guardian was appointed in January 2023 and will continue to grow the FTSU agenda.

According to the 2022 Staff Survey, there has been a negative differential in the experiences of staff speaking up in relation to clinical versus non-clinical concerns.

The Trust's Freedom to Speak Up self-assessment is well-underway, once complete the intention will be to present the final results and ensuing plans to August's Board for approval.

Previously considered by:

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

Strategic Objectives

☒ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☒ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.

☐ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
☒ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	01 June 2023
Agenda Item	41/23v		
Report Title	FREEDOM TO SPEAK UP – ANNUAL REPORT & SELF ASSESSMENT UPDATE		
Report Author	Tania Strong, Freedom to Speak Up Guardian/Head of HR		
Purpose	To provide details of the Trust's Freedom to Speak Up Annual Report for 2022. To provide an update on plans for the Trust's self-assessment in relation to Speaking Up.		

1. SCOPE

1.1 People Committee receive bi-monthly activity reports in relation to Freedom to Speak Up (FTSU) and as part of the Committee's business cycle, an Annual FTSU Report is produced in May each year – this can be seen at Appendix 1.

1.2 The Annual Report for the period 2022/23 highlights activity, developments and details of the 2022 Staff Survey results pertaining to the NHS People Promise 'We each have a voice that counts.'

1.3 The Trust is required to undertake a self-assessment every two years in relation to Freedom to Speak Up - this report provides an update on progress in relation to this.

2. FREEDOM TO SPEAK UP ANNUAL REPORT

2.1 In summary and as can be seen from the full Annual Report in Appendix 1, the Trust has maintained visibility in relation to FTSU and numbers of concerns have increased compared to 2021/22. During 2022/23 a total of 13 concerns were raised with the FTSU Guardian, compared to 3 in 2021/22 – comparatively an increase of 77%. Whilst numbers remain low, the visibility of the newly appointed Lead Guardian will be a continuing focus for 2023/24.

2.2 The majority of concerns raised were open (84%) - a greater proportion of open concerns demonstrates higher levels of psychological safety in the workforce.

2.3 The main theme for concerns being raised was patient safety – however the 2022 staff survey results have evidenced a negative decline in the confidence levels of staff feeling able to speak up about clinical concerns compared to the same staff survey

question in 2021/22 – a drop of 4.9%. Further work is required in this area to understand this metric and actions will be agreed with the Lead Executive.

2.4   Evaluations in relation to learning and training delivered, including attendance at corporate induction have been positive, and more in-reach work with teams combined with a media campaign will be used to promote the Lead Guardian and the new FTSU in the NHS Policy.

3.   FREEDOM TO SPEAK UP – SELF ASSESSMENT UPDATE INFORMATION

3.1   Nationally all Trusts in England are asked to review their Speaking Up processes every two years.

3.2   All Trusts have been asked to complete their reviews using a revised self-assessment tool and guidance by January 2024. (The relevant templates for reference are at Appendix 2 – Freedom to Speak Up: A guide for leaders in the NHS and organisations delivering NHS Services and Appendix 3 – Freedom to Speak Up: a reflection and planning tool).

3.3   The guide focuses on two aspects of Speaking Up – part 1 includes the transactional information and systems needed to carry out Freedom to Speak Up processes effectively, and part 2 looks at growing wider cultural change as part of building psychological safety within the workforce, which in turn encourages workers to Speak Up about anything concerning them.

3.4   Following on from the Board meeting held in February, the Trust's draft self-assessment is well underway – when completed, the outputs from this will inform the organisations actions over the next 2 years and will be used to develop the Trust's subsequent FTSU plans. The self-assessment and proposed plans will be presented to Board in August for review and approval.

3.5   Additionally, the self-reflection tool incorporates specific input and evaluation from the Lead Executive for FTSU, Non-Executive Lead for FTSU, the Lead Executive for Organisational Development, and more widely Senior Leaders in the Trust. The reflection tool will be circulated to all Board members for input as part of the self-assessment prior to August's Board meeting.

4.   RECOMMENDATION

4.1   That the Board note the content of the FTSU Annual Report and that progress in relation to the self-assessment is underway with plans for all Board member to input into the review.

PEOPLE COMMITTEE REPORT

Title of Meeting	**PEOPLE COMMITEE**	**Date**	**10 May 2023**
Agenda Item	**54/23**		
Report Title	**FREEDOM TO SPEAK UP ANNUAL REPORT**		
Report Author	Tania Strong, Freedom to Speak Up Guardian/Head of Human Resources		
Purpose	To provide an overview of Freedom to Speak Up Activity during 2022/23.		

1. SCOPE

1.1 The FTSU Annual Report is a summary of the FTSU activity during 2022/23.

1.2 This report provides:

- An overview of developments including current mechanisms for 'Speaking Up'
- Details activity undertaken during 2022/2023
- Provide data in relation to the number and type of cases raised via 'Speaking Up' processes.
- Provides details of the national staff survey results relevant to 'Speaking Up'.
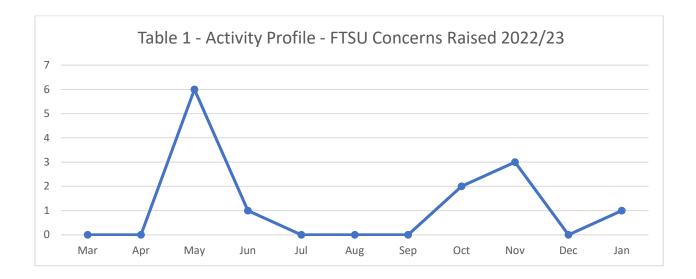
2. INTRODUCTION

2.1 Speaking Up is integral to enabling the Trust to continuously improve through demonstrating positive behaviours and living our values. When staff have the freedom to 'Speak Up', they have psychological safety in their place of work and will feel able and safe to contribute diverse ideas and opinions about what is going well, or wrong and what should improve, be resolved, or done better.

2.2 In January 2023 a Lead Freedom to Speak Up Guardian was appointed through an open recruitment process to provide a dedicated resource (0.4 wte) to growing the Speaking Up agenda, and who will carry on the work that has already taken place to date. They are supported by a second Guardian and a small network of Champions and will continue to support staff, leaders and managers. The FTSU cycle of Speak Up, Listen Up, Follow up is integral to the Trust's core PEOPLE values of being:

- Person centred
- Empowered
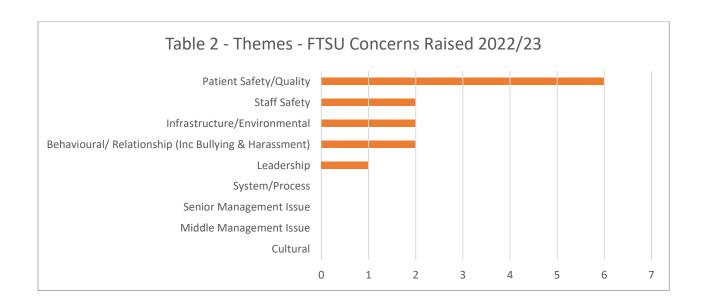
- Open and honest
- Professional
- Local and
- Efficient

2.3　Details for both the Guardian(s) and Champions are on the intranet and the link to the FTSU page is now displayed on the main intranet home page under 'Latest news and updates'. If staff feel the need to seek support from the FTSU Guardians or Champions, they can do so either face to face or via a phone call or email, or via Microsoft Teams. Regular updates are included in the Trust's Bulletin and information cascade system the 'Team Brief' which all staff can attend monthly.

2.4　Speaking Up activity, themes and trends of concerns raised to the FTSU Guardians are reported to the Trust Board, bi-monthly to the People Committee and quarterly to the National Guardian's Office. Going forward in 2023/24, reporting to Board will take place at least twice per year.

3. ACTIVITY OVERVIEW
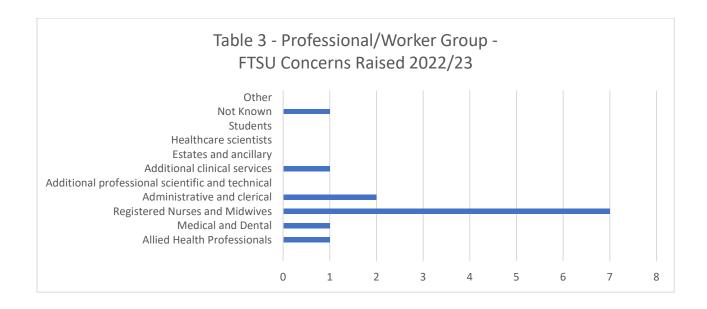
3.1　During 2022/23 a total of 13 concerns were raised with the FTSU Guardian, compared to 3 in 2021/22 – comparatively an increase of 77%. This has been attributed to the greater level of awareness raising activities undertaken during 2022/23, with correlation surrounding Speaking Up month in October 2023.

Table 1 - Activity Profile - FTSU Concerns Raised 2022/23

3.2　Of those concerns raised, the majority focused on Patient Safety and Quality (Table 2). Infrastructure and Environmental themes incorporated elements relating to Estates matters, and whilst the main themes are detailed below, the concerns were often multi factorial in nature.

Table 2 - Themes - FTSU Concerns Raised 2022/23

Theme	Value
Patient Safety/Quality	6
Staff Safety	2
Infrastructure/Environmental	2
Behavioural/ Relationship (Inc Bullying & Harassment)	2
Leadership	1
System/Process	0
Senior Management Issue	0
Middle Management Issue	0
Cultural	0
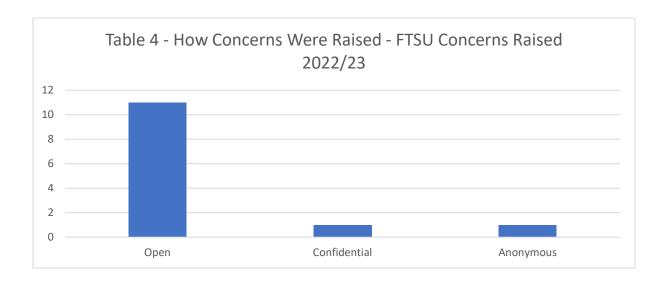
3.3   From a worker category perspective, the main professional group reporting concerns are registered nurses and midwives (Table 3) - this reflects our overall workforce demographic as nurses make up the largest proportion of our workforce.

Table 3 - Professional/Worker Group - FTSU Concerns Raised 2022/23

Group	Value
Other	0
Not Known	1
Students	0
Healthcare scientists	0
Estates and ancillary	0
Additional clinical services	1
Additional professional scientific and technical	0
Administrative and clerical	2
Registered Nurses and Midwives	7
Medical and Dental	1
Allied Health Professionals	1

3.4   Staff can raise concerns openly (where the person raising the concern is happy for their identity and nature of the concern to be shared), confidentially (where only the Guardian and identified persons have access to the reporter's identity), or anonymously. All concerns are listened to, and recommendations made. No actions are taken without the consent and agreement of the person raising the concern.

3.5   Following the raising of a concern through FTSU, recommendations might include self-management of next steps, FTSU intervention to facilitate resolution, or the triggering of review or investigation. A greater proportion of open concerns demonstrates higher levels of psychological safety in the workforce, and as seen in Table 4, the majority of the cases reported were open in nature.

Table 4 - How Concerns Were Raised - FTSU Concerns Raised 2022/23

4   STAFF SURVEY RESULTS

4.1   In March 2023 the results for the 2022 staff survey were released and under the People Promise theme of 'We each have a voice that counts', questions Q19a, Q19b, Q23e, Q23f were about raising concerns.

4.2   The total number of staff who completed the questionnaires was 828 (a response rate of 56%).

4.3   Feeling secure about raising a concern about clinical practice and feeling confident that it would be addressed were questions (19a and 19b) that showed a deterioration of 4.9% and 3.3% respectively from the 2021/22 results.

4.4   Question 23e and 23f are identical in nature to 19a and 19b but relate to concerns that are not specifically focused on unsafe clinical practice and encompass other areas of work – question 23e showed a smaller deterioration of 1% and question 23f showed an improvement of 0.5% compared to 2021/22.

Q19a I would feel secure raising concerns about unsafe clinical practice:

	2018	2019	2020	2021	2022
Your org	69.7%	71.5%	75.3%	84.7%	79.8%
Best	82.8%	82.3%	83.7%	85.9%	85.1%
Average	76.3%	78.1%	78.5%	83.1%	82.1%
Worst	63.9%	71.1%	73.4%	77.6%	74.4%
Responses	1165	736	765	851	827

Q19b I am confident that my organisation would address my concern:

	2018	2019	2020	2021	2022
Your org	59.8%	58.5%	64.6%	71.7%	68.4%
Best	73.9%	75.5%	76.7%	77.0%	76.3%
Average	65.0%	67.2%	70.7%	72.5%	70.0%
Worst	43.7%	55.0%	59.0%	61.5%	59.3%
Responses	1162	737	765	848	826

Q23e I feel safe to speak up about anything that concerns me in this organisation:

	2020	2021	2022
Your org	68.1%	70.2%	69.2%
Best	77.9%	76.4%	76.9%
Average	72.1%	71.4%	71.3%
Worst	63.4%	59.2%	61.8%
Responses	764	848	826

Q23f If I spoke up about something that concerned me, I am confident my organisation would address my concern:

	2021	2022
Your org	57.5%	58.0%
Best	69.3%	69.4%
Average	62.0%	61.0%
Worst	48.6%	49.2%
Responses	850	825

4.5   As local intelligence has shown earlier in this text, of the Speaking Up cases raised in 2022/23, 6 out of 13 concerns related to Patient Safety or Quality (46%). Given the differential in the confidence levels between those staff Speaking Up about non-clinical matters versus unsafe clinical practice, this will become an area of focus for 2023/24.

4.6   Overall, five out of the nine elements of the staff survey remain static and unchanged when compared against the Community Trust average. Four elements have shown a

decrease and will be the areas that the organisation will focus on as part of its 2023/24 action planning.

4.7　These are:

1. We are recognised and rewarded
2. We are always learning
3. We work flexibly
4. We are a team

4.8　Although 'We each have a voice that counts' is not cited as an area of improvement across the overall Trust staff survey results, the Lead FTSU Guardian will continue to focus on raising their profile and promoting the cycle of Speak Up, Listen Up, Follow up.

5　AWARENESS RAISING AND PROMOTION

5.1　Throughout 2023 a variety of promotion and awareness raising activities took place to raise the profile of Speaking Up, with a focus in October as Freedom to Speak Up Month.

5.2　Awareness of Speaking Up was raised via our 'Team Brief' – a monthly key organisational messages and Q&A session, and a series of items for the weekly Bridgewater Bulletin cascade following the theme for 2022 of 'Freedom to Speak Up for Everyone'. Each week had a specific focus – Week 1 to Speak Up for Safety, Week 2 Civility and Week 3 Inclusion. Week 4 brought together all professions, worker groups and sectors, both within health and social care and beyond.

5.3　As a community Trust our geography and footprint means that Guardian visibility offers specific challenges – as part of Speaking Up month upwards of 18% of the Trust workforce were able to specifically able to see, meet, attend an awareness raising session or talk to the Guardian through a variety of events and walkabouts – these included:

- Taking part in the Marketplace running alongside the Annual Members Meeting/Staff Awards Event in September
- Attendance at October's Engagement Champions Event looking at the role of the Champion, Speaking Up as an element of this and how the Champions can support awareness of Speaking Up
- Meeting a cohort of Learners as part of a development day to talk about Speaking Up and their experiences whilst on placement with the Trust.
- Attendance and connection with the Race Inclusion Staff Network Meeting to chat about Speaking Up and raise awareness, especially considering the barriers that staff from a black and minority ethnic background may experience.
- Attendance booked at a variety of service team meetings throughout October and November.
- Attendance at the first Dental Network Symposium in November since the lifting of pandemic restrictions.

5.4 From December 2022 the FTSU Guardian delivered a bespoke session at the Trust's corporate induction, so that all new starters could meet the Guardian and have a greater awareness of Speaking Up – this group of staff can traditionally experience barriers to Speaking Up in the form of not wanting to 'rock the boat' or not knowing whom they can talk to about a concern or suggestion, but they as fresh eyes can often provide valuable insight and awareness of improvements needed.

5.5 To date evaluation feedback from the session has been excellent and the session will continue to develop based on constructive feedback received, including where possible examples of where the Trust has made improvements through our Speaking Up processes. Some comments received include:

> 'Great information about the various ways we can speak up and what it means. Thanks.'

> 'Great way to make staff feel catered for and feel comfortable in the workplace'

> 'Very relaxed atmosphere and good information'

5.6 Students and Learners in practice have received a combination of awareness raising and input via a bespoke 'Virtual Induction' combined with a rolling programme of attendance at the Trust's Learners Forum – the sessions combined the complementary elements of Equality, Diversity and Inclusion and a Just and Learning Culture (the Trust's approach to system learning and supporting psychological safety) alongside Speaking Up.

6 CONCLUSION
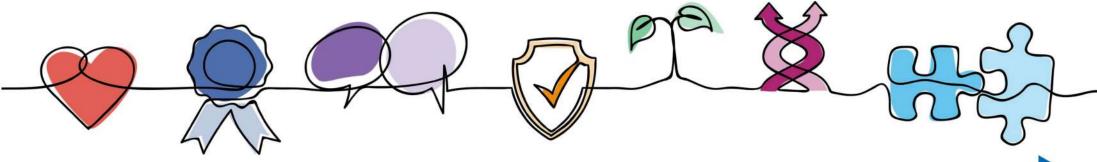
6.1 Freedom to Speak Up Activity has been maintained throughout 2022/23 pending the arrival of a dedicated Lead Freedom to Speak Up Guardian.

6.2 Activity has increased, albeit numbers still remain low – visibility and promotion will form part of the work plan for 2023/24 for the incoming Lead Guardian.

6.3 Given the differential in the confidence levels between those staff Speaking Up about non-clinical matters versus unsafe clinical practice, this will become an area of focus for 2023/24.

6.4 The People Committee is asked to note the contents of this report.

Freedom to Speak Up:

A guide for leaders in the NHS and organisations delivering NHS services

Contents

This guide is a collaboration between NHS England/National Guardians Office 2022.

Introduction

We want to make the NHS the best place to work.

We want our workers to feel valued and respected at work and to know that their views are welcomed. By meeting their needs, we also enable them to deliver the best possible care.

To do that, we need to provide the best possible working environment – one where speaking up is not only welcomed, but valued as an opportunity to learn and improve.

> ### We each have a voice that counts
>
> Ensuring that all our workers – permanent employees, agency staff, students, volunteers – have a voice that counts is a key part of the NHS People Promise:
>
> We all feel safe and confident to speak up.
>
> And we take the time to really listen to understand the hopes and fears that lie behind the words.
>
> **NHS People Promise**

Why speaking up matters

When people speak up, everyone benefits. Building a more open culture, in which leadership encourages learning and improvement, leads to safer care and treatment and improved patient experience.

People are the eyes and ears of an organisation. Their views, improvement ideas and concerns can act as a valuable early warning system that a policy, process or decision is not playing out as anticipated or could be improved.

A speaking-up culture benefits staff satisfaction and performance, too. When people feel that their opinions matter and are valued and acted on, they become more committed – and performance and retention improve.

When people feel that speaking up about poor behaviour is welcomed and encouraged, and that it will be addressed at an early stage, organisations become less entrenched in formal employee relations processes. These can be costly and damage relationships.

So, people's voices play a vital role in informing and driving improvement. However, speaking up is not always easy – especially in organisations where leaders do not welcome challenge or change. That is why putting in place effective, person-centred speaking-up processes will support people to speak up and protect them in doing so. That way, more people should feel able to do so – to the benefit of your organisation and workers.

Who this guide is for

This guide is designed to be used by any senior team, owner or board in any organisation that delivers NHS commissioned services. This includes all aspects of primary care; secondary care; and independent providers. This audience has been chosen because it is the behaviour of senior leaders that has the biggest impact on organisational culture and behaviours.

Using this guide, and the accompanying self-reflection tool, will help you:

- build a culture and behaviours that is responsive to feedback from workers

- ensure that your organisation focuses on learning, to continuously improve quality of care and the experience of staff, patients and service users alike

- improve staff survey scores and other worker experience metrics

- demonstrate to regulators or inspectors the work you are doing to develop your speaking-up arrangements.

How to use this guide

This guide provides ideas for how your organisation might adhere with the Principles for leaders and managers (see page 6), with detailed information on key topics and recommendations for further reading. The accompanying reflection and planning tool, available at www.england.nhs.uk/ourwork/freedom-to-speak-up/developing-freedom-to-speak-up-arrangements-in-the-nhs, is designed to help you identify strengths in yourself, your team and your organisation – and any gaps needing work.

This resource is made up of:

Part 1 is the main guidance, with each section covering the Principles for leaders and managers (see page 7 - the transactional information you need to develop your speakng-up process).

Part 2 shows how speaking up sits within the wider context of a compassionate and inclusive culture, how all elements of such a culture are closely linked to Freedom To Speak Up (FTSU), and must be implemented alongside it (see page 36 - the transformational information you need for culture and behavioural change).

Use this guide alongside the reflection and planning tool as follows:

Step 1: Read the guide.

Step 2: Use the first stage of the reflection and planning tool to evaluate your existing arrangements or to reflect on which principles you want to focus on embedding.

Step 3: Use the second stage of the reflection and planning tool to plan your next steps.

Step 4: Share your plan with your workers, senior team or board, for their feedback or oversight.

Every organisation has its own set of strengths and challenges, and some will be at a more advanced stage in developing speaking-up arrangements than others. This is particularly the case for primary care and integrated care systems. Through 2022/23 NHS England and the National Guardian's Office are working to understand more about how speaking up can be embedded in these organisations and systems.

For this reason, this guide does not give instructions that must be followed from start to end. Instead, it offers guidance within different themes, leaving you free to work on the priorities most relevant to your organisation. The accompanying self-reflection tool will help you ascertain what those are.

A mechanical, tick-box approach to the self-reflection tool is unlikely to lead to a better culture and behaviours. Fundamentally, speaking up involves having a conversation. To be effective, this conversation requires trust and respect. So, improving speaking-up arrangements should begin with honest reflection on how you and your colleagues respond when people do speak up to you.

Terms used in this guide

Organisations	Integrated care boards, NHS trusts, NHS foundation trusts, primary care networks, GP confederations, GP practices, community pharmacies, dentists, optical businesses, independent providers, community interest companies
The leadership	In a trust or integrated care board, the board; in smaller or less complex organisations, a senior leadership group or contract holder
Senior leader	In a trust or integrated care board, executive directors; in primary care, GP partners, principal dentists, superintendent pharmacists, or directors or responsible officers for an optical business
Senior leader for Freedom to Speak Up	In a trust or integrated care board, the executive director responsible for Freedom to Speak Up; in primary care, a member of the senior leadership team
Speaking up	Encompasses matters often referred to as raising concerns, making suggestions for improvement, whistleblowing and protected or qualifying disclosures
Worker	An employee, secondee, contractor, student, volunteer, agency or temporary staff member, locum or governor delivering NHS care

The fundamentals of a healthy speaking-up culture

The principles below are the fundamental requirements for an environment where people feel safe to speak up with confidence.

Principles for leaders and managers

1. Value speaking up.

2. Role-model speaking up and set a healthy Freedom to Speak Up culture.

3. Make sure workers know how to speak up and feel safe and encouraged to do so.

4. When someone speaks up, thank them, listen up and follow up.

5. Use speaking up as an opportunity to learn and improve.

6. Support Freedom to Speak Up guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements alike.

7. Identify and tackle barriers to speaking up.

8. Know the strengths and weaknesses of the organisation's speaking-up culture and take action to continually improve.

Part 1
Guidance for leaders

Part 1 sets out the transactional information that you need to carry out the Freedom to Speak Up process.

You can work through the sections from start to finish or focus on areas of highest need for your organisation.

Valuing speaking up

Principle 1: Value speaking up.

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top. This section sets out the ways you can demonstrate that commitment.

Understanding the value of speaking up

Before an organisation's leaders can begin to effectively implement their speaking-up arrangements, they need to understand what speaking up is and the value it brings to the organisation.

A culture in which workers feel safe and can confidently share their voice and speak up plays a critical role in organisational effectiveness. Organisations where workers can highlight issues, challenge the status quo or question the norm are better able to innovate, perform well and provide ever safer, more effective care.

Your organisation will not successfully embed this cultural change without the absolute commitment of the people at the top. If you sense any hesitancy or resistance at this level to embedding speaking-up culture across your organisation, you need to invest the necessary time and resource to explore any fears. This may include providing development and coaching to ensure that the value of speaking up is embraced wholeheartedly.

Find out more

A good starting point to understand the importance of speaking up is Sir Robert Francis' Freedom to Speak Up Review report and the National Guardian's website.

The senior lead responsible for Freedom to Speak Up

Having a senior person to champion Freedom To Speak Up (FTSU) and support your Freedom to Speak Up guardian helps demonstrate to your organisation your commitment to speaking up. Importantly, this person should be widely considered a credible role-model of the behaviours that encourage speaking up. They should be able to show that they are clear about their role and responsibility, and to evidence how they have helped improve the organisation's speaking-up culture.

The senior lead should be accountable for these aspects of the FTSU guardian role:

- fair, inclusive recruitment (see page 23)

- capacity (see page 24)

- evaluating speaking-up arrangements (see page 30 - 33).

They should also be able to explain to oversight bodies the rationale for decisions around:

- ringfenced time, as well as the checks and balances put in place to show this time is sufficient and effective

- how the guardian was appointed

- how the organisation reviews its speaking-up arrangements.

The non-executive director responsible for Freedom to Speak Up

This non-executive director (NED) role is a senior, independent lead role specific to organisations with boards. In this context, the NED is predominantly a support for the guardian: a fresh pair of eyes to ensure that investigations are conducted with rigor and to help escalate issues, where needed.

They should have an in-depth knowledge of FTSU and be able to readily articulate:

• why a healthy speaking-up culture is vital (see page 8)

• the indicators of a healthy speaking-up culture (see page 4 and page 11)

• the indicators that there is sufficient support for speaking up and wider culture transformation (see page 24)

• the red flags that should trigger concern (see page 11 and page 32).

The NED is also there to challenge the most senior people in the organisation to reflect on whether they could do more to create a healthy, effective speaking-up culture. This might involve constructively raising awareness about poor behaviours.

Organisations without boards – especially those sharing a guardian across a partnership or network – are likely to benefit from having an equivalent role.

The person responsible for people and organisational development

If your organisation has a dedicated person responsible for organisational development, they have a crucial role in promoting a speaking-up culture and behaviours – especially in ensuring that this permeates throughout the organisation. This requires work in a range of interconnected areas, set out in detail in Part 3: Communicating about speaking up (page 36).

Investing in a Freedom to Speak Up guardian

The Freedom to Speak Up guardian role is a complex and challenging one. Those in the role need both practical and emotional support.

All guardians should have ringfenced time to fulfil workers' needs. When you are calculating the amount of ringfenced time required for the role, consider the activities set out in the universal job description and the guidance from the National Guardian's Office. Also, factor in time for them to attend network events, supporting other guardians and for training and development in the role.

Contingency planning

It is important that you have contingency plans in place in case a FTSU guardian is unable to work. The plan should ensure:

• timely and helpful communications are sent explaining interim arrangements

• continuity of support for workers

• both the confidentiality agreed and the security of information shared with the Freedom to Speak Up guardian are maintained

Role-modelling speaking up

Principle 2: Role-model speaking up and set a healthy Freedom to Speak Up culture.

Role-modelling by leaders is essential to set the cultural tone of the organisation. This section sets out the ways you can role-model behaviour that leads to a healthy speaking-up culture.

Setting the tone for culture

The cultural tone of the organisation is set at the top. Leadership has the biggest impact on how workers behave – and actions speak louder than words. Workers take their cues on how to behave from the behaviour, decisions and communication style of their leadership. So, as a leader, it is essential that you embody the culture and behaviours you want to see.

To meet the challenges that face health and care, workers need to be curious, innovative, and challenge when they think something is not right. For this to happen, you need to demonstrate that you welcome people speaking up about ideas, issues, problems, challenges, opportunities and innovations.

You also need to show that everyone's voice matters. This involves identifying the barriers to speaking up that your people encounter and working with them to overcome them. Finally, you need to show that you value what you are told, by thanking people and sharing updates on the actions you have taken.

Speaking-up behaviours for leaders: do's and don'ts

DO...

✓ Ask workers for their opinions.

✓ Speak up yourself.

✓ Measure the impact of change.

✓ Show how you value speaking up as an opportunity to improve.

✓ Tell stories about the change that has occurred from speaking up stories.

✓ Encourage others to speak up and constructively challenge one another.

✓ Acknowledge that people face barriers to speaking up, understand where they exist, who they affect and develop actions to reduce them.

✓ Be visible and approachable and welcome approaches from workers.

✓ Listen with gratitude and respond with curiosity rather than defensiveness.

✓ When someone speaks up, listen, thank them, act, provide feedback and ask for feedback yourself.

✓ Take a 'learn, not blame' approach to dealing with issues and be willing to embrace new ways of working.

✓ Publicly acknowledge any mistakes.

✓ Accept your guardian's constructive challenge – they are there to help your organisation be the best it can be.

DON'T...

✗ Seek out those who have spoken up.

✗ Blame people for things that have gone wrong; instead, learn how to improve processes or behaviours.

✗ Focus on the person who has spoken up; focus on the issue.

✗ Warn people against speaking up 'outside' the organisation.

✗ Take a narrow approach to looking into speaking-up matters. Instead, try to get as much learning as possible.

✗ Be defensive and immediately start explaining away rather than listening and acknowledging a person's experience.

✗ Be too busy to listen.

✗ Talk about how to 'limit the damage' of speaking up. Instead, acknowledge mistakes and embrace the opportunity to learn and improve.

Reflecting on leadership behaviour

Given the significant impact of leaders' behaviour, it is vital that you and each of your senior colleagues reflect on your ability to shape culture and, specifically, whether your behaviour encourages or inhibits speaking up.

Ask colleagues to critique your behaviour. Receiving this feedback can be difficult – especially if it is critical – but it offers invaluable opportunities to reflect, learn and develop, so must always be welcomed.

Questions to reflect on

1. Why and how are outcomes different when you are listening in order to learn, rather than to instruct, correct or win?

2. How have you widened or changed who you listen to in the last year?

3. Who are you instinctively biased towards and against (even if you wish you weren't)?

4. Where is the best place to meet people so that they'll feel comfortable speaking up to you?

5. Do people have a choice about where they can talk to you?

6. Where do you feel most ready and able to hear what people say?

7. Where in your diary is there space for spontaneous conversation?

8. Do normal meetings incorporate enough slack for others to reflect, inquire, challenge and offer new ideas?

9. What's your reaction to being challenged?

10. What do you do to make others feel important, comfortable and significant?

11. How do you phrase your questions in ways that help other people to open up?

Further reading

Edmonson AC (2018). The Fearless Organization: Creating psychological safety in the workplace for learning, innovation, and growth. Wiley

Kline N (2002). Time to Think. Cassell.

Reitz M, Higgins J (2019). Speak Up: Say what needs to be said and hear what needs to be heard. FT Publishing International

Sinek S (2018). How to change your company's culture with just a pen and paper (video)

West M (2016). If it's about culture, it's about leadership (blog). London: The King's Fund. Available at: https://www.kingsfund.org.uk/blog/2016/01/if-it%E2%80%99s-about-culture-it%E2%80%99s-about-leadership

West MA (2021). Compassionate Leadership: Sustaining wisdom, humanity and presence in health and social care. The Swirling Leaf Press

West R, Eckert R, Stewart K, Pasmore B (2014). Developing collective leadership for healthcare (blog). London: The King's Fund.

Horizons A-practical-guide-to-the-art-of-psychological-safety-in-the-real-world-of-health-and-care-.pdf (horizonsnhs.com)

Cole M, Higgins, J (2021) Stuck in the middle – and feeling the pinch (blog)

Cole M (2021) Questioning power (blog)

Communicating about speaking up

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so.

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality. This section sets out how to develop a communication strategy and the key messages you can use.

Write your speaking-up policy

The first step is to write your speaking-up policy, drawing on the National [Speaking Up policy template](). Its aim is to encourage speaking up by providing people with information about how to do this and what will happen when they do. Make sure it is well publicised and easily accessible to everyone and that the information it contains is accurate. Update changes, especially to named contacts, as soon as required.

The policy should include options for workers to speak up internally but also externally, if they feel this is preferable.

Top tip: Reaching diverse communities

The best way to reach someone will depend on a range of factors, including their role, their hours, whether they are desk based and any individual access issues, such as language, literacy, disability or health needs. The people who face the greatest barriers to speaking up may be the very people with the greatest need to do so.

Develop strong communication

To create a speaking-up culture, workers need to know that it is right to speak up. They also need to know how to do so and who they can speak to. To embed this understanding, they need to receive regular messages and clear information. This is best managed through a communications strategy.

Your communications strategy should include the following key messages, which you should regularly and consistently share:

• Speaking up is the right thing to do.

• Senior leaders welcome speaking up.

• Leaders want to hear from anyone who has a matter to raise, including ancillary staff, clerical staff, volunteers and temporary staff.

• Speaking up helps keep patients and service users safe and creates a more positive working environment.

• The leadership will take seriously any instances of staff being bullied, discriminated against, harassed or victimised for speaking up.

It should also include:

• clear information about how to speak up – with clear explanations of procedures and examples of different approaches, emphasising that people can speak up informally through day-to-day conversations

• examples, stories and data showing the impact of speaking up, the improvements made and learning generated as a result

• ways to communicate with different groups of workers about speaking up.

Alongside the communications strategy, build in measures to assess the impact of your communications. This enables you to:

- know if you are reaching the whole workforce. This is important, as by identifying who you are not reaching you can determine what other communication channels you should be using

- know which channel, messages or presenter has the biggest impact so that you can exploit that approach when needed

- provide assurance that all workers know how to speak up and have heard that speaking up is welcomed.

Tips:
Things to consider when planning a communication

- Who is the audience (or audiences)?

- What do you want the audience to think, do, say and feel as a result of the communication?

- What are the needs or preferences of each stakeholder group?

- What angle and approach will work best? For example, you might focus on injustice, a 'feel-good' story or someone's personal experience.

- Be persuasive by focusing on the 'why' before the 'how' and the 'what'.

Further reading

Communications Planning: Getting the right message across in the right way. MindTools

Firstup (2019). How to Improve Internal Communications: Goals & KPIs

Sas C, Schmidt N, Patel A (2001). A Systems Approach to Communication Process: Case study within an online community. Department of Computer Science, University College Dublin.

Sinek S (2011). Start with why: How great leaders inspire everyone to take action. London: Penguin

Timms H, Heimans J (2019). New power: how anyone can persuade, mobilize, and succeed in our chaotic, connected age. New York: Knopf Doubleday Publishing Group

Wheatley M, Frieze D (2006). Using emergence to take social innovation to scale.

Find out more

The National Guardian's Office has produced a policy review framework that you can use as a tool to assess your policy.

Responding to speaking up

Principle 4: When someone speaks up, thank them, listen up and follow up.

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved. This may require managers to embed new behaviours and to have the training needed to enable this.

National Guardian's Office training

The National Guardian's Office has published guidance for delivering speaking-up training for health and care workers: National Guidelines on Freedom to Speak Up Training.

The office has also worked with Health Education England to produce online learning for anyone working in health and care. The Freedom to Speak Up in Healthcare in England programme is designed to help workers understand their vital role in building a healthy speaking-up culture that protects patients and service users and enhances worker experience.

Module 1: Speak up is for all workers, including volunteers, students and trainees. Its aim is to help everyone to understand what speaking up is, how to speak up and what to expect when they do.

Module 2: Listen up is for managers at all levels and focuses on listening and understanding the barriers to speaking up.

Module 3: Follow up is aimed at all senior leaders, to help clarify their role in setting the tone around speaking-up culture and behaviours and how speaking up can promote organisational learning and improvement.

Support managers

Managers play a vital role in supporting senior leaders to set the right cultural tone for speaking up and for handling speaking-up matters effectively. Like you, and your senior colleagues, your managers will have influence over how their teams and colleagues behave. Leaders at every level need to role-model the speaking-up principles. It helps workers feel safe, valued and confident to speak up and workers are likely to emulate the values and behaviours they see in their more senior colleagues.

Make sure managers receive the support they need to handle speaking-up concerns. This could include training on listening and providing emotional and psychological support.

For some, it may also require training on how to carry out investigations where appropriate. It can be helpful to produce support material for managers, to help them create healthy, business as usual, speaking-up cultures.

The tips below are for you, as a leader, to share with your managers.

Tips: Guidance for managers

- Encourage workers to speak up in daily working life, including team meetings, supervisions and informal chats. Remind them that speaking up does not have to involve a formal process.

- Thank workers who speak up and give them feedback if necessary.

- If you have concerns of your own, be a positive role-model by speaking up yourself.

- Familiarise yourself with your organisation's speaking-up arrangements.

- Encourage curiosity about – and, where you think appropriate – challenge the status quo.

- Work hard to shift the focus from who has spoken up to what is being said, and from blaming to asking what can be learnt.

- Be aware of the barriers that may prevent workers from speaking up. These include perceptions that speaking up is not acted on, barriers that differing levels of seniority may introduce, or negative responses that make workers feel speaking up is unwelcome.

- Work hard to understand the barriers that colleagues from minority ethnic communities or people who have been recruited from abroad might face. Other groups of workers may face particular barriers to speaking up, as well – gain an understanding of these too.

- Accept that not everyone will feel comfortable speaking up to their line manager. This is not necessarily a reflection on the manager's abilities – it could be for many reasons. Make sure your workers know who they can speak to other than you and share contact details for the organisation's guardian in case they need them.

Learning from speaking up

Principle 5: Use speaking up as an opportunity to learn and improve.

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers. The information gleaned through speaking up is a precious resource that can help boost understanding and performance.

Triangulate data to identify wider issues

To help the board or leadership team identify patterns, trends and potential areas of concern, it is helpful to compare the themes in speaking-up cases with other data and information. You can use this intelligence to identify 'hotspots' where speaking up may be happening more or less often than expected, and to identify what aspects of patient safety and quality, worker well-being and culture need attention.

Below is a list of the types of data that could be used. The size of your organisation will determine how much of this you have available. At a minimum, a smaller organisation could triangulate speaking-up matters with indicators of the quality and safety of patient care (such as patient complaints) and indicators of work well-being (such as sickness rates).

Questions to ask of your data
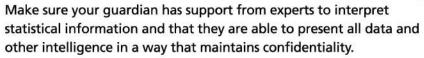
• Why do some departments and staff groups have no issues?

• Who are the outliers, and why?

• Which departments and staff groups have consistently occurring issues?

• How have some departments been able to reduce their number of issues or increase the levels of speaking-up matters raised?

• What is the cause of unexpected spikes?

• Are any issues concentrated in one department or directorate, or do all types appear across different teams or parts of the organisation?

Data you could compare

Patient safety	Worker experience
Patient complaints	Grievance numbers and themes
Patient claims	Employment tribunal numbers and claims
Safeguarding issues	Exit interview themes
Patient safety incidents	Sickness rates
Near misses	Retention figures
Never events	National Staff Survey results, including response rates
Patient experience dashboard data	The National Quarterly Pulse Survey
Friends and Family Test data	Polls or pulse surveys
	Workforce Race Equality Standard, Workforce Disability Equality Standard, Stonewall Equality Index data
	Levels of suspension
	Use of settlement agreements
	Leadership behaviours survey
	Thematic reviews
	Use of suggestion and similar schemes
	Engagement in worker reward and recognition schemes

Tip: Working with data

Make sure your guardian has support from experts to interpret statistical information and that they are able to present all data and other intelligence in a way that maintains confidentiality.

Learn for improvement

The process of building a speaking-up culture requires an organisation to learn over time. As well as putting training in place (see page 16), it is helpful to learn from other organisations going through similar changes or facing similar issues to your own, and sharing good practice. The steps below show how to apply this learning to your organisation.

Step 1: Identify good practice This may be in a number of places including (but not limited to):

- National Guardian's Office case or speaking-up reviews

- NHS England bulletins

- National Guardian's Office monthly newsletters, blogs and case studies published on its website

- FTSU guardian regional and national networks

- FTSU support groups operating in integrated care systems or primary care networks

- your organisation's public information on speaking up – for example, on your website or in board papers or improvement plans.

Step 2: Carry out a gap analysis Complete a simple self-assessment or gap analysis against the good practice. Consider which aspects of the good practice are relevant to your organisation. If, at first, some appear irrelevant, could you adjust them to your organisational circumstances?

Step 3: Update your plan If you identify any improvement actions, add them to your annual improvement plan, to give your senior team or board an overview of the continuous improvement work you are doing.

Step 4: Share the good practice you have seen or generated, following the communications advice in Section 3.

Supporting Freedom to Speak Up guardians

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements.

The guardian role is a wide-ranging and complex one. Not only does it involve responding to workers who speak up and supporting them – it also involves:

• gaining a deep understanding of the organisation's speaking-up culture

• working extensively across the organisation to enable all speaking-up process to work well

• working in partnership and challenging senior leadership

• acting as a point of triangulation where quality of services and worker experience meet.

The role is expected to operate with a high degree of independence. However, this must be achieved without creating a sense of isolation or at the expense of co-operation. Guardians deal with complex, often distressing situations, supporting workers who may be in crisis. So, in addition to practical support, they need time and access to support mechanisms for themselves.

Find out more

The guardian job description must follow the <u>universal job description</u> drawn up by the National Guardian.

The guardian must follow the guidance produced by the <u>National Guardian's Office</u>.

Guardian development must follow the <u>National Guardian's education and training pack</u>.

The National Guardian's Office provides <u>guardian training</u> and maintains a <u>guardian database</u>.

The guardian role

The guardian role is designed to meet several important outcomes. To achieve them, the role involves:

- **Reactive elements** Responding to workers who want to speak up and managing each case, including the initial conversation, by accurately recording, following up and feeding back

- **Proactive elements** Specifically:
  - looking at barriers to speaking up and working in partnership to help reduce them
  - communicating the role and making sure there is appropriate training on speaking up
  - supporting and challenging senior leaders, including through producing regular reports for the senior team or board

- **National requirements** Fulfilling the expectations of the National Guardian's Office, including:
  - providing information and regular data returns such as details of the cases they handle
  - reading and carrying out gap analyses based on case review or speaking-up review reports
  - playing an active part in guardian networks, including attending regional and national meetings, training and other events
  - making sure their knowledge and skills are current, including taking part in National Guardian Office training, keeping abreast of and implementing national guidance, and taking part in other activities such as webinars and conferences

- **Other elements** Including self-development, taking part in supervision or mentoring where needed, and supporting their own emotional and psychological well-being.

Guardian models

If the workers in your organisation do not already have access to a guardian, decide whether you want to appoint one to support your own organisation or to share guardian support with a partner organisation.

For smaller organisations, there are pros and cons for each option:

- **Guardians who work within the organisation they support** are close to where care is delivered and the people who deliver it. They understand local culture and can build trust. However, managing confidentiality and real or perceived conflicts of interest can be challenging. Guardians may be too close to the issues that workers wish to speak up about and risk losing essential impartiality.

- **Guardians who work outside the organisations they support** may be seen as more independent, but their distance from the organisation could affect their visibility, relationship building and capacity for proactive culture-building activities.

Further reading

National Guardian's Office (2021). Exploring Freedom to Speak Up. [For primary care and integrated settings.] London: NGO

Sharif N (2020). Inclusive Recruitment Toolkit. London: NHS England

Zapantis E (2021). Recruiting for Inclusion. Blog. NHS Confederation

Recruiting guardians

Appointments to guardian roles – whether paid or voluntary – must be based on fair, open and inclusive competition. This is important for three reasons:

- It reassures workers that their guardian will operate independently, impartially and objectively (as they are required to).

- It gives workers more assurance they will be supported and listened to when they speak up.

- It provides opportunities for a diverse pool of candidates who can bring a wide range of skills, experience and values to the role.

Despite this, in 2020 62% of respondents to the National Guardian's 2020 Survey report revealed they had been recruited without open competition. This presents a risk for their organisations: if workers do not trust that their guardian is independent and impartial, they may not speak up.

Tips: Appointing a guardian

- Given the importance of being able to encourage minority ethnic workers and other groups of people to speak up, make sure the selection process includes an assessment of the candidates' ability to:
  - understand unconscious bias
  - sensitively ask probing questions to draw out discrimination
  - appreciate the factors that may prevent minority ethnic people from speaking up
  - understand people's different cultures and behaviours.

- Once the guardian is recruited, they need to undertake training from the National Guardian's Office and register on the Guardian Directory. Your guardian cannot begin to publicise their role or handle cases until they have been trained and registered.

Evaluating ringfenced time

However much ringfenced time is currently allocated to the guardian, you must have measures in place to evaluate whether they, and those who support them, have enough time.

Tips:

Questions to help evaluate the adequacy of ringfenced time

- Does the guardian have time to carry out both the reactive and the proactive parts of the role as well as satisfying development needs?

- How long do workers wait between approaching the guardian and the initial conversation, to better understand the matter they are speaking up about?

- How far are champions satisfied with the amount and quality of leadership and training they receive to support them in their role?

- What does feedback highlight about workers' experience of the speaking-up guardian when they have spoken up?

- Has the guardian completed all their actions on the speaking-up improvement action plans - on time and to a high standard?

Factors to include in your calculations

- **The number of workers in your organisation** - The larger your workforce the more time your guardian will need to help them speak up.

- **The number of organisations your guardian supports** - Irrespective of the number of staff, the more organisations your guardian supports, the more time they will need to engage with different senior leadership teams, work in partnership with others and properly understand and address barriers to speaking up.

- **Geographical spread and the number of sites** - In spread-out organisations, guardians may need to spend more time to connect with people, developing digital communications and engagement, or providing leadership to champions.

- **Progress against indicators** - The greater the need for improvement highlighted by tools like the NHS Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES), the more likely it is your workers need to speak out. It is also more likely that the issues they do speak out about will be complex and will take more time to talk through, understand and resolve.

- **Improvement initiatives -** Any widescale work that seeks to address cultural issues may increase people's awareness of, and willingness to speak up about, related matters.

- **The wider context -** The general environment in which your organisation is operating has an impact on workers. So, at times of change – such as mergers, organisational or operational restructuring, changes in Care Quality Commission (CQC) rating or entering special measures – guardians may see increased workloads.

Line managing the guardian

Unless the guardian has the skills, resources and support to provide a positive speaking-up experience, workers may lack the confidence to speak up – or, if they do, may not want to repeat the experience. So, as with any other role, the guardian will benefit from the support of a line manager as well as senior people to escalate matters to.

They also need to meet their organisations' wider expectations around line management – for example, supporting guardians to evaluate and address any development needs and to assess their performance appropriately.

Line managing a guardian is similar to line managing any other role. The main differences relate to the risks of breaching confidentiality or impinging on the guardian's independence. The guardian and their line manager need to address and clarify those issues early in their relationship, to make sure expectations are clear.

Find out more

Line managers will find the National Guardian Office's universal job description and guardian's education and training guide useful, as well as other guidance.

Troubleshooting

The level of speaking up in an organisation, and the support that a guardian will need to provide, will fluctuate over time. Periods of significant change, incidents that identify poor quality, and external factors that might affect the workforce may all indicate that the available level of guardian support should be reassessed.

Case-handling procedures

It is important to have clear procedures in place around how cases are managed and handled. This helps with transparency and enabling everyone to understand the role they play. Having clarity on roles will help you swiftly escalate serious safety issues. Ideally, develop these procedures in partnership with managers, as they play a key part in looking into the concerns brought to the guardian.

Speaking-up data

The guardian is required to provide data to the National Guardian's Office each quarter. This enables learning and gives confidence to workers about the commitment of the organisation to building an open culture. Please support your guardian in this regard.

Tackling barriers to speaking up

Principle 7: Identify and tackle barriers to speaking up.

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether across the entire organisation or in small pockets. Finding and addressing them is an ongoing process.

Identify barriers to speaking up

Barriers are likely to shift over time, depending on how safe and confident workers feel at work (their internal, psychological wellbeing) and on external factors, such as changes in others' behaviour, financial security, difficulties at home or colleagues gossiping.

It is vital that the leadership team has a deep understanding of their workforce and empathy for those who are least heard. Freedom To Speak Up (FTSU) guardians play an important role in helping leaders identify the groups of people facing barriers and in helping deliver actions to bring about change.

Examples of barriers to speaking up

• Perceptions that nothing will happen as a result

• Fear of being viewed as a troublemaker

• Fear of judgement about raising a matter

• Fear of reprisals from colleagues, peers, managers

• Fear of impact on career

• Fear of jeopardising employment or residency status

• Language and cultural barriers

• Lack of confidence in the process

• Lack of trust in the FTSU guardian

• Lack of confidence the senior team will take the concern seriously

• Lack of positive experience about the benefits of speaking up

• Lack of time or not knowing how to speak up

• No response from the senior team after speaking up before

• Dissatisfaction with the investigation into, or response to, a previous speaking-up matter

• Communications about speaking up being delivered in a narrow or formulaic way

Groups that may face barriers

Anyone may feel vulnerable or encounter barriers to speaking up at any time. However, the 2020 Guardian Survey highlighted the following people as facing particular barriers to speaking up:

- members of minority ethnic groups

- people identifying as LGBTQ+

- people living with disabilities or long-term health conditions

- people who have spoken up previously

- people without regular access to IT

- people on the lower pay bands

- students

- junior doctors on rotation, part-time workers, night-shift workers and community-based workers

- very senior workers who are concerned about career progression

- people who have been recruited from abroad and are working in England on a visa

- people who trained abroad

- people who had previously lived or worked in a culture in which concerns were not raised.

Tackling barriers

The best way to identify the barriers and assess how prevalent they are is to talk to people: through one-to-ones, focus groups, discussions with networks, forums, polls, surveys, digital message boards and social media.

Staff networks provide a place for people to come together and share their experiences. They may be somewhere those who are least often heard feel safe and included. So, it is crucial that Guardians build strong connections with all staff networks as part of their work to understand the barriers some people face to speaking up. The very purpose of staff networks is to make a difference, so working with them to co-create solutions would be sensible, and may give proposed changes more traction.

Barriers break down gradually as trust grows – and this happens when people's actions match their words. Most of the work to break down barriers involves ensuring clear and consistent messaging, role-modelling the behaviour you ask of others and following through on your commitments.
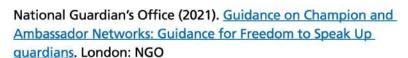
Appoint speaking-up champions
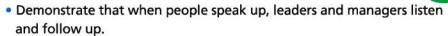
Only FTSU guardians can handle cases, but to promote speaking up and build trust with people who experience barriers to speaking up, many organisations also use a network of champions. This approach has been particularly effective in organisations with a large geographical spread and multiple sites, or where a guardian works across a partnership or networks of organisations.

It is important that the champion role is well understood – by the champions themselves and by the workers they are supporting.

Find out more

National Guardian's Office (2021). Guidance on Champion and Ambassador Networks: Guidance for Freedom to Speak Up guardians. London: NGO

Tips: Building trust

- Demonstrate that when people speak up, leaders and managers listen and follow up.

- Communicate through a variety of traditional, digital and social-media channels and enlist the help of community influencers.

- Include speaking up in all local induction programmes – not just the corporate one.

- Repeatedly emphasise to groups most likely to face barriers that you value the voice and experience of all your workers.

- Repeatedly send messages to the whole organisation that you, and other senior leaders, will not tolerate people victimising those who speak up.

- Raise awareness of the importance of civility, respect, diversity and inclusion.

- Talk to people about their fears and ask what would help them speak up, making sure you respond compassionately and empathetically and thank them for sharing their experiences.

- Implement a 'just culture' approach across the whole organisation to ensure that the emphasis is on improvement, not blame.

- Understand your own biases.

- Understand the pressures workers face, and their fears – particularly in those from under-represeted groups or those that have faced exclusion or discrimination.

- Show you will take time to listen well and take issues around bias and discrimination seriously.

Tackle detriment

Speaking up is often associated with retaliation or detriment.

• **Retaliation** is intended harm to the person who has spoken up.

• **Detriment** is the harm experienced by the person who has spoken up, even if this harm was not intended.

Retaliation and detriment can impact on the person's health and well-being and may lead them to leave the team or organisation. Some people who have spoken up say that even though they felt that speaking up led to a positive outcome, they found the process stressful and believe that this stress had a negative impact on their performance.

Examples of detriment

• Being dismissed, a contract not being renewed or being made redundant

• Receiving a negative performance appraisal or disciplinary action

• Being moved to less-desirable duties or locations, or being demoted or suspended

• Being denied the information or resources to do the job properly

• Being overlooked or denied accesses to promotion or training

• Being criticised for speaking up

• Being refused support to manage the stress associated with speaking up

• Being bullied, excluded or treated negatively

• Being perceived as a troublemaker

If a worker feels they have experienced detriment as a result of speaking up, the matter should be looked into by their manager or someone more independent, or through your formal grievance procedure. You may also consider signposting the worker to NHS England's Speaking Up Support Scheme. Your organisation's process should be set out in your speaking-up policy.

Ideally, a senior speaking-up lead, such as the non-executive director (NED), should have sight of any grievances that involve allegations of detriment.

You and your senior colleagues need to communicate that detriment will not be tolerated. When it does occur, it is important that you act – and are seen to act.

It is one thing to respond to detriment when it happens. It is another to proactively try and prevent it occurring. So, it is important that guardians share themes and learning from the work they do around allegations of detriment to enable individuals and teams responsible for organisational development to think through how to prevent it.

Continually improving speaking-up culture

Principle 8: Know the strengths and weaknesses of the organisation's speaking-up culture and take action to continually improve.

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.
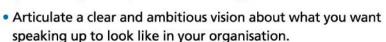
Writing your improvement strategy

You will want to develop a Freedom To Speak Up (FTSU) improvement strategy, but it does not matter what you call it as long as it incorporates goals that are well thought out, measurable and have been signed off by the senior team or board.

The strategy should set out clearly how speaking up fits in with the organisation's overall strategy and how it supports the delivery of related strategies. So, it should highlight the benefits of developing your speaking-up culture alongside other work to develop a healthy culture and behaviours, compassionate leadership and an inclusive workplace, and to increase civility and respect. Part 3 of this guide (page 36) shows how working on Freedom to Speak Up has a positive knock-on effect on many other important aspects of your culture and improvement work.

The strategy needs full buy-in from managers because its success depends on their willingness and ability to look into whatever matters are raised through the guardian.

Tips: Writing the improvement strategy

- Articulate a clear and ambitious vision about what you want speaking up to look like in your organisation.

- Set out ambitions and aims, based on a diagnosis of any speaking-up issues or areas for improvement that the organisation is currently facing. This should draw on learning from the National Guardian's case-review recommendations and best practice from others (for example, peer networks).

- Highlight any groups of people, geographical locations or service areas needing focus.

- Include clear objectives, measures and targets to monitor improvement.

- At the planning stage, think about what the values, behaviours, skills or knowledge you need to underpin your strategy.

- Co-producing the strategy with a diverse range of relevant stakeholders, including managers, will ensure there is a shared vision for speaking up.

- It should be signed off by the senior team or board, with planned periodic updates.

- Make sure the objectives include a focus on developing leadership values, behaviours, skills and knowledge that will help deliver the speaking-up vision.

The improvement and delivery plan

An improvement and delivery plan will help you deliver the strategy and attain the goals it sets out.

At first, the plan may focus on delivering your strategy, but over time it may evolve to include further actions in response to ad hoc gap analysis from best practice or recommendations from the National Guardian's guidance or case reviews.

A good plan will contain success measures and information about how you will measure whether you have achieved your improvement goals.
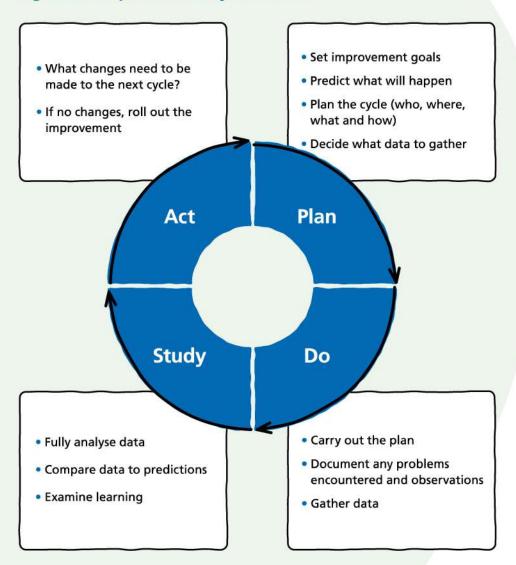
Sharing the updated plan and a progress report with your workers, senior team and board, if you have one, will demonstrate that you value speaking up.

Continuous improvement

Implementing a speaking-up culture is not a linear process. It takes time, and discovering which activities make the most difference to your organisation involves trial and error. Once you have implemented your improvement action plan (see above), you need to measure its impact to assess whether it is genuinely leading to positive change. The best way to do this is through a quality improvement approach to measuring and assessing for improvement.

A common model used in quality improvement is plan, do, study, act (PDSA) – also known as small cycles of change. This model (shown in Figure 2) shows an ongoing process of implementing, testing and changing, to create incremental improvements rather than a single, radical transformation, with each cycle of change building on previous learning.

Figure 2: The plan, do, study, act model

- What changes need to be made to the next cycle?
- If no changes, roll out the improvement

- Set improvement goals
- Predict what will happen
- Plan the cycle (who, where, what and how)
- Decide what data to gather

Act **Plan**

Study **Do**

- Fully analyse data
- Compare data to predictions
- Examine learning

- Carry out the plan
- Document any problems encountered and observations
- Gather data

Find out more

Plenty of resources are available to help you develop your understanding of quality improvement and build skills. NHS England provide several useful resources:

- **Improvement Fundamentals** is a free course providing an introduction to improvement.

- **The Sustainable Impact Framework** is a tool that systematically captures the impact of widescale change programmes, tailored to support improvement work in complex systems.

- **Making Data Count** is a suite of practical guides and tools to help in using data to measure progress over time in system and service improvement. The resource includes simple tools and guidance on run charts and statistical process control charts.

- **The Statistical Process Control Tool** is free and easy to use. Paste in your data and it will generate a chart and flag anything needing investigation.

Indicators of concern

- Low numbers of cases (or none at all) are being raised with guardians.

- A high proportion of the cases raised are anonymous.

- A high proportion of the cases raised include an element of detriment for speaking up.

- The guardian does not have enough time to complete the activities set out in the universal job description, follow the guidance from the National Guardian's Office, attend network events and develop in the role.

- Guardians express frustration at the lack of support or action from their board or senior leaders.

- A guardian has been recruited through a process that was not fair and open.

- The annual staff survey (if your organisation has one) has a low participation rate.

- Your organisation scores poorly in response to Question 18f in the NHS Staff Survey or has a high overall score but certain groups score negatively.

- There is a low reporting rate for serious incidents and never events.

- There are lengthy delays in looking into speaking-up cases.

- Little change or learning is identified from speaking-up cases.

- There is high staff turnover overall, or in specific areas.

- Levels of worker satisfaction indicated by the staff survey, or within specific groups of people, are low overall.

Assurance

An important part of a speaking-up culture is having assurance that certain factors are working well. You and your senior colleagues or board need to seek ongoing assurance that the following are taking place:

- workers speak up with confidence and are treated well

- if there is evidence that a worker has been victimised as a result of speaking up, action is taken to address this

- workers who have suffered victimisation as a result of speaking up receive appropriate support and redress

- barriers to speaking up are identified and tackled

- all leaders and managers role-model speaking up and set a positive tone for speaking up

- learning is identified and shared across the organisation

- improvement actions are monitored and evaluated to ensure they lead to improvements.

Ways to gather assurance

Seeking assurance requires a proactive approach as the factors above may not be immediately apparent without some investigation, using a number of different approaches to gather information. For example:

- **Listen to workers** - Gather people's experience through walkabouts, conversations with governors, speaking-up cases, guardian user feedback, grievance themes, exit interviews, worker experience stories, polls and surveys, social-media comments, culture and behaviour reviews, staff networks and trade union representatives. What are workers telling you about the speaking-up culture and what needs improving?

- **Request a report from your guardian** - You should receive this at least twice a year.

- **Identify and audit the 'problem areas'** - Go out and actively seek problems, hold listening interventions and identify issues and themes, compare data from different sources to get a bigger picture, and do deep dives to identify what aspects of your speaking-up culture need to improve.

- **Assess governance** - If you have a NED, ask them to assess the effectiveness of your organisation's processes to ensure that the board, senior team and managers get to hear about risks and issues.

- **Learn from others** - Complete a gap analysis against what other organisations are doing, new national guidance, Model Hospital data, National Guardian Office case reviews (summary doc) or CQC thematic reports, to identify what about your speaking-up culture needs improving. Most of the analysis will be completed by your guardian. However, this does not preclude the senior lead for FTSU or the senior team or board forming their own views on areas for improvement.

The guardian report

The guardian writes and presents this report. The senior lead may support the guardian in this to ensure their report reflects internal house style, but the ideas, themes or issues they present must not be distorted. The report should not simply consist of a list of data, themes or activities carried out. It has to contain a detailed assessment – the 'so what?'.

> **Further reading**
>
> National Guardian's Office (year). Recording Cases and Reporting Data: Guidance for Freedom To Speak Up guardians. London: NGO

The guardian report should have three parts.

Part 1 (assessment of cases) should provide assurance that matters being spoken up about are quickly evaluated, escalated and responded to. It should also observe whether change has occurred as a result and what assurance the Guardian has received from the relevant manager that any change will address the issues highlighted and prevent them from arising again.

Part 2 (action taken) focuses on:

- providing assurance that FTSU arrangements are continually evaluated and improvements identified

- illustrating the barriers that exist in your organisation and what the plan is to remove them

- providing information on the level of detriment for speaking up and any issues underlying this

- offering assurance that there are good processes for dealing with this, that the processes are used and there is an action plan for improvement (no matter how good or bad things are)

- assurance that the speaking-up arrangements are continually improving as a result of user feedback, audit and gap analysis against good practice.

In Part 3, the report makes recommendations.

Full detail of the contents is shown on the next page.

What the guardian report should include

Part 1. Assessment of cases

• The number and types of cases being handled by the guardian(s)

• Analysis of trends, including whether the number of cases is increasing or decreasing, any themes in the matters being raised (such as types of issue, particular groups of workers who speak up or areas of the organisation in which matters are being raised more or less frequently than might be expected), and information on which groups of workers are, or are not, speaking up

• What has been learnt and what improvements have been made as a result of workers speaking up

• Potential patient-safety or worker-experience issues

• How speaking-up matters fit into a wider patient safety or worker experience context, to help build a broader picture of the speaking-up culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve.

Part 2. Action taken to improve speaking-up culture

• Actions taken to increase the guardian's visibility and promote all speaking-up channels

• Actions taken to support any workers who are unaware of the speaking-up process or who find it difficult to speak up

• Assessments of the effectiveness of the speaking-up process and individual case handling, including user feedback, pulse surveys and learning from case reviews

• Potential improvements following reports of workers feeling they have suffered detriment for speaking up

• Actions taken to improve the skills, knowledge and capability of workers to speak up, to support others to do so, and to respond to the issues they raise effectively.
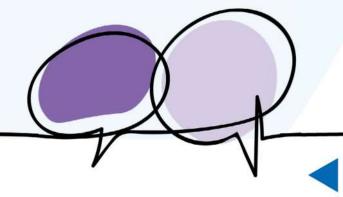
Part 3. Recommendations

Recommendations for any required action, with data and other intelligence presented in a way that maintains confidentiality.

Part 2
Building widespread cultural change

Part 2 sets out other transformational work that you could carry out alongside work on Freedom to Speak Up.

Carry out wider cultural improvement
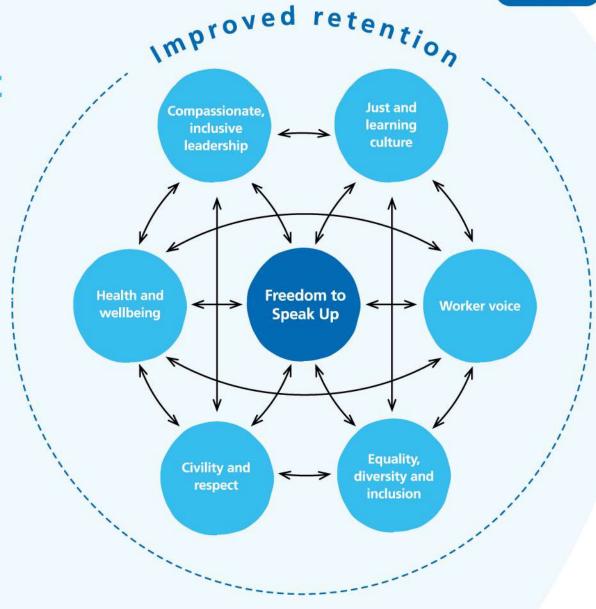
Ideally, improving your speaking-up culture should form part of wider culture improvement work because a healthy speaking-up culture is also one where people feel safe and confident to:

• share their thoughts, experiences and improvement ideas

• participate in health and wellbeing conversations

• call out incivility, discrimination or bullying.

Compassionate and inclusive working environments have a positive impact on staff engagement, too. If people feel comfortable doing all these things, this increases the likelihood they will stay working within the NHS.

For detailed information on how to retain staff read the Improving staff retention: a guide for line managers and employers.

This part of the guide highlights the powerful links between Freedom to Speak Up (FTSU) and other elements of a compassionate and inclusive culture. The individual sections provide an overview of the relevant elements. They are not presented in priority order.

Improved retention

Compassionate, inclusive leadership

Just and learning culture

Health and wellbeing

Freedom to Speak Up

Worker voice

Civility and respect

Equality, diversity and inclusion

Compassionate, inclusive leadership

Compassionate and inclusive leadership has a profound impact on health and care at every level, from the experience of patients, service users and workers to the effectiveness of teams, organisations and systems. This approach to leadership is a key component of positive worker experience and wellbeing. Research has shown that the experience of staff supported by compassionate leaders is strongly associated with good quality of care for patients and service users.

It is also a powerful facilitator for innovation. Compassionate leaders support the creative and problem-solving process by giving time to every individual, understanding their challenges, empathising with them, and having the motivation to help each person to whom they offer leadership.

It involves being present for all and helping all those they lead. To nurture a culture of compassion, organisations require their leaders to be the 'carriers of culture' – to embody compassion in their leadership.

How it links with speaking up

When leaders set a tone of psychological safety in an organisation, people feel more able to speak up about the things that concern them. Creating a compassionate, inclusive culture ensures that every voice really matters and that every concern or issue raised will be treated respectfully. This supports staff wellbeing as well as retention.

Leaders are key to creating an environment that enables psychological safety, through:

- paying attention to those around them and seeing for themselves the challenges that colleagues face

- listening carefully and getting alongside colleagues who feel there are concerns within the organisation

- seeking to truly understand and empathise with those who want to improve care by raising issues

- taking action to determine how, together, colleagues can make the changes they wish to see.

Find out more

NHS England's Culture and Leadership programme is a modular, which provides organisations the opportunity to understand more about their own culture using evidence based tools to help them develop compassionate, inclusive and collective leadership that will being about culture change.

Further reading

Catlin K (2021). Better Allies – Everyday actions to create inclusive, engaging workplaces, 2nd edn. Better Allies Press.

NHS England. The Culture and Leadership programme links to a host of resources including guidance, case studies and wider reading, in particular:

- Changing healthcare cultures – through collective leadership

- What does compassionate and inclusive leadership mean to us?

- Trauma Informed Compassionate Leadership – Helping NHS leaders, teams and individuals to recover from the trauma of COVID-19, a compassionate approach

West MA (2021). Compassionate Leadership: Sustaining wisdom, humanity and presence in health and social care. The Swirling Leaf Press.

Wise T (2020). Fieldnotes on Allyship: Achieving equality together. Our Human Family Inc.

Just and learning culture

'Just culture' is a concept adopted from systems thinking. It holds that mistakes usually result from organisational issues rather than individual fault. 'Learning culture' is a related approach in which the senior teams or board commit to ongoing learning. In health and care, a just and learning culture helps workers feel confident to speak up when things go wrong, rather than fearing blame if they do so. Supporting workers to be open about their mistakes allows valuable lessons to be learnt so that organisations can prevent the same errors from being repeated.

How it links with speaking up

A just and learning culture creates an environment where Freedom To Speak Up can thrive – because speaking up when things go wrong becomes normal, everyday practice. Both approaches focus on learning when things go wrong and improving as a result, rather than finger-pointing or seeking blame (sometimes expressed as 'what was responsible, not who is responsible').

This does not equate to an uncritical, overly tolerant culture where 'anything goes': it means everyone being accountable but also feeling supported by their organisation.

Further reading

NHS England. A Just Culture Guide.

Horizons A-practical-guide-to-the-art-of-psychological-safety-in-the-real-world-of-health-and-care-.pdf (horizonsnhs.com).

Find out more

Principles and Practice of Restorative Just Culture. Four-day course. Mersey Care NHS Foundation Trust in partnership with Northumbria University.

Worker voice

Worker voice (also known as staff voice or employee voice) is the means by which people communicate their views at work and influence matters that affect them. A person's level of psychological safety strongly affects how they feel about sharing thoughts with others in the workplace, so this provides a bedrock for voice.

Effective voice contributes to multiple positive outcomes, not only for individuals but also for organisations and systems, as it supports innovation, productivity, increased job satisfaction, employee engagement and wellbeing and, ultimately, staff retention. When workers can speak out about their experience, this enables organisations to create a great work environment. This, in turn, helps organisations provide the best possible care, attract and retain staff, and improve staff health and wellbeing.

Like other areas of cultural improvement, building effective voice within an organisation has to be done through multiple initiatives – designing and developing approaches to communications and line management that nurture trust, which, in turn, enables workers to use their voice. It also involves looking at other factors that impact on worker experience, such as wellbeing, employer brand and communication. To be effective, this work must be championed by leaders.

How it links with speaking up

This guide focuses on speaking up as a means of reporting an area of concern. However, speaking up also encompasses completing the national NHS Staff Survey, the new quarterly pulse survey, sharing thoughts with a senior leader on a board walkabout or using social media to share an opinion. All of these are ways for workers to share their voice.

Find out more

NHS England. We each have a voice that counts. Includes links to multiple resources including webinars, books, case studies, articles and training.

In April 22 the Staff Engagement Team in NHS England published a Listening Strategy. The document is designed to consolidate existing information about the national tools available to listen to staff and how each provides a complementary view of worker behaviour and sentiment to support improving employee experience and in tandem – patient experience. It also proposes several ways that NHS Trusts could expand on their approach to listening. The document will be available via Employee Experience and Engagement - FutureNHS Collaboration Platform.

For NHS organisations three listening tools are available: the NHS Staff Survey, the National Quarterly Pulse Survey and the monthly Pulse Survey, as well as the accompanying free People Pulse Diagnostic Tool.

A short animation describing how the Staff Survey links to the People Promise https://youtu.be/UT2Qwj8nqvc

Equality, diversity and inclusion

Equality, diversity and inclusion (EDI) has been described as the golden thread that runs through everything that happens in health and care. It informs behaviour, planning, policy, practice, process, operations and strategy and – above all – care. Applying the EDI lens to our work means consciously and actively advancing equality and producing evidence for continuous improvement, to keep workers, patients and service users physically and psychologically safe. This is not just our duty as care providers: it is a moral imperative.

Inclusion through speaking up can further be reinforced by enabling an 'effective ally' workforce. This involves workers effectively intervening, reporting incidents and speaking up on behalf of others. An effective ally can help de-escalate or even stop wrongdoing and put a halt to bad behaviours.
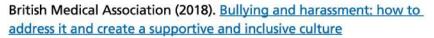
This is in contrast to a bystander culture within workplaces where, despite witnessing wrongdoing to others, people do not speak up. This can have detrimental effects on workplace experience and, ultimately, patient care.

How it links with speaking up

The most vulnerable workers need to feel that it is safe to speak up. By collecting and analysing data to identify any differences in the workplace experiences of different groups, colleagues with a focus on EDI and speaking up can work together to make sure everyone has equal access to speaking up and no one feels that speaking up is not for 'someone like them'.

As a relational exercise, speaking up is effective only if 'listening up' occurs too. This can happen only in psychologically safe spaces where equality and inclusion are the norm and where people across organisations (including line managers and guardians) are familiar with EDI principles. So, it is important that organisations support the growth of staff networks and encourage people's engagement with them. Guardians should reach out to the workforce via the staff networks.

Further reading

British Medical Association (2018). Bullying and harassment: how to address it and create a supportive and inclusive culture

Kline R (2019). Leadership in the NHS. BMJ Leader 3(4).

Kline K, Somra G (2021). Difference matters: the impact of ethnicity on speaking up. National Guardian's Office.

NHS England. NHS Workforce Race Equality Standard.

West E, Nayar S, Taskila T (2017). The progress and outcomes of Black and Minority Ethnic (BME) Nurses and Midwives through the Nursing and Midwifery Council's Fitness to Practise Process. London: University of Greenwich/NMC.

NHS England - Equality, Diversity and Inclusion resources on FutureNHS

Civility and respect

Civility and respect sit behind a positive workplace culture – they are the way people should treat each other. 'Civility' describes a behaviour: treating someone politely or with courtesy. 'Respect' involves valuing other people's experience and feelings. The two are closely linked, as people show their respect for someone by acting with civility.

In health and care, civility and respect involve supporting, valuing and respecting workers for what they do and showing kindness, compassion and professionalism towards workers, patients and service users.

This means addressing behaviours such as unconscious bias, micro-aggressions and micro-behaviours, gossiping, undermining or excluding individuals, along with more obviously visible examples of bullying or harassment, such as rude or unkind behaviour, using a harsh tone of voice, raising one's voice, rolling one's eyes, making sharp comments or being overtly critical.

It also means ensuring that people are civil in their digital communication, avoiding making sharp, harsh or insulting comments on email or social media.

Working in an environment where these behaviours take place can have a debilitating impact on people's health and wellbeing, as well as their performance. Supporting our workers to demonstrate civility and respect, and resolving conflict effectively and informally, is likely to help reduce sickness absence, turnover, presenteeism and low morale, as well as addressing poor communication skills that may lead to allegations of bullying and harassment.

How it links with speaking up

People need to feel confident that if they call out poor behaviour, they will not experience detriment or retaliation (). Creating and promoting psychologically safe spaces by promoting positive working relationships helps make staff feel secure, supported and confident to speak up, providing a healthier outlook for all. A speaking-up culture – whether speaking to line managers or guardians – plays a crucial role in developing a culture of civility and respect.

Further reading

NHS Employers (2019). Professionalism and Cultural Transformation Toolkit. NHS Employers.

Porath C (2016). Mastering Civilty: A manifesto for the workplace. New York: Grand Central Publishing
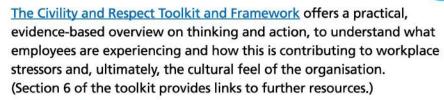
Turner C. When rudeness turns deadly. TED talk about incivility by UK emergency medicine consultant.

Find out more

The Civility and Respect Toolkit and Framework offers a practical, evidence-based overview on thinking and action, to understand what employees are experiencing and how this is contributing to workplace stressors and, ultimately, the cultural feel of the organisation. (Section 6 of the toolkit provides links to further resources.)

civilitysaveslives.com is the website of a group of UK health professionals who aim to raise awareness of the power of civility in medicine.

Health and wellbeing

For health and care organisations to provide high quality patient care, and to retain a happy and healthy workforce, colleagues need to feel supported at work and able to talk about wellbeing when they need to. Leaders, teams and employers should be offering their workforce access to support that helps them stay well at work. Support should always be available, and at a range of levels – including across teams, organisations, and sectors.

Before COVID-19, the NHS had started to put increasing emphasis on the health and wellbeing of its workers. The NHS People Plan and People Promise make key commitments to create and sustain cultures of wellbeing across the NHS and build on learning gained during the pandemic. This includes leaders thinking about wellbeing in a holistic manner and the many ways someone's wellbeing can be affected, as well as considering the impact of every experience, from a workplace induction to having access to breaks and safe spaces or to the relationship with their line manager.

Organisations are encouraged to promote and support the health and wellbeing of their workforce, not take the traditional approach of acting only when someone is unwell. This includes actively supporting colleagues to access occupational health and wellbeing when needed, and proactively checking in with colleagues to ask how they are. Creating an environment where people are happy and healthy, and supported to achieve their individual ambitions while delivering the highest levels of care, will help retain them in the NHS.

How it links with speaking up

For workers to speak up, they need to feel safe, respected and included, and assured that they will not be discriminated against. But they also need to feel they will be supported, looked after and cared for.

At the same time, developing a culture where workers feel safe to speak up and that, if they do, action will be taken, will help them feel more able to be open and honest during conversations about their health and wellbeing.

Find out more

The NHS health and wellbeing framework and diagnostic tool sets out the standards organisations need to meet for their workers to feel well, healthy and happy at work.

Three initiatives are being rolled out in the NHS:

- **Wellbeing guardians** are new roles, designed to provide oversight on speaking up at board level.

- **Health and wellbeing champions** are being appointed at all levels, to promote, identify and signpost ways to support wellbeing to colleagues.

- **Health and wellbeing conversations** are one-to-one meetings focus on the health and wellbeing every worker, revised at least annually. These conversations are designed to support the above two roles. Organisations can use this guidance on how to approach a conversation about wellbeing.

Find out more about health and wellbeing champions.

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This publication can be made available in a number of other formats on request.

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Freedom to Speak up
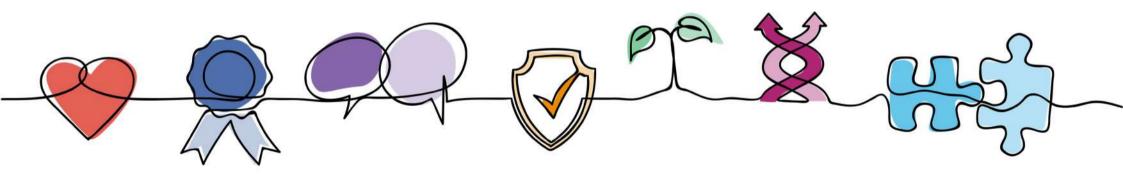
A reflection and planning tool

Introduction

The senior lead for FTSU in the organisation should take responsibility for completing this reflection tool, at least every 2 years.

This improvement tool is designed to help you identify strengths in yourself, your leadership team and your organisation – and any gaps that need work. It should be used alongside Freedom to speak up: A guide for leaders in the NHS and organisations delivering NHS services, which provides full information about the areas addressed in the statements, as well as recommendations for further reading.

Completing this improvement tool will demonstrate to your senior leadership team, your board or any oversight organisation the progress you have made developing your Freedom to Speak Up arrangements.

You may find that not every section in this tool is relevant to your organisation at this time. For this reason, the tool is provided in Word format to allow you to adapt it to your current needs, retaining the elements that are most useful to you.

If you have any questions about how to use the tool, please contact the national FTSU Team using england.ftsu-enquiries@nhs.net

The self-reflection tool is set out in three stages, set out below.

Stage 1

This section sets out statements for reflection under the eight principles outlined in the guide. They are designed for people in your organisation's board, senior leadership team or – in the case of some primary care organisations – the owner.

You may want to review your position against each of the principles or you may prefer to focus on one or two.

Stage 2

This stage involves summarising the high-level actions you will take over the next 6–24 months to develop your Freedom to Speak Up arrangements. This will help the guardian and the senior lead for Freedom to Speak Up carry out more detailed planning.

Stage 3

Summarise the high-level actions you need to take to share and promote your strengths. This will enable others in your organisation and the wider system to learn from you.

Stage 1: Review your Freedom to Speak Up arrangements against the guide

What to do

- Using the scoring below, mark the statements to indicate the current situation.

  1 = significant concern or risk which requires addressing within weeks

  2 = concern or risk which warrants discussion to evaluate and consider options

  3 = generally applying this well, but aware of room for improvement or gaps in knowledge/approach

  4 = an evidenced strength (e.g., through data, feedback) and a strength to build on

  5 = confident that we are operating at best practice regionally or nationally (e.g., peers come to use for advice)

- Summarise evidence to support your score.

- Enter any high-level actions for improvement (you will bring these together in Stage 2).

- Make a note of any areas you score 5s in and how you can promote this good practice (you will bring these together in Stage 3).

Principle 1: Value speaking up

For a speaking-up culture to develop across the organisation, a commitment to speaking up must come from the top.

Statements for the senior lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I have led a review of our speaking-up arrangements at least every two years	
I am assured that our guardian(s) was recruited through fair and open competition	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am regularly briefed by our guardian(s)	
I provide effective support to our guardian(s)	
Enter summarised commentary to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements for the non-executive director lead responsible for Freedom to Speak Up to reflect on	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
I am confident that the board displays behaviours that help, rather than hinder, speaking up	
I effectively monitor progress in board-level engagement with the speaking-up agenda	
I challenge the board to develop and improve its speaking-up arrangements	
I am confident that our guardian(s) is recruited through an open selection process	
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	
I am involved in overseeing investigations that relate to the board	
I provide effective support to our guardian(s)	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture

Role-modelling by leaders is essential to set the cultural tone of the organisation.

Statements for senior leaders	Score 1–5 or yes/no
The whole leadership team has bought into Freedom to Speak Up	
We regularly and clearly articulate our vision for speaking up	
We can evidence how we demonstrate that we welcome speaking up	
We can evidence how we have communicated that we will not accept detriment	
We are confident that we have clear processes for identifying and addressing detriment	
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up	
We regular discuss speaking-up matters in detail	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)	
1	
2	

Statements for the person responsible for organisational development	Score 1–5 or yes/no
I am knowledgeable about Freedom to Speak Up	
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans	
We have adapted our organisational culture so that it becomes a just and learning culture for our workers	
We support our guardian(s) to make effective links with our staff networks	
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how much time the guardian(s) has to carry out their role	Score 1–5 or yes/no
We have considered all relevant intelligence and data when making our decision about the amount of ringfenced time our guardian(s) has, so that they are able to follow the National Guardian's Office guidance and universal job description and to attend network events	
We have reviewed the ringfenced time our Guardian has in light of any significant events	
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s)	
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so

Regular, clear and inspiring communication is an essential part of making a speaking-up culture a reality.

Statements about your speaking-up policy	Score 1–5 or yes/no
Our organisation's speaking-up policy reflects the 2022 update	
We can evidence that our staff know how to find the speaking-up policy	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about how speaking up is promoted	Score 1–5 or yes/no
We have used clear and effective communications to publicise our guardian(s)	
We have an annual plan to raise the profile of Freedom to Speak Up	
We tell positive stories about speaking up and the changes it can bring	
We measure the effectiveness of our communications strategy for Freedom to Speak Up	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 4: When someone speaks up, thank them, listen and follow up

Speaking up is not easy, so when someone does speak up, they must feel appreciated, heard and involved.

Statements about training	Score 1–5 or yes/no*
We have mandated the National Guardian's Office and Health Education England training	
Freedom to Speak Up features in the corporate induction as well as local team-based inductions	
Our HR and OD teams measure the impact of speaking-up training	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about support for managers within teams or directorates	Score 1–5 or yes/no
We support our managers to understand that speaking up is a valuable learning opportunity and not something to be feared	
All managers and senior leaders have received training on Freedom to Speak Up	
We have enabled managers to respond to speaking-up matters in a timely way	
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 5: Use speaking up as an opportunity to learn and improve

The ultimate aim of speaking up is to improve patient safety and the working environment for all NHS workers.

Statements about triangulation	Score 1–5 or yes/no
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them	
We use triangulated data to inform our overall cultural and safety improvement programmes	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about learning for improvement	Score 1–5 or yes/no
We regularly identify good practice from others – for example, through self-assessment or gap analysis	
We use this information to add to our Freedom to Speak Up improvement plan	
We share the good practice we have generated both internally and externally to enable others to learn	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements

Statements about how our guardian(s) was appointed	Score 1–5 or yes/no
Our guardian(s) was appointed in a fair and transparent way	
Our guardian(s) has been trained and registered with the National Guardian Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about the way we support our guardian(s)	Score 1–5 or yes/no
Our guardian(s) has performance and development objectives in place	
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders	
Our guardian(s) has access to a confidential source of emotional support or supervision	
There is an effective plan in place to cover the guardian's absence	
Our guardian(s) provides data quarterly to the National Guardian's Office	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about our speaking up process	Score 1–5 or yes/no
Our speaking-up case-handling procedures are documented	
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	
We are assured that confidentiality is maintained effectively	
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Principle 7: Identify and tackle barriers to speaking up

However strong an organisation's speaking-up culture, there will always be some barriers to speaking up, whether organisation wide or in small pockets. Finding and addressing them is an ongoing process.

Statements about barriers	Score 1–5 or yes/no
We have identified the barriers that exist for people in our organisation	
We know who isn't speaking up and why	
We are confident that our Freedom to Speak Up champions are clear on their role	
We have evaluated the impact of actions taken to reduce barriers?	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about detriment	Score 1–5 or yes/no
We have carried out work to understand what detriment for speaking up looks and feels like	
We monitor whether workers feel they have suffered detriment after they have spoken up	
We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment	
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed	

Enter summarised evidence to support your score.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1

2

Principle 8: Continually improve our speaking up culture

Building a speaking-up culture requires continuous improvement. Two key documents will help you plan and assess your progress: the improvement strategy and the improvement and delivery plan.

Statements about your speaking-up strategy	Score 1–5 or yes/no
We can evidence that we have a comprehensive and up-to-date strategy to improve the speaking-up culture	
We are confident that the Freedom to Speak Up improvement strategy fits with our organisation's overall cultural improvement strategy and that it supports the delivery of related strategies	
We routinely evaluate the Freedom To Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation	
Our improvement plan is up to date and on track	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	
2	

Statements about evaluating speaking-up arrangements	Score 1–5 or yes/no
We have a plan in place to measure whether there is an improvement in how safe and confident people feel to speak up	
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach	
Our speaking-up arrangements have been evaluated within the last two years	
Enter summarised evidence to support your score.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1	1
2	2

Statements about assurance	Score 1–5 or yes/no
We have supported our guardian(s) to structure their report in a way that provides us with the assurance we need	
We have we evaluated the content of our guardian report against the suggestions in the guide	
Our guardian(s) provides us with a report in person at least twice a year	
We receive a variety of assurance that relates to speaking up	
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement	

Enter summarised evidence to support your score.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1

2

Stage 2: Summarise your high-level development actions for the next 6 – 24 months

Development areas to address in the next 6–12 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Development areas to address in the next 12–24 months	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

Stage 3: Summary of areas of strength to share and promote

High-level actions needed to share and promote areas of strength (focus on scores 4 and 5)	Target date	Action owner
1		
2		
3		
4		
5		
6		
7		
8		

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	Date	**01/06/23**
Agenda Item	**42/23i**		
Report Title	**WELL LED REVIEW**		
Executive Lead	Colin Scales, Chief Executive Officer		
Report Author	Jan McCartney, Trust Secretary		
Presented by	Colin Scales, Chief Executive Officer		
Action Required	☒ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary
In January 2023 the Trust commissioned an independent external Well-Led governance review. This paper presents the final report to the Board and asks for the recommendations be agreed.

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

Strategic Objectives

☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☒ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.

☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.

☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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	01 June 2022
Agenda Item	42/23i		
Report Title	WELL LED REVIEW		
Report Author	Jan McCartney, Trust Secretary		
Purpose	In January 2023 the Trust commissioned an independent external Well Led Governance review. This paper presents the final report to the Board and asks for the recommendations be agreed.		

1. BACKGROUND

1.1 In 2018 the Trust was subject to a CQC inspection which resulted in a 'Requires Improvement' rating for the domain of Well Led. The Trust was due for a re-inspection in 2020 however due to the COVID-19 pandemic all CQC inspections were suspended and to date the Trust has not been reinspected. As a result, the Trust commissioned Facere Melius to conduct an independent Well Led Governance review during 2020, which was conducted during the height of the pandemic. The first report was received by the Board in December 2020 at which it accepted the 35 recommended actions.

1.2 In December 2021, KPMG, as part of its external audit work, undertook assessment of the Trust's CQC Well Led Inspection and action plan.

1.3 The action plan was monitored by the Audit Committee at the request of the Board. Whilst completion was delayed due to COVID-19, the Audit Committee signed off most of the actions as completed in October 2022 and agreed that the Well Led Review to be undertaken by Facere Melius early in 2023 would supersede the actions identified by KPMG.

1.4 The Well Led review by Facere Melius commenced in January 2023.

2. PROCESS OF REVIEW

2.1 The review team examined a large number of documents ranging from Trust Board papers (both Public and Closed) and Committee, Executive Team and Trust Council meeting reports and papers.

2.2 Fourteen meetings were observed including Board strategy sessions, with 31 face-to-face and video interviews completed with Board, staff and external partners.

2.3 Facere Melius presented the draft report at a Board Time Out session on 11 May 2023. This was an opportunity for the Board to be taken through each section of the report and consider the recommendations.

2.4 The 2023 report has nine recommendations, these recommendations will be overseen by the Executive Team who will report on progress to the Audit Committee.

3. RECOMMENDATION

3.1 It is recommended that:

a. The report is accepted by the Board, and

b. That the Executive Team will take ownership of the action plan which will report to the Audit Committee.

Confidential Well-led Governance Review for

Bridgewater Community NHS Foundation Trust

Private and Confidential

May 2023

Acknowledgements

Governance review summary of findings and recommendations

A review was undertaken against each of the eight CQC well-led key questions.

1. Is there the leadership capacity and capability to deliver high-quality, sustainable care?

Summary
- Board, a full complement of non-executive and executives in post
- A stable board with executive directors in post for at least two and a half years
- Board, board committees, executive team meetings and council meetings well led and effective
- Robust frameworks and secretariat support
- Board and individual director development in place

Recommendations
1. The trust develops succession -planning for its senior leaders.

2. Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Summary
- The trust has a newly refreshed strategy aligned with ICB/IPC and placed based partners.
- The trust is currently developing its engagement approach and plan.
- The trust has a good data platform to support emerging methodologies – treat, prevent and create.

Recommendations
2. The board agrees its new strategy and delivers its engagement plan.
3. The board agrees on how best to assure itself that its new strategy is being delivered and engaged with, within the trust and externally.
4. Following the agreement of the new strategy, the trust examines the opportunity to align its headings to reports at the board, board assurance framework and the integrated quality and performance report.

3 Is there a culture of high-quality, sustainable care?

Summary
- The board and the senior leadership team demonstrate evidence of a culture of high-quality, sustainable care.

- Strong evidence of trust investment into improving its culture
- Number of HR and OD initiatives in place

Recommendations

5. The board continue to focus on improving its mandatory compliance and PPDR performance.

4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Summary

- The board and executive understand their roles and responsibilities.
- Robust governance frameworks are in place to support the discharge of accountabilities and responsibilities at the board and executive level.
- A newly developed accountability performance framework will help the sub-executive level.
-

Recommendations

6. When the trust implements the accountability performance framework, a support programme is developed for the sub-executive cohort.

5. Are there clear and effective processes for managing risks, issues and performance?

Summary

- The trust provided evidence of clear and effective processes for managing risks, issues and performance.
- Evidence of strong engagement within the trust at all levels
- Good understanding of risk management at the board, board committee and council levels.
- Performance well managed across the trust with effective reporting.

Recommendations

7. The trust should develop a corporate risk register report that themes risks so an overview of the trust's top risks can be presented to the executive for review and then shared with the board and board committees.

6. Is appropriate and accurate information being effectively processed, challenged and acted on?

Summary

- The trust has appropriate and accurate information which is being effectively processed, challenged and acted on.
- All staff interviewed stated they had the correct information promptly to support them, and their teams manage the services for which they were accountable.
- Evidence of effective management of information and its governance.

7. Are the people who use services, the public, staff and external partners engaged and involved to support high-quality, sustainable services?

Summary

- The trust has reviewed and refreshed its strategy for 2023-26. It has engaged with a large group of stakeholders.
- The trust is developing its further engagement approach and plan to support the delivery of its strategy.
- Strong evidence of staff engagement managed by HR & OD

Recommendations

8. The trust delivers on its engagement plan and ensures that measures of engagement are built into the trust's performance reporting.

8. Are there robust systems and processes for learning, continuous improvement and innovation?

Summary

- The trust has developed an effective improvement methodology and has used it to support service improvement (Boost).
- There are several initiatives embedded to improve trust services and celebrate staff achievements.

Recommendations

9. The trust builds on the work carried out by HR &OD to pull together all the achievements of staff, teams and services so this can be highlighted both internally and externally.

1. Background

Bridgwater Community NHS Foundation Trust commissioned Facere Melius to carry out a governance review during 2020. FM carried out this review during the height of the Covid-19 pandemic, and FM shared the findings and recommendations with the trust board in December 2020. The board subsequently developed an action plan and has worked hard to implement the actions contained within it. Two and a half years later, the trust commissioned Facere Melius to carry out another governance review, with the engagement and fieldwork commencing in January 2023.

This report is strictly private and confidential to the chair and chief executive; it should not be shared without their express agreement. The scope was agreed with the chair and chief executive.

2. Facere Melius

Facere Melius (FM) means to make better. We are a healthcare improvement consultancy which offers unique combination of insight, innovation and experience. experts in corporate, quality, and safety governance we bespoke our support to client need, evolving our delivery plans as we understand the heart of the problem.

We are an approved NHS framework provider for NHS independent investigations, well-led governance reviews and governance improvement. We work with organisations that want to achieve excellence or for those in challenging situations.

We specialise in:
- Patient safety training
- Improvement and review work
- Investigation work

3. Review Process

The trust's chair and chief executive agreed to the scope of the review. The review team was led by Howard Scott, senior associate, and the report was reviewed by Darren Thorne, Facere Melius managing director.

Document review

The review team had access to and examined a range of documents ranging from and including trust board papers (public and private), board committee reports and papers, executive team meeting reports and papers, several trust council meeting papers and papers supporting DIGIT and the transformation process (see appendix one).

Some documents were provided for reference, whilst others have been considered in more detail. The review team has not assessed compliance of policies against national legislation or guidance.

Observations
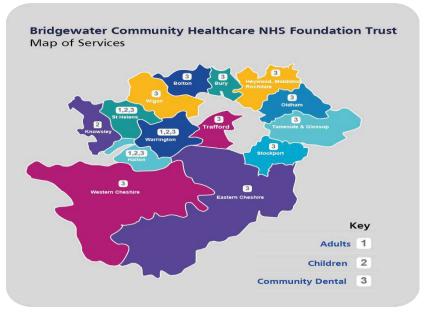
The review team completed 14 board, board committee and other meeting observations, which include the strategy session, board, board committees, operational and management groups (see appendix two). This aimed to assess and evaluate meeting preparedness, discipline, effectiveness, the maturity of discussions and decision-making processes, and the robustness of assurance. Observations were undertaken during January and February 2023.

Interviews

Thirty-one face-to-face and video conference interviews were completed throughout the review. Interviews were conducted with the chair, chief executive, governors, non-executive directors, executive directors, directors, deputy, assistant / associate directors, and senior partner officers from other NHS organisations, local authorities and place (see appendix three). FM arranged these interviews to understand current practices and gather views on the maturity and effectiveness of the trust's current governance and engagement arrangements.

4. Background and context

Bridgewater Community Healthcare NHS Trust (Bridgewater) was established in April 2011 when community service providers from PCTs in Warrington, Halton, St Helens, Trafford plus community dental services transferred into a single trust (formerly Ashton, Leigh and Wigan Community Healthcare NHS Trust). The trust achieved 'Foundation Trust' status in 2014.

Bridgewater Community Healthcare NHS Foundation Trust
Map of Services

Key

Adults   1
Children   2
Community Dental 3

The trust provides community and specialist services to people living in:

- Halton
- St. Helens
- Warrington

Community Dental Network. Services in all the above areas plus Bolton, Bury, Heywood, Middleton, Rochdale, Tameside, Trafford, Glossop, Stockport and Western Cheshire.

The trust aims to deliver its services closer to patients home and most of its services are delivered in patients' homes or at locations close to where they live. Such as:

- clinics
- health centres
- GP practices
- community centres
- and schools.

The trust is a provider of both mainstream and specialist care, and its role is to focus on providing cost effective NHS care. It attempts to do this by keeping people out of hospital and supporting vulnerable people throughout their lives.

The trust aims to keep people healthier for longer by developing more specialist services to support people to live independently at home.

The trust has relationships with other providers that are key to enable them to effectively meet the needs of the people in those communities it serves. The trust works closely with Warrington and Halton Hospitals NHS Foundation Trust in both a strategic and operational capacity to support the delivery of joined-up care.

The trust has a large geographical footprint and works closely with acute hospitals and other healthcare providers in its different localities. The trust is part of the Cheshire & Merseyside Health & Care Partnership which has 9 Places. It works with the newly created [July 2022] Integrated Care Board (ICB) and Integrated Care Partnership.

In each place, there are programmes of work at the system or place level that focus on addressing health inequalities across the population and joining up health and care systems to provide the right care at the right time at the right place. The trust originally developed its 'Our Quality and Place strategy' 2018 and set out its strategic plans for 2018 – 2023. This was further updated and refreshed in 2021-23. The new strategy 'Communities Matter - Creating stronger, healthier, happier communities', has been developed to cover the period 2023 – 2026.

The trust's primary NHS commissioners are NHS Cheshire and Merseyside Integrated Care Board.

5. Opening statement

The purpose of good governance is to promote the best long-term interests of the organisation. It requires an effective board of directors, with an appropriate balance of skills and experience and well-motivated individuals as directors. The composition of the board, its functions and responsibilities, and effectiveness are, therefore, core issues in governance [ref: ICSA health service handbook].

A sound and effective framework of governance is essential; it provides a safe and supportive environment within which high-quality healthcare can be delivered and gives an assurance that public money is being used well and for its intended purpose. [ref: HFMA NHS Governance]

6. Key findings

The well-led framework is structured around eight key lines of enquiry (KLOEs):

6.1 Does the leadership have capacity and capability to deliver high quality, sustainable care.

Background

When Facere Melius carried out the trust's well-led governance review in 2020, the board had gone through a period of instability over the previous few years regarding appointments. During our current review (2023), the chair, chief executive, many of the non-executive directors and all the executive directors were the same as when we presented our last report. This has provided a strong foundation and stability for the trust in the intervening years.

Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

As a part of our well-led review, we interviewed all appointed board members except one unavailable executive. The chair, chief executive, non-executive and executive directors could clearly explain their roles and accountabilities and the collective responsibilities of the board, board committees and the executive team.

The senior leaders within the trust could describe and evidence how at both operational and strategical levels, quality, safety, performance and finance was managed. We saw evidence of effective leadership through the chairing and engagement at various boards, board committees, executive team meetings and councils. Where appropriate, the board and board committees asked for deep dives or more detailed reports, and there is evidence that areas for further consideration were escalated.

As well as being clear about their roles, the senior leadership within the trust could describe the roles of their colleagues in the leadership team. The board worked in a respectful atmosphere where challenge was understood to be the norm, and the focus was on the effective leadership of the trust. Senior leaders had reflected on whether the stability of the board could at any point make it less challenging and complacent, which is good practice, however, this was not evident in any of our observations or reviews of the papers.

During our review, there was evidence of high-quality papers being presented at all the meetings we reviewed and observed. There was evidence of appropriate challenge not just from non-executives at board and board committees but at executive team and council meetings.

The trust has developed a template for the board committee chairs to report back to the board on the work being undertaken at their committees and this has been effectively implemented and supports a consistent approach to governance.

The trust's strategy was kept alive dynamically through numerous strategy meetings and update reports. The board assurance framework (BAF) was reviewed and updated regularly

at the appropriate meetings. Senior leaders regularly engaged in discussions on how the current strategy was being implemented across their catchment area and with their partners and stakeholders. Board members were also fully involved in the recent refresh of the trust's existing strategy.

When FM carried out the governance review in 2020, it was recommended that the trust consider board development in the future, and there is evidence that this has occurred. The board have developed a good balance of formal meetings and development days. At the time of this review, the board and executive team were stable, and there was evidence of good induction for new non-executive directors joining the trust.

The board recently agreed to a new board development programme for 2022-24. This programme is well balanced and includes strategy, strategic objectives and risk and risk appetites, finance, new national standards, such as patient Safety Incident Response Framework (PSIRF), anti-fraud, safeguarding and freedom to speak up. The trust has commissioned external support from The Good Governance Institute and MIAA to support this work.

The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands the challenges, and takes action to address them.

The trust has developed good governance around managing key areas such as quality and safety, risk, finance and performance. At an operational level, 'council' meetings have been established and are chaired by a director. Standard templates have been set for reports to maintain the consistency of reported information.

In interviews, non-executive directors informed the review team that they had attended some of the council meetings to understand the work that was undertaken prior to it being shared at board committees. It was evident from interviews with senior leaders and review of meeting agendas, minutes and papers that any issues or strategic/operational challenges that were discussed at the trusts' council meetings were escalated to the executive team, board committees and board.

The review team saw evidence of issues and reports being presented and discussed not only from a trust perspective but also on an Integrated Care System (ICS), Integrated Care Board (ICB) and Integrated Care Partnership (ICP) basis. Senior leaders within the trust provided regular reports and updates on the trust's broader challenges aligned to the wider system and the place-based partnerships they were involved with.

The chair and non-executives were actively engaged through board meetings in strategic and operational discussions with effective challenge and discussions around the trust's priorities. A good example was discussions and challenges in the public board meeting in February 2023.

The trust has expertise available through its council, executive, board committee and board processes to manage the diversity of its operational and strategic responsibilities. The level of discussion we observed at all levels of meetings was appropriate in detail and scrutiny. Executive directors demonstrated a grasp of their portfolios and an ability to report effectively and respond to challenges.

The senior leaders in the trust engage dynamically with the board assurance framework (BAF) in several forums. This is used effectively as an assurance tool, alongside the integrated quality and performance report, as to how well the trust's strategy is being implemented.

Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment, support processes, and succession-planning.

During our review the trust's board was fully recruited with a cohort of well-established non-executives and executive directors. The trust has engaged in NHS providers facilitated board development programme to support the growth of the board. The Chief Executive has encouraged executive directors to find coaches to help with their personal development.

Non-executive and executive colleagues have developed a 'buddy' relationship with the opportunity to work outside the usual 'committee' networks. Part of this initiative includes both ned and executive director visiting teams (clinical and corporate) to hear feedback as part of the 'time to talk process.

As mentioned previously, the board has agreed on its 2023/24 board development plan, which has already started.

Over the last few years, the structure below the executive team has been reviewed and a new operational structure has been developed and recruited to. During our review, the chief operating officer had developed an accountability performance framework; this was part of the more comprehensive work connected with the integrated quality and performance report. However, the board were aware of capacity challenges around the implementation of the new framework, and there were ongoing discussions about the best time to implement the framework.
The trust has also developed an operational manager leadership development programme which contains key governance elements.

At a senior level, the trust acknowledges it has further work to do around succession-planning. Whilst it has had a very stable few years at a senior leadership level, this work must be developed.

Leaders at every level are visible and approachable.
A programme of visits across the trust has been developed for non-executive directors and this is described as working well together with non-executives engaging with the trust's 'time to talk' sessions. Operational staff interviewed describe the executive team as visible and approachable. Senior leaders are described as responsive and eager to meet with staff.

Summary

- Board, a full complement of non-executive and executives in post
- A stable board with executive directors in post for at least two and a half years
- Board, board committees, executive team meetings and council meetings well led and effective
- Robust frameworks and secretariat support
- Board and individual director development in place

Recommendations

1. The trust develops succession -planning for its senior leaders.

6.2 Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined achievable and relevant objectives.

The new Bridgewater Quality & Place strategy, 'Communities Matter - Creating stronger, healthier, happier communities', has been developed to cover the period 2023 – 2026. The strategy was discussed at the board in April 2023. The trust has developed its own strategy within the national and regional context. It has a clear mission statement.

"We will improve health, health equity, wellbeing and prosperity across local communities, by providing person-centred care in collaboration with our partners".

As part of the trust's strategic review, it has renewed its six strategic objectives.

- ***Quality*** - *We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.*
- ***Health equity*** - *We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.*
- ***Staff*** - *We will ensure the trust is a great place to work by creating an environment for our staff to develop, grow and thrive.*

- ***Resources*** *- We will ensure that we use our resources in a sustainable and effective way.*
- ***Equity, Diversity and Inclusion*** *- We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.*
- ***Partnerships*** *- We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.*

To support these six strategic objectives, the trust has created four aims, and these are intended to be embedded into the trust's impact and measurement approach to ensure the trust is:

- Improving the health and wellbeing of local people and communities (including equity in that health and wellbeing)
- Improving the health and wellbeing of our staff (including equity in that health and wellbeing)
- Improving the quality of services provided (including equity in benefits from those services)
- Improving the sustainable and efficient use of resources.

Each of the objectives has its own set of deliverables in place.
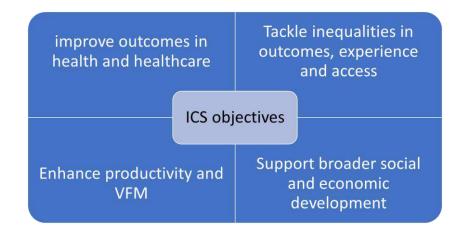
During our review, work was ongoing with directorate leadership teams and services to develop annual delivery plans aligning with these corporate objectives and deliverables. Once created, the review team understand that the intention is to embed them in the trusts' new performance assurance framework.

The trust recognises the importance of values, and this was evidenced in interviews with senior leaders. The trust had recently reviewed and updated its values with its staff and was continuing to embed them across all its services.

The strategy is aligned to local plans in the wider health and social care economy and services are planned to meet the needs of the relevant population.

During our review, the trust was developing its Quality & Place Strategy 2023-2026 – 'Communities Matter'. The trust strategy development builds on the national context of the recent Health and Social Care Act 2022 and the four ICS objectives.

The trust has aligned its strategic direction with the missions/visions from four of its key partners:

Cheshire & Merseyside Health Care Partnership

We want everyone in C&M to have a great start in life and get the support they need to stay healthy and live longer.

Greater Manchester Health & Social Care Partnership

Our vision is to make Greater Manchester one of the best places in the world to grow up, get on and grow old.
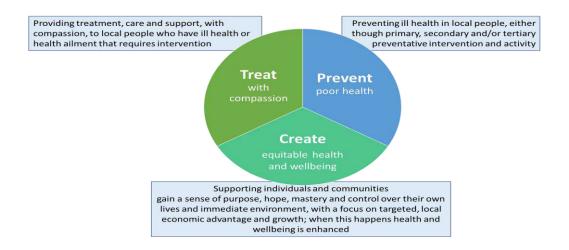
Warrington Together

To ensure Warrington is a place where we work together to create stronger neighbourhoods, healthier people and greater equality across our communities.

One Halton

To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community-based support and ensuring high quality services for those who need them.

The trust has aligned its strategy and ambitions with objectives and emerging priorities of the new ICSs and in the places that it delivers care. It's strategy and engagement are aligned with starting well, living well and ageing well principles. There was evidence of the trust developing models to support these principles such as treat, prevent and create.

Within the strategy, there is a clear narrative on how the trust plans to respond to NHS initiatives on quality, performance and sustainability. It is clear about how the trust will work with partners to meet the needs and improve the health of the population it provides services for.

Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

During the FM governance review, a refreshed trust strategy was discussed at the public board meeting. Non-executive directors and executive directors were involved in the strategy development together with the next tier of trust management. There is evidence that management staff understood how the strategy had been developed and its links with the performance reporting arrangements in the future. Senior staff could also articulate how the strategic objectives were included within the board assurance framework (BAF) and how this was reviewed and updated at the meetings they attended.

It was clear further work was required in engaging with the trust's staff and external partners with their understanding of the trust's refreshed strategy. Interviews with external partners evidenced that there needed to be more discussion around the new strategy. However, this had been identified within the trust's strategy, and a full engagement workstream was being developed for 2023. This engagement included staff, public and partner engagement.

The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

In interviews with senior staff and a review of strategic documentation and the trust's board and executive papers, it is clear there has been a structured approach to reviewing and renewing the trust's strategy. The whole board has taken an active and thorough role in the production of the strategy. The trust has appointed a programme director for collaboration and integration who has led the strategic development work. Over the last six months, a broad range of partners and stakeholders have been involved in conversations, inputs, insights and engagement to help shape and influence the trust's mission and objectives.

The trust's engagement has involved its staff, governors, its partners in place, local people and community/voluntary sector organisations and support services.

Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood, and an action plan is in place.

The current strategy has five objectives:
- Equality, diversity and inclusion
- Innovation and collaboration

- People
- Quality
- Sustainability

The trust board meeting agenda is aligned under these headings, which is good practice. The trust has developed a BAF with eight strategic risks aligned with the five objectives.

- BAF 1 Failure to implement and maintain sound systems of corporate governance (people & sustainability)
- BAF 2 Failure to deliver safe & effective patient care (quality)
- BAF 3 Managing demand & capacity (people & quality)
- BAF 4 Financial sustainability (sustainability)
- BAF 5 Staff engagement & morale (people & quality)
- BAF 6 Staffing levels (equality, diversity and inclusion, people, quality)
- BAF 7 Strategy & organisational sustainability (innovation and collaboration, sustainability)
- BAF 8 Digital services (innovation and collaboration, people, quality, sustainability, equality, diversity and inclusion)

This BAF was regularly reviewed and updated and was used dynamically across the trust.

The FM review team evaluated the trust's integrated quality and performance report (IQPR), which is presented under the following headings:
- Trust Overview
- Operations – Responsive
- Safe, High-Quality Care (Quality)
- People
- Finance - Making Good Use of Resources

The IQPR is produced monthly and presented at board, committees and executive meetings. Delivery of directorate performance is presented and reviewed at the performance council meeting.

The trust has developed a good framework for delivering its current strategy, which is being implemented effectively. Whilst the frameworks and monitoring are practical, there is an opportunity for the trust to consider greater alignment of how its strategic objectives are monitored through its BAF and IQPR as there needs to be a standardised way this is presented.

Summary
- The trust has a newly refreshed strategy aligned with ICB/IPC and placed based partners.
- The trust is currently developing its engagement approach and plan.
- The trust has a good data platform to support emerging methodologies – treat, prevent and create.

Recommendations
2. The board agrees its new strategy and delivers its engagement plan.
3. The board agrees on how best to assure itself that its new strategy is being delivered and engaged with, within the trust and externally.
4. Following the agreement of the new strategy, the trust examines the opportunity to align its headings to reports at the board, board assurance framework (BAF) and the integrated quality and performance report (IQPR).

6.3 Is there a culture of high quality, sustainable care?

Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance are inconsistent with the vision and values are acted on regardless of seniority.

Senior leaders were observed chairing meetings, engaging and contributing to meetings, with a clear focus on understanding the issues and a focus on improvement. All the meetings the FM team observed, whilst focussed and effective, demonstrated respectful and supportive behaviours.
The chairing of meetings was of a high standard and inclusive for all those who attended. Time was given to present, challenge, and discuss issues. The staff below the executive tier explained how responsive they and their executive colleagues were to any staff issue and that the visibility of senior leaders was evident.

The trust has a well-established people committee, and there was evidence provided from reports and observation of discussion on a wide range of areas relating to staff recruitment, retention and ongoing professional development.

The trust has developed People Operational Delivery groups (PODs) which support the delivery of the NHS People Plan and People Promises. The four PODs are:
1. Recruitment and Retention
2. Health and Wellbeing

3. Education and Professional Development and;
4. Culture and Leadership

The trust has established programmes to celebrate staff and their contribution to high quality sustainable care. This includes the annual 'thank you awards', 'time to shine' and the 'leader in me' which are well supported by the board.

Other initiatives which we evidenced was the visits made by both governors and the non-executive directors to visit trust services and teams.

The FM team have noted that since the last review in 2020, the trust has won the Nursing Times 'best recruitment experience' award and reached the top three finalists in the 'best employer for staff recognition'.

Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns, and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same from happening again.

The trusts' senior leadership effectively described the processes in place for managing incidents, serious incidents and complaints. The trust has established a clear process for managing incidents and serious incidents. The quality and safety committee receives regular incident and patient experience information through the IQPR report and specific serious incident report from the director of quality governance. The trust has established a patient safety group which meets weekly to review all patient safety incidents and escalates appropriately any that meet the requirements for serious incidents. The trust has effective management in place for the review of all incidents, the management of serious incidents and the completion of action plans following sign-off by the ICB.
Learning from incidents and feedback is included within established reports to the quality and safety committee, and when required, deep dives are commissioned by the committee into areas such as waiting lists, harm or specific services (i.e., dermatology services).

The trust has been involved in developing Just Culture, and the principles of its just and learning culture journey continue to be implemented into everyday practice. This is evidenced by the trust's employee relations data, where grievances and disciplinary processes remain very low.

The trust has ensured that the values central to a just and learning culture are integral to those of the trust and are underpinned by the respect charter, which includes a range of equality, diversity and inclusion initiatives and the trust's recently developed civility and respect training.

The FM team noted that the trust had invested significantly in the Restorative Just Culture programme delivered by Merseycare in partnership with Northumbria University, and this had been attended by 40 members of staff, including trust board members and senior management.

The trust has a well-established freedom to speak up (FTSU) process in place, and this is reported on regularly. The trust has appointed a newly appointed lead FTSU guardian.

There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

The trust has established a competency framework group. The aim is to support better career progression through staff understanding the competency requirements they need to achieve to move forward.

The trust is working in partnership with the North-West Leadership Academy, and the Mary Seacole local programme continues to be offered within Bridgewater as part of the Mersey and Cheshire Network.

The trust provided evidence of a first-line manager development programme, developed for new and aspiring managers and offered as a rolling programme. The programme commenced in October 2022 with an initial cohort of 31 managers.

Bridgewater, like many other trusts, has struggled to meet its target for PPDR, which was 85%. Senior leaders informed the review team that the pandemic recovery's ongoing impact, including unprecedented sickness levels in clinical and non-clinical staff and increased demands on staff, particularly during winter pressure months, continued to be a challenge. Reminders continue to be communicated to managers in various forums and via the Trust Bulletin to help improve this situation.

The board and executive team were very focused on increasing mandatory training performance, including PPDR.

Equality and diversity are actively promoted, the causes of any workforce inequality are identified, and action is taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

Senior leaders within the trust could describe the organisation's governance and approach to equality, diversion and inclusion. The people committee receives regular updates from the director of people and organisational development.
In January 2023, the people committee received a report on progress on workforce-related equality objectives and action plans and a report on progress related to staff networks for assurance. At the February 2023 board meeting, the final Gender Pay Gap Report 2022 was presented for assurance.

There was evidence of updates being given on the progress on the new equality delivery system 2022, which included details of both service/patient experience, and workforce experience.

The FM team are aware that the trust was gaining final sign-off by Healthwatch Halton and ICB (Integrated Care Board) Equality Leads and the people committee to enable the trust to meet the deadline for submission to NHS England before 28 February 2023.

The documentation and observations review demonstrated that senior leaders received and reviewed metrics on staff engagement, bullying, harassment, recruitment and promotion among those with protected characteristics and the wider workforce.

There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively, and responsibility is shared.

There was a clear demonstration of effective teamworking in all areas of the trust reviewed. Teams at all levels were aligned, respectful and supportive. The board led by example, and there was evidence of positive relationships between the chair and chief executive, the non-executives and executive directors.

The board had carried out a self-assessment of its board committees and received positive feedback on how the meetings were chaired, organised and run.

Senior leaders who spoke to the FM team said executive directors would respond quickly to any operational issues and were highly visible and approachable.

The newly developed performance accountability framework, developed during our review, is planned to support the collective responsibility culture. The executive team were in the process of discussing this with the board and senior leadership colleagues.

Where issues were identified, a supportive process to improve services was undertaken by the senior leaders in the trusts working with the trust's teams and services.

Summary

- The board and senior leadership team provide evidence of a high-quality, sustainable care culture.
- Strong evidence of trust investment into improving its culture
- Number of HR and OD initiatives in place

Recommendations

5. The board continue to focus on improving its mandatory compliance and PPDR performance.

6.4 Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

The board and executive team have been very stable over the last three years. At the board and executive level, all senior leaders were clear about their responsibilities and roles and how they worked within the trust to support and deliver good governance and management.

Every member of the trust that spoke to the FM team could describe their role and purpose within the organisation, how their individual area was managed, how the trusts governance framework from board to senior leadership teams operated, and where decisions were made. Assurance was understood and so was the need to provide assurance through the governance framework to board committees and the board.

The trust has developed effective board [public and private] meetings, board committees, executive meetings and directorate meetings. The agendas of each team were appropriate and well-balanced to support a robust system of internal control. There is a clear focus on quality and safety, performance and financial management, information management and

technology and estates and facilities. There was a demonstration of close working between quality and safety, clinical, operational and corporate teams in managing the trusts' services.

Concerns, issues and risks were escalated appropriately through the trusts' governance frameworks. Waiting times, harm and service-specific deep dives and reports evidenced review and escalation of concerns and issues within the trust's governance framework.

Senior leaders within the trust have developed effective working relationships with partner organisations and this was evidenced through the recent covid-19 pandemic. The trust is part of the Cheshire & Merseyside Health & Care Partnership which has 9 Places. It works with the newly created (July 2022) Integrated Care Board (ICB) and Integrated Care Partnership (ICP).

As the ICB/ICP have been developing their governance frameworks, senior leaders from the trust have been working with colleagues to help shape and support the development and implementation. Work has also been ongoing with place-based partners on their governance frameworks and accountabilities, and responsibilities.

There was evidence of feedback into the trust at several meetings, including the board, board committees, and councils, from senior leaders about ongoing partnership working and initiatives. As part of its strategic review, the trust had collated detailed information on its services, which was being shared with partners.

The board and other levels of governance in the organisation function effectively and interact with each other appropriately.

The board is operating as an effective unitary board. There was clarity about its role, and there was an agreed work plan together with the board committees. There is appropriate focus and discussions at the board, board committee and executive levels. The chair and trust secretary met ahead of each board meeting to agree on the agenda for both public and private meetings. In terms of transparency, there is an apparent aim to ensure as much of the agenda was in the public meetings as possible.

There is clear evidence of effective information flows from within the trust at the council level to the executive, board committees and the board.

Staff are clear on their roles and accountabilities.

It was clear from interviews with senior leaders that staff members understood the trusts' key quality, operational and financial priorities. And in turn, how their goals and objectives contribute to the organisation's overall performance and how this was measured. Staff

members understood that they were accountable for delivering high-quality, sustainable care and optimising the use of the trust's resources.

Once fully agreed, the new accountability performance framework will further support the clarity of staff roles and accountabilities.

Summary

- The board and executive understand their roles and responsibilities.
- Robust governance frameworks are in place to support the discharge of accountabilities and responsibilities at the board and executive levels.
- A newly developed accountability performance framework will help the sub-executive level.
-

Recommendations

6. When the trust implements the accountability performance framework, a support programme is developed for the sub-executive cohort.

6.5 Are there clear and effective processes for managing risks, issues and performance?

There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

Senior leaders were able to describe the process by which risks were managed within the trust and how they were escalated and de-escalated. The trust has developed a detailed BAF that aligns with the organisation's strategic objectives, which is used dynamically at all senior levels. The BAF contains details of the individual eight strategic risks and their alignments to the trust's strategic objectives, risk ratings and risk appetite. Prevent and detect controls are also included together with assurances. Aligned risks from the corporate risk register with a current risk score of 15 or above are also included.

The risk council was observed twice so the FM team could track risk discussions. The risk council is well attended by operational teams, and it was clear that risks were being discussed and escalated appropriately. It was observed that the trust had very few risks scoring 15 or more, and it was noted that certain risks were not being scored at 5 (certain) for likelihood when the risk had materialised. This is perhaps a minor point, as all appropriate risks were discussed at the correct meetings.

All directorates submitted their risk reports in good time for the risk council, which were then presented and discussed. Whilst there is an Excel corporate risk register containing all risk scoring over 12 and above, this information is not compiled into a corporate risk register (CRR) report. The trust should review its current scoring of risks, and once completed, develop a corporate risk register report and align its risks into themes where appropriate. This report should include the top 3-5 risks the trust is challenged with.

It is noted that the board is currently reviewing its risk appetite, and the outcome of this work should be reflected in the trusts BAF and CRR.

Financial pressures are managed to maintain the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.

The trust has a well-established financial governance framework for managing finance and performance. The performance council has been developed to scrutinise the trust's performance concerning finance, operational delivery, people and quality in all the trusts' boroughs/directorates and to triangulate each element to enable the performance of services to be fully understood. The performance council makes recommendations to the relevant committee(s), where the performance of a service needs to be escalated due to over or underperformance.

The trust has a well-established finance and performance committee which supports the work of the board. All the finance and performance meetings were chaired well and focussed effectively on their terms of reference.

The organisation has the processes to manage current and future performance.

The trust has developed and implemented an integrated quality and performance report (IQPR), and which is produced monthly. It covers:
- Trust Overview
- Operations – Responsive
- Safe, High-Quality Care
- People
- Finance - Making Good Use of Resources

Senior leaders could describe the frameworks and processes in place to manage performance across the trust. Leaders articulated that the measures in place were correct and that they had information in time to manage their services effectively. The trust also developed a CIP council to focus on the delivery of CIP across the trust. This council meeting

was observed, and whilst challenging in terms of delivery of CIP it was a focused supportive meeting to enable the best outcomes for teams and colleagues.

The finance director gives frequent updates in relevant meetings and reports regularly to board colleagues. These updates include the finance report and the 2023/24 plan.

Clear structures and processes escalate performance issues to the appropriate committees and the board.

All performance issues are escalated through the finance and performance governance framework. This includes alignment with the BAF and CRR, once agreed actions are tracked through each appropriate committee or meeting.

Clinical and internal audit processes function well and positively impact quality governance, with clear evidence of action to resolve concerns.

The quality and safety committee receives reports and updates, including MIAA reports and clinical audits. During this review (February 2023), the trust did not have any audits with limited or moderate assurance.

The trusts' draft clinical audit plan 2023-24 was approved at the quality council meeting in March 2023. The trust's clinical audit plan is refreshed and updated on an annual basis. The draft plan for 2023-24 is based on priorities agreed upon by the directors of nursing, the medical director and the trust dental network. It includes re-audits of audits conducted in 2022-23 as well as any clinical interest audits. Topics for inclusion in the audit plan were also sought from clinical services, the medicines management team and quality matrons.

Progress with the clinical audit plan is reported on a quarterly basis to the borough quality meetings, dental governance meetings, the clinical audit and research steering group and the quality council.

Summary

- The trust provided evidence of clear and effective processes for managing risks, issues and performance.
- Evidence of strong engagement within the trust at all levels
- Good understanding of risk management at the board, board committee and council levels.
- Performance well managed across the trust with effective reporting.

Recommendations

6.6 Is appropriate and accurate information being effectively processed, challenged and acted on?

Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive valuable data daily, which supports them to adjust and improve performance as necessary.

Following the observations of meetings and discussions with senior leaders, it was clear that at each tier, the meetings received and discussed appropriate information covering quality, operations and finance. The information supplied to each meeting that was observed supported their terms of reference and informed and supported members of the meeting to make informed judgements. There was evidence of a robust challenge of information and its interpretation by senior leaders in meetings at all levels.

All senior leaders reported that they had the information required to effectively manage their services. Managers outlined that from the information provided, they could offer whatever assurance when required.

Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people with quality, operational and financial information.

The trust has developed its IQPR, which is presented and discussed at board, board committees and executive meetings. There were no issues identified in the supporting information used to generate the IQPR. Exception reporting was included within the report to identify any areas of good or poor performance.

The trust is working with directorate teams to develop a dashboard approach to support the broader IQPR process, linking this with the strategic development work.

Performance information is used to hold management and staff to account.

The finance and performance council and committee provide the governance framework for monitoring and management across the trust, with the board having overall responsibility. Links to other councils and committees about performance issues are well managed. Key

strategic and operational risks are identified and escalated appropriately, with staff being held to account for the management of the trust's controls and performance.

The newly developed assurance performance framework is aimed at supporting staff in understanding their roles and responsibilities.

The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address weaknesses.

During the review, the FM team saw a mix of qualitative and quantitative intelligence included within reports to the board, board committees and councils. Information was challenged robustly and if any uncertainties were highlighted the information was reviewed once more for assurance and updated if required.

There was a clear understanding of how information flowed at all levels and what information was required by each trust tier.

Information technology systems are used effectively to monitor and improve the quality of care.

The trust had recently established a Digital Information Governance and Information Technology meeting (DIGIT) chaired by the medical director. The trust had developed both terms of reference and a business cycle for the group. The usual items discussed at this meeting include the digital strategy review and plan, information technology and information governance. It receives reports from the head of IT, and any MIAA IT reports, such as IT cyber security. The digital programme group also provides an update on its activities. Appropriate policies are presented at the digital group for review and consideration.

Data or notifications are consistently submitted to external organisations as required.

The trust through regular reporting to councils and committees provides evidence that directorate and services understand the routine and exceptional data requirements of external bodies. Evidence was provided in relation to EDI, SIs and finance.

There are robust arrangements for the availability, integrity and confidentiality of patient-identifiable data, records and data management systems.

Through its DIGIT meeting, the trust receives a regular information governance update, including any breaches. The report includes any serious incidents, risks, activity reports for freedom of information requests, data security training and subject access requests.

Senior leaders outlined to the FM team that they had confidence in the systems and processes they used and the systems' ability to flag problems and issues.

The trust had also commissioned an internal audit on cyber security.

Summary
• The trust has appropriate and accurate information which is being effectively processed, challenged and acted on.
• All staff interviewed stated they had the correct information promptly to support them, and their teams manage the services for which they were accountable.
• Evidence of effective management of information and its governance.

6.7 Are the people who use services, the public, staff and external partners engaged and involved to support high-quality sustainable services?

A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

Following the launch of 42 Integrated Care Systems (ICSs) as statutory bodies on 1 July 2022, the various elements of the new systems continue to evolve and embed. Within Cheshire and Merseyside, work continues on developing the Integrated Care Partnership (ICP) Interim Strategy, with input and feedback being co-ordinated via the nine place-based teams.

The trust has worked across all portfolios of the ICS to develop and embed new and evolving arrangements, with the trust's teams and leads involved and influencing directly, as well as via the place-based partnership.

The trust is prominent in the Cheshire and Merseyside provider collaborative with the chief executive chairing the Cheshire and Merseyside people board. At a national level, the trust's chief operating officer is a national intermediate care board member.

The trust has engaged with One Halton and Warrington Together in developing integrated neighbourhood delivery models.

In Warrington, there is evidence that the trust is actively participating in the work of all the 'wells', Starting Well, Staying Well and Ageing Well and all the enabling groups. The chief operating officer is the senior responsible officer for Ageing Well, and the director of people

and organisational development is leading the workforce and organisational development, and there are representatives on all the other groups.

The 'wells' and the enabling groups are all developing their own delivery plans and risk registers, which will be reviewed by the delivery oversight committee and signed off via the Warrington Together Partnership Board. The ageing well programme board already has an established number of programmes, all of which the trust is contributing to and which the trust envisages will have a significant impact on the delivery of community services moving forward.

The trust is developing work around integrated community teams in Warrington, and this is supported by the work which is being done internally around the community nursing transformation with the integration of district nursing and specialist nurses.

The Integrated Management Structure for Intermediate Care is now almost fully in place, and a significant amount of work has been undertaken around the delivery to embed the 'Home First' approach both to patients being discharged from hospital and for patients remaining in their own homes.

A Workforce & OD Enabler Group (WEG) has been established.

The group are involved in:
- The commissioning of a Place based Workforce Strategy to address risks and opportunities around integration. Three bids have been evaluated with dates for interviews currently being pursued.
- Grants and wider support are being sought for the independent domiciliary care sector to encourage uptake of international recruitment and build sustainable market capacity that meets our strategic vision for 'Home First'.
- The development of recruitment, training and career opportunities to 'grow our own' through the Warrington Health and Care Academy and The Cheshire and Warrington Pledge
- The development of Health and Social Care job roles and career pathways that meet the requirements of integrated services and can increasingly work across health and social care settings.

The trust is still developing its engagement approach around its new 'Communities Matter - Creating stronger, healthier, happier communities' strategy for the period 2023 – 2026. strategy and the mechanisms it may use:

MISSION

We will improve health, health equity, wellbeing and prosperity across local communities, by providing person-centred care in collaboration with our partners

Place-based outcome metrics/targets	JSNA/Place PMO
Staff feedback/insights	Staff survey
Public feedback/insights	Public survey
Partner feedback/insights	Partner survey

OBJECTIVES

Quality

We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered

Service quality metrics	Internal KPIs
Staff feedback/insights	Staff survey
Patient feedback/insights	Patient survey

Health Equity

We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk

Place-based outcome metrics/targets	JSNA/Place PMO
Public feedback/insights	Public survey
Partner feedback/insights	Partner survey

People

We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive

Staff feedback/insights	Staff survey
Key People indicators	People KPIs

Resources

We will ensure that we use our resources in a sustainable and effective way

Trust financial position	Finance reports
Trust PP delivery	Finance reports

EDI

We will ensure that equity, diversity and inclusion are at the heart of what we do and we will create compassionate and inclusive conditions for patients and staff

Staff feedback/insights	Staff survey
Patient feedback/insights	Patient survey
Key EDI metrics	EDI KPIs

Partnership

We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities

Place-based outcome metrics/targets	JSNA/Place PMO
Partner feedback/insights	Partner survey
Public feedback/insights	Public survey

There is evidence of good engagement with the trust's governors at the council of governor's meetings, and it is noted that governors have continued to observe board and board committee meetings providing feedback, which is good practice.

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

The trust reviewed its 2022 NHS Staff Survey feedback while FM was undertaking this governance review, with 56% of Bridgewater staff completing the survey, which was the best response rate for the trust.

Within the staff survey, the trust performed well in relation to its NHS North-West geography and its regional Cheshire and Merseyside ICS geography.

The staff survey outlines a positive breakdown comparison from a regional perspective. It shows the trust performing well across all people promise themes and the two elements of staff engagement and morale.

Whilst performing well in its north-west geography, the report showed that five out of the nine elements/themes remain static when compared against the national community trust average. Four elements/themes show a decrease.

People Promise Element / Theme	BCHFT 2022 score	Community Trust Average	Trust results v's Community Trust Average	North West Average	Trust results v's North West Average	C&M ICS Average	Trust results v's CM ICS Average
We are compassionate and inclusive	7.6	7.6	0	7.2	0.4	7.3	0.3
We are recognised and rewarded	6.1	6.4	-0.3	5.8	0.3	6	0.1
We each have a voice that counts	7.1	7.1	0	6.7	0.4	6.8	0.3
We are safe and healthy	6.3	6.3	0	6	0.3	6.1	0.2
We are always learning	5.3	5.9	-0.3	5.2	0.1	5.1	0.2
We work flexibly	6.4	6.7	-0.3	6.1	0.3	6.1	0.3
We are a team	7	7.1	-0.1	6.7	0.3	6.7	0.3
Staff engagement	7.2	7.2	0	6.8	0.4	6.9	0.3
Morale	6.1	6.1	0	5.8	0.3	5.8	0.3

These will be the areas that the trust has stated it will work closely on as part of its organisation-wide action planning:

- We are recognised and rewarded
- We are always learning
- We work flexibly
- We are a team

The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

The trust has reported to the board that staff survey action plans will be created trust-wide (owned by the People Directorate) and at the directorate team level (owned by the directorate).
The trust has developed a dedicated staff survey action plan group on Microsoft (MS) Teams.

There is evidence from discussions with senior leaders and reviews of the board, board committees and the people council of a robust framework for engaging with all trust staff.

Summary
- The trust has reviewed and refreshed its strategy for 2023-26. It has engaged with a large group of stakeholders.
- The trust is developing its further engagement approach and plan to support the delivery of its strategy.
- Strong evidence of staff engagement managed by HR & OD

Recommendations
8. The trust delivers on its engagement plan and ensures that measures of engagement are built into the trust's performance reporting.

6.8 Are there robust systems and processes for learning, continuous improvement and innovation?

There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

The trust board agenda is aligned to its strategic objectives, so it receives updates on innovation and collaboration every time it meets in public or in private.

The trust has worked hard to develop a continuous improvement culture, driven by its people and quality teams. We evidenced initiatives such as leader in me events, time to shine and staff awards as examples of how the trust had invested in its staff and culture. The trust described this process as how they captured and shared great practice and innovation. Senior leaders were able to describe their approach of developing and embedding Just Culture as they strived to improve people practices and focus on fairness and learning.

At the time of our review, the trust was preparing to implement the new patient safety incident response framework (PSIRF), which is the NHS's approach to developing and maintaining effective e systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. It replaced the current Serious Incident Framework. PSIRF represents a significant shift in the way the NHS responds to patient safety incidents and is a key part of the NHS patient safety strategy.

The trust has recognised the importance of ensuring our staff feel valued and supported and has developed an enhanced model of preceptorship; they have also introduced Professional Nurse Advocates.

The trust has also developed and implemented a 'Building On Our Strengths Together' (BOOST) methodology to drive forward continuous quality improvements in the services provided, led by staff. Evidence of this was a recent BOOST event associated with the trust's dermatology services.

The trust has an established process for managing its research, and this report regularly into the quality governance framework.

There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

The Bridgewater BOOST was developed in July 2022 and is a programme of work that the trust hopes will deliver real change and improve patient care and staff morale. An early example of the improvement work has been in the dermatology service.

The trusts' staff drives the programme through a series of supported workshops to develop and agree on priorities, objectives and opportunities for all services moving forward.

Staff influence and shape how services are developed and delivered in an integrated way across the trust's local communities.

The service effectively uses internal and external reviews, and learning is shared effectively and used to make improvements.

The trust fully uses internal and external reviews to assure itself and support improvements. In reviewing action plans at all meetings, the trust manages its actions to completion effectively. The trust's audit committee is run effectively, reviews and actions are appropriately discussed and agreed, and subsequent action plans are well managed.

Staff are encouraged to use the information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

Senior leaders articulated that staff were clear about their personal priorities and objectives. The existing performance framework provides feedback to teams and individuals on progress in delivering objectives and targets. Senior staff were hopeful that the trust's BOOST methodology could be rolled out further to support teams to improve their services and boost morale.

There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

The trust has already undertaken a lot of work identifying and publicising service improvements. There is much work, some nationally acknowledged that the trust has undertaken, and HR and OD have started to pull much of this work together.
Further opportunities exist to pull this identification of excellent individual staff, team and service achievements.

Summary
- The trust has developed an effective improvement methodology and has used it to support service improvement (BOOST).
- There are a number of initiatives embedded to improve trust services and celebrate staff achievements.

Recommendations
9. The trust builds on the work carried out by HR &OD to pull together all the achievements of staff, teams and services so this can be highlighted both internally and externally.

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7. Conclusion

In 2020 when we carried out our well-led governance review, the trust was just starting to stabilise its leadership team after a period of vacancies. During our current review, there is evidence that the board and executive team are stable and mature. The board and executive team are well-established and engaged in an ongoing board development programme.

The board, executive team and the trust have faced enormous challenges in leading and managing the organisation during the Covid-19 pandemic. This has involved a tremendous amount of 'control and command' culture, and going forward, a new management culture will need to be strengthened, which will be more 'devolved autonomy' focussed. The trust has recognised this and is in the process of agreeing and implementing its new assurance performance framework.

The trust has good governance structures and a high level of understanding of how good governance should work within its senior leadership.

Developing a new strategy 2023-26 provides a foundation and focus for ongoing engagement work with patients, staff, partners and the communities the trust works within. It provides an opportunity for the trust and its workforce to align with it and engage with its

communities and partners. The developing engagement approach and plan provides a useful mechanism to support the delivery of the trust's strategy.

The trust's senior leaders demonstrated effective leadership and engagement in all the meetings we observed, and there was a culture of improvement focussed behaviours. The respectful challenge is embedded within management practice, and we evidenced numerous challenges in different meetings, which were met with appropriate responses. Information is used effectively and presented well within all tiers of the trust meetings we observed and reviewed. Staff interviewed all felt they had timely information available, allowing them to manage their teams and services and provide assurance. Accountabilities and responsibilities are understood, and senior leaders are appropriately held to account. The trust is developing its assurance performance framework to support the wider understanding of accountability. This will undoubtedly help support good governance within the trust, and support for the sub-directorate tier will need to be put in place as this is implemented.

The trust has several processes for innovating and improving its services, which are working well. The trust should consider how it can best co-ordinate and celebrate all its innovation and improvement activities so it can communicate these to staff, partners and the communities the trust serves.

Recommendations

1. The trust develops succession -planning for its senior leaders.
2. The board agrees its new strategy and delivers its engagement plan.
3. The board agrees on how best to assure itself that its new strategy is being delivered and engaged with, within the trust and externally.
4. Following the agreement of the new strategy, the trust examines the opportunity to align its headings in relation to reports at the board, board assurance framework and the integrated quality and performance report.
5. The board continue to focus on improving its mandatory compliance and PPDR performance.
6. When the trust implements the accountability performance framework, a support programme is developed for the sub-executive cohort.
7. The trust should develop a corporate risk register report that themes risks so an overview of the trust's top risks can be presented to the executive for review and then shared with the board and board committees.
8. The trust delivers on its engagement plan and ensures that measures of engagement are built into the trust's performance reporting.

9.	The trust builds on the work carried out by HR &OD to pull together all the achievements of staff, teams and services so this can be highlighted both internally and externally.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01/06/23**
Agenda Item	**42/23ii**		
Report Title	**FIT AND PROPER ANNUAL REVIEW**		
Executive Lead	Colin Scales, Chief Executive Officer		
Report Author	Samantha Scholes, Head of Corporate Governance		
Presented by	Jan McCartney, Trust Secretary		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary
The Trust is responsible for ensuring the continued fitness of those persons to whom the Fit and Proper Persons Test Regulations apply. On an annual basis, and in compliance with CQC Regulation 5 guidance and the Trust's Fit and Proper Persons Test Policy, self-declarations are sought and checks undertaken to provide assurance that all members, including those who regularly attend and advise the Board, remain Fit and Proper Persons.

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

Strategic Objectives

☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.

☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.

☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.

☒ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.

☐ **Resources -** We will ensure that we use our resources in a sustainable and effective way.

☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

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**	**01/06/23**
Agenda Item	**42/23i**		
Report Title	**FIT AND PROPER ANNUAL REVIEW**		
Report Author	Samantha Scholes, Head of Corporate Governance		
Purpose	To provide assurance that Board members and those who regularly attend and advise Board, remain Fit and Proper Persons		

1. SCOPE

1.1 A review of Fit and Proper Person Test (FPPT) compliance for all Board members and those who regularly attend and advise the Board is undertaken annually.

1.2 There are 14 Board members and two people who regularly attend and advise the Board.

1.3 An audit of the Fit and Proper Persons Test process was undertaken by MIAA in June 2022 and was given High assurance.

2. INFORMATION

2.1 Following receipt of FPPT self-declarations and in conjunction with received Declarations of Interest from 15 of the 16 people identified, the following tests were undertaken and recorded:
- Companies House Registers
- Insolvency & Bankruptcy Registers
- Disqualified Directors Registers
- Charity Commission Registers for those identified as a Trustee
- Internet searches for news reports plus Twitter and LinkedIn accounts

3. OUTCOME

3.1 Of the 15 people whose declarations were tested, the Head of Corporate Governance is satisfied that they all meet the criteria for a Fit and Proper Person.

3.2 Due to the long-term absence of the Chief Nurse, their search is outstanding and the FPPT has been undertaken for the Acting Chief Nurse.

4. RECOMMENDATION

4.1 The Board is asked to accept the assurance that the Trust's Fit and Proper Persons Test has been undertaken for all available members and advisors and that all continue to meet the criteria.

- Appendix 1: 2023 Board FPPT

Role	Name	FPPT Self-declaration received	DOI received	Companies House Register	Action	Bankruptcy & Insolvency Register	Action	Disqualified Director Register	Action	Charity Commission - Trustee	Action	Web Searches	Action	FPP	Date
NED	**Abdul Siddique**	13/03/23	27/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	24/04/2023
Exec	**Aruna Hodgson**	20/03/23	27/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	02/05/2023
Exec	**Colin Scales**	13/03/23	23/03/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	02/05/2023
Exec	**Edward (Ted) Adams**	20/03/23	20/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	15/05/2023
NED	**Elaine Inglesby**	24/01/23	17/03/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	24/04/2023
NED	**Gail Briers**	05/04/23	01/03/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	25/04/2023
Advisor	**Jan McCartney**	20/03/23	22/03/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	17/05/2023
Acting Chief Nurse	**Jeanette Hogan**	22/05/23	05/04/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	22/05/2023
Chair	**Karen Bliss**	31/03/23	22/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	24/04/2023
NED	**Linda Chivers**	15/03/23	23/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	17/04/2023
Exec	**Lynne Carter**														
NED	**Martyn Taylor**	13/03/23	01/03/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	25/04/2023
Exec	**Nick Gallagher**	20/03/23	23/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	15/05/2023
Exec	**Paula Woods**	13/03/23	27/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	16/05/2023
Advisor	**Rob Foster**	21/03/23	19/04/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	16/05/2023
Exec	**Sarah Brennan**	13/03/23	27/02/2023	✔	None	✔	None	✔	None	✗	None	✔	None	Yes	17/05/2023
NED	**Tina Wilkins**	31/03/23	23/02/2023	✔	None	✔	None	✔	None	✔	None	✔	None	Yes	24/04/2023

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**		**Date**	**01/06/23**
Agenda Item	**43/23iii**			
Report Title	**NHS PROVIDER LICENCE SELF-CERTIFICATION**			
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
NHS Foundation Trusts are required to self-certify whether they have complied with the conditions of the NHS provider licence. This paper presents the certificates to Board and requests sign-off for this self-certification and thus to publish on the website.

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

Strategic Objectives
☐ **Equity, Diversity and Inclusion -** We will ensure that equity, diversity and inclusion are at the heart of what we do, and we will create compassionate and inclusive conditions for patients and staff.
☐ **Health equity -** We will collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk.
☐ **Partnerships -** We will work in close collaboration with partners and their staff in place, and across the system to deliver the best possible care and positive impact in local communities.
☐ **Quality -** We will deliver high quality services in a safe, inclusive environment where our patients, their families, carers and staff work together to continually improve how they are delivered.
☒ **Resources -** We will ensure that we use our resources in a sustainable and effective way.
☐ **Staff -** We will ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive.

How does the paper address the strategic risks identified in the BAF?							
☒ **BAF 1**	☐ **BAF 2**	☐ **BAF 3**	☐ **BAF 4**	☐ **BAF 5**	☐ **BAF 6**	☐ **BAF 7**	☐ **BAF 8**
Failure to implement and maintain sound systems of	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

corporate governance							

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**01 June 2023**
Agenda Item	**43/23iii**		
Report Title	**NHS PROVIDER LICENCE SELF-CERTIFICATION**		
Report Author	Jan McCartney, Trust Secretary		
Purpose	The Board is asked to approve the attached self-certification of the provider licence.		

1. INFORMATION

1.1 NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance requirements.

1.2 Providers need to self-certify the following after the financial year end:

    a. The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))

    b. The provider has complied with required governance arrangements (Condition FT4(8))

    c. If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

1.3 To do this, the Trust has elected to use the self-certification templates (attached) as provided by NHS Improvement. Condition CoS7 does not apply as this Trust does not provide any designated Commissioner Requested Services.

2. RECOMMENDATION

2.1 The Board is asked to approve the certificates as attached.

Self-Certification Template - Condition FT4

Bridgewater Community Healthcare NHS Foundation Trust

Insert name of organisation

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

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

These self-certifications are set out in this template.

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

Financial Year to which self-certification relates   **2022/23**   Please Respond

Corporate Governance Statement (FTs and NHS trusts)

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

	Corporate Governance Statement	**Response**	**Risks and Mitigating actions**
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	No material risks identified. Assurance include the Annual Report (declaration of compliance with the Code of Governance) and systems and controls assurances are obtained via the Audit Committee as described in the Annual Governance Statement (AGS) 2022/23. The Head of Internal Audit Opinion for 2022/23 stated an overall opinion of 'Substantial Assurance, can be given that there is an adequate system of internal control....' Effectiveness review of Board Committees are also undertaken. #REF!
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	No material risks identified Key documents are highlighted/circulated to the Board through the Trust Secretary. Legislative and regulatory changes are disseminated through membership of the NW FT Company Secretary Network and NHS Providers Complany Secretary Network. The Board reviews/discusses key guidance at Board meetings and/or Board Development sessions. #REF!
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	No material risks identified Committees are established with clear lines of reporting. Board approved Terms of Reference are in place clearly describing the Committee responsibilities, memberships and reporting arrangements. Along with the Committee Cycles of Business, the Terms of reference are updated annually to reflect the changing needs of the organisation. There are a wide rannge of additional controls in place including an approved Scheme of Delegation, Standing Financial Instructions, Board member appraisal process and agreed Executive portfolios. #REF!
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	No material risks identified There are a range of systems/and or processes in place which evidence the Trust's ongoing compliance with the requirement. These include: Trust Board Meetings, presentation of the Integrated Quality Performance Report to each Board meeting which covers Quality, Finance,Performance and People presented to the Board. The Trust's Board Assurance Framework is reviewed at each Board and Committee of the Board. The External and Internal Audit Annnual opinion and Audit Annual Plan are approved by the Audit Committee. #REF!
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	No material risks identified Non-Executive and Executive Directors during 2022/23 all received a robust performance and appraisal review. This included the Board members who have clinical, medical, financial, operational, and HR expertise. The Board includes clinical non-executive directors, a Medical Director and Chief Nurse who are accountable for assurance of and delivery of the quality agenda. Quality metrics are scrutinised at the Quality and Safety Committee and assurance provided to the Board via the Chair's report. The Quality dashboard is reviewed at a number of levels before being presented to the Committee of the Board. Robust arrangements are in place for staff, patients and members of the public to raise concerns in relation to the quality of care including Freedom to Speak up Guardian, PALS and Complaints. There are Friends and Family Test systems in place and the Trust has an active Council of Governors with a keen focus on quality of care. There is clear accountability for quality of care throughout the Trust allowing for appropriate escalation to the Board. Indpendant external Well led review conducted. Ongoing Board development facilitated by GGI and NHS Providers. #REF!
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Board is satisfied. During 2022/23 the Board of Non-Executive and Executive Directors were sufficient in number and appropritely qualified. The Executive Directors are all substantive appointments and have a range of skills, knowledge and experience. Non-Executive Directors and the Chair also have a variety of skills, knowledge and experience and are from a range of backgrounds, including operational, financial and clinical #REF!

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

Signature   **Signature**

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

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

A   Please Respond

Worksheet "Training of governors"

Financial Year to which self-certification relates

2021/22   *Please Respond*

Certification on training of governors (FTs only)

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

Training of Governors

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

Confirmed

OK

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

Signature   **Signature**

Name Karen Bliss   **Name** Colin Scales

Capacity Chair   **Capacity** Chief Executive Officer

Date   **Date**

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

A

Self-Certification Template - Conditions G6 and CoS7

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

NHS Improvement

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

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence

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

These self-certifications are set out in this template.

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

Financial Year to which self-certification relates

Please complete the explanatory information in cell E36

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

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

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

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

Confirmed

OK

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

EITHER:

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

Confirmed

Please fill details in cell E22

OR

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

Please Respond

OR

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

Please Respond

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

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

Internal Audit - Substantial Assurance
Board committees
Trust continuous improvement plan in place
Internal audit plan agreed for 23/24
Leader in Me
Governance Structure
Declarations of Interests
Independent external Well Led review

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

Signature

Signature

Name   Karen Bliss

Name   Colin Scales

Capacity   Chair

Capacity   Chief Executive Officer

Date

Date

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