Bridgewater Community Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING

Thursday 3 August 2023, 10am
Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
50/23	10.00	(i) Apologies for Absence (ii) Quoracy Statement (iii) Declarations of Interest in items on the agenda		Information Assurance
51/23 (i) Page 4 (ii) Page 13	10.00	Minutes of the last meeting: (i) Board meeting held 1 June 2023 (ii) Extraordinary Board held on 28 June 2023		Assurance/ Approval
52/23 Page 15	10.05	Matters Arising from the Action Log		Assurance
53/23	10.10	Any urgent items to be taken at the discretion of the Chair		
54/23	10.10	Patient Story – Neuro Rehabilitation Service		Information
55/23 Page 22	10.30	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Assurance/ Approval
56/23 Page 39	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				
57/23 (i) Page 46 (ii) Page 57 (iii) Page 85 (iv) Page 141	10.55	(i) IQPR new format report – presented by the Chief Operating Officer (ii) IQPR Report Month Two – presented by Executive Leads (iii) Freedom to Speak Up Report – presented by the Freedom to Speak Up Guardian (iv) Report from the Quality and Safety Committee held on 22 June 2023 – presented by the Committee Chair	ALL 2,3,5, 6 2,3,6 2,3,6	Approval Assurance Approval Assurance

BREAK – 10 MINUTES				
RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
58/23 (i) Page 152 (ii) Page 162 (iii) Page 169 (iv) Page 180	12.00	(i) Finance Report – presented by the Director of Finance (ii) Adaptive Reserve Report – presented by the Director of Finance (iii) Reports from the Audit Committee held on 28 June (Extraordinary meeting), 6 July and 26 July (Extraordinary meeting) 2023 - presented by the Committee Chair (iv) Report from the Finance and Performance Committee held on 20 July 2023 – presented by the Committee Chair	4 4 1, 4 4,7,8	Assurance Assurance Assurance 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				
59/23 Page 188	12.50	(i) Integration and Collaboration Update – presented by the Programme Director of Integration and Collaboration	3-8	Assurance
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				
60/23 (i) Page 192 (ii) Page 217 (iii) Page 258	1.00	(i) Report from the People Committee held on 12 July 2023 (appendices provided within separate pack) – presented by the Committee Chair (ii) Update on North West Anti-Racist Framework – presented by the Director of People (iii) NHS Long Term Workforce Plan – presented by the Director of People	5, 6 5, 6 5, 6	Assurance Assurance Assurance
OVERARCHING CORPORATE GOVERNANCE ITEMS				
61/23 (i) Page 283 (ii)Page 289 (iii) Page 336	1.30	(i) Strategy and Board Assurance Framework Update – presented by the Trust Secretary and the Director of Integration and Collaboration (ii) Board Terms of Reference – presented by the Trust Secretary (iii) Board Business Cycle – presented by the Trust Secretary	1 1 1	Assurance Approval Approval
62/23	2.00	Review of meeting and Items to be added to the Board Assurance Framework		Information
63/23	2.05	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 5 October 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

Bridgewater Community Healthcare NHS Foundation Trust

Unapproved Minutes from a Public Board Meeting
Held on Thursday 1 June 2023, 10am
Ground Floor Meeting Room, Spencer House, Dewhurst Road, Birchwood, Warrington

Present
Karen Bliss, Chair
Colin Scales, Chief Executive
Ted Adams, Medical Director
Gail Briers, Non-Executive Director
Sarah Brennan, Chief Operating Officer
Lynne Carter, Chief Nurse
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

In Attendance
Jeanette Hogan, Deputy Chief Nurse
Mike Baker, Deputy Director of Communications and Engagement
Tania Strong, Head of Human Resources (from item 41/23i)
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

For Patient Story
Michelle Martin, FNP Supervisor, Halton Family Nurse Partnership
Helen Seddon, Family Nurse, Halton Family Nurse Partnership

Observers/members of the Public
Bill Harrison, Public Governor, Rest of England
Peter Hollett, Public Governor, Halton
Andrew Mortimer, Public Governor, Warrington

The Chair welcomed all to the June meeting of the Board. She reminded all that this was a Board meeting held in public but was not a meeting for the public to take part in, with the exception of questions that could be presented to the Board at the end of the meeting.

31/23 (i) APOLOGIES FOR ABSENCE
Linda Chivers, Non-Executive Director
Paula Woods, Director of People and Organisational Development
Rob Foster, Programme Director of Integration and Collaboration

(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.

32/23 MINUTES OF THE LAST MEETING HELD ON 6 APRIL 2023

The minutes of the last meeting were approved as an accurate record.

33/23 MATTERS ARISING FROM THE ACTION LOG

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

55/22 Board Assurance Framework

Following the Board time out session on 11 May which considered risk appetite, a review of the Board Assurance Framework would be undertaken following this session and the recent agreement of new Trust strategic objectives. **The Trust Secretary would review with the Executive Management Team and the updated Board Assurance Framework would then be presented back to the Board. The Board agreed that the blue rating for this action would be turned to green until the updated Board Assurance Framework was presented in August 2023.**

88/22ii Update on Provider Collaboratives

The Chair advised that discussions focussed on involving Non-Executive Directors in the Provider Collaborative were taking place. The Chair would be holding a discussion on Non-Executive engagement with the Provider Collaborative Director, Tony Mayer and Isla Wilson to take this forwards and devise an agenda for an event that would take place virtually with Non-Executive Directors from each of the nine member organisations. The Chair asked the Non-Executive Directors to contact her if they had any suggestions for that agenda.

21/23 Board Assurance Framework

The Board agreed that the session to consider risk appetite and setting of target risks had taken place on 11 May. This action could therefore be rated as blue.

23/23i IQPR

The Chief Operating Officer reported that work was underway on a new format for the IQPR with considerations being given as part of this work on how to include disaggregated data as discussed at the April Board meeting. A proposal would be presented to the Finance and Performance Committee in July 2023 and a suggested format would be presented back to the Board in August 2023. She advised that a meeting of the Non-Executive Director task and finish group, that had been convened previously to review the IQPR, would take place in early July to review and discuss the proposed report to ensure that it had captured all of the required areas. The Executive Management Team would also be kept sighted.

23/23ii Performance Framework

Discussion took place concerning the previously agreed action. Non-Executive Director, Tina Wilkins suggested that the Board Committee Chairs should not have regular meetings with the Chairs of the Councils. It was agreed that this action should be focussed on standardising the reports that were being brought forward through the Councils into the Board Committees and providing support to the Chairs of the Councils which would be a one off piece of work and not ongoing. It was agreed that this would be the role of the lead Executive Director rather than the Committee Chairs. **The action would be refined to reflect this.**

23/23iii Committee Chair's report from the Quality and Safety Committee (potential change of risk management reporting system)

The Board noted that this work had now been paused until the implementation of the Patient Safety Incident Response Framework (PSIRF).

23/23iv Learning from Deaths

The Medical Director had discussed the report and detail with Deputy Chief Nurse, Jeanette Hogan and Non-Executive Director, Gail Briers as Chair of the Quality and Safety Committee. Further work would be undertaken to refine the report. Non-Executive Director, Gail Briers asked that this include a review of current policy and what the Trust had agreed to report on in terms of learning from deaths and whether the policy needed to be revised. The report would need to describe the actions being taken within the organisation, where matters in relation to learning from deaths were being considered and how the Trust was managing the learning process. She advised that there would be further discussion on this matter at the June meeting of the Quality and Safety Committee. The Chief Executive noted that organisations across the system would have different ways of reporting on learning from deaths and suggested that a piece of work could be undertaken across the system across the Provider Collaborative to learn and share across a broader set of organisations. **It was agreed that the Medical Director would take this forwards.**

24/23i Finance Report – month 11 (incentives being offered for new staff)

The Chief Executive reported that the matter discussed at the April Board concerning incentives being offered by some organisations in advertisements for vacancies had not yet reached a conclusion. The organisations concerned still appeared to be offering incentives when advertising roles. Further discussions would continue and the Board would be kept updated. He advised that the impact of the incentives on Bridgewater's recruitment would be examined and this should provide a sense of whether clinicians were moving to other organisations due to incentives being offered. The matter had been raised with the ICB who had shared its frustrations on this matter, and this had been discussed as other forums with partners in Halton. Non-Executive Director, Martyn Taylor referred to a recent advertisement from an organisation in question which did not mention incentives. This may indicate that the matter was being resolved.

27/23iii Staff Survey

The Deputy Director of Communications and Engagement confirmed that the required actions had been addressed with the updates given in the circulated paper later on the agenda.

27/23v Statutory and Mandatory Training

An update was provided within the action log with a paper included later on the agenda.

It was agreed that the following completed blue rated items could be removed from the action log:
88/22i Integration and Collaboration Update/Children's transformation
91/22i Accountability Framework
08/23i IQPR
09/23ii Trust's response to the planning priorities guidance
09/23iv Chair's Report from the Audit Committee/Board self-effectiveness feedback

34/23 ANY URGENT ITEMS TO BE TAKEN AT THE DISCRETION OF THE TRUST CHAIR

The Chair confirmed that there were no urgent items of business to be taken. She wished to mark the passing of Paul Mendeika, one of the Trust's Public Governors for Warrington. She commented that he had been a huge advocate for the people of Warrington and for the Trust.

35/23 PATIENT STORY – HALTON FAMILY NURSE PARTNERSHIP

Michelle Martin, FNP Supervisor and Helen Seddon, Family Nurse attended the Board to present the story of a patient from their service. The patient had a child at 19 years old and had an unsettled environment and family history. She was supported by the service after being referred to the FNP by her Midwife. The service supported her through post-natal depression and had also provided support to the patient's family, including her partner and child, making them feel involved both collectively and as individuals. The patient received support and advice by phone/text messaging and support with practical aspects of caring for her child. As a result of the FNP's involvement and support, the patient had then felt confident to engage with other services as she had progressed with the programme. She had also gained an improved level of confidence and had made several positive life changes and was studying for a degree. The Board acknowledged the difference that community services such as FNP made for the population and the impact that it had due to early intervention and the ripple effect of positive changes for families, with mothers learning to parent with skills that they would then pass down to their children. It was noted that the service had an ambition to become a hub of excellence and the importance of the work around early years and Population Health. A national blog related to the patient's story was to be published via Public Health England that would be shared once it was available.

36/23 BOARD ASSURANCE FRAMEWORK

The Trust Secretary presented the Board Assurance Framework and highlighted a number of changes recommended by Board Committees during the period for the Board's approval:

BAF7: changes suggested by the Executive Management Team and accepted by the Finance and Performance Committee:
The Committee was asked by the Executive Management Team to consider reducing the risk rating for BAF7 due to the ongoing maturity with system working and the additional prevent controls in place. The Committee recommended a reduction to the current risk rating from 12 (high) to 8 (medium), this would bring this part of the Board Assurance Framework to its target risk rating.

BAF8: The Finance and Performance Committee discussed this section and recommended that it remained at target.

The Trust Secretary advised that there would need to be a review of the Board Assurance Framework to align with the new strategic objectives as discussed earlier in the meeting.

The Board accepted all of the recommendations from Board Committees as set out within the circulated report for the proposed amendments to be made to the Board Assurance Framework.

37/23 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. One particular area of highlight was Non-Executive Director, Abdul Siddique's visit to the House of Lords on 4 May for a conference as part of a Seacole group of BAMER Non-Executive Directors.

Discussions were focussed on reducing health inequalities and improving BAMER representation on Boards, as well as issues related to the cost of living crisis. Bridgewater's work on those aspects and Equality, Diversity and Inclusion were highlighted during the conference.

The Board also noted that correspondence had been received from Amanda Pritchard, NHS Chief Executive and Sir David Sloman, NHS Chief Operating Officer, to advise that the NHS was stepping down from the level three COVID-19 incident.

The Board received the report.

38/23 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

(i) IQPR

The Board received the report for month 12 which detailed notable improvements in operational performance including dermatology, 18 weeks RTT and the 28-day faster diagnosis standard, which was at 91% and one of the best scorings across Cheshire and Merseyside. The Chief Operating Officer reported that one indicator was reporting as red: Warrington Dermatology Cancer 62 day for first treatment (urgent GP Referral) which was due to factors outside of the control of the Trust. Within Warrington Audiology, there had been nine breaches and some challenges within the service due to having to manage the national incident and an increase in referrals in reception hearing screenings with the backlog from the pandemic. Dental services had seen several challenges with waits in Greater Manchester and discussions would be taking place with commissioners. Further information and discussions would be taken through the Finance and Performance Committee on this matter. There had been challenges on the Paediatric General Anaesthesia pathway and work was underway to reduce the number of patients. Regarding quality elements, the Board noted that there were no new red rated indicators. There had been a reported improvement in compliance with Information Governance training and a decrease in safeguarding level three compliance. There had been a decrease in the percentage of risks identified as high.

A discussion took place concerning dental referrals and capacity and demand. The Chief Operating Officer confirmed to Non-Executive Director, Martyn Taylor that modelling had been produced and that a plan would be taken into the Finance and Performance Committee in July 2023 and discussions were to take place with commissioners.

(ii) Report from the Quality and Safety Committee held on 20 April 2023

The Board received a report for assurance from Non-Executive Director and Committee Chair, Gail Briers. One point of clarification was noted due to a typographical error in the report: In terms of complaints for quarter three, a total of 14 formal complaints had been received during the period. This was compared to 15 received during quarter two and eight during the same period last year.

The Board particularly noted and welcomed the Committee's detailed considerations and discussions concerning PSIRF and risk management systems and timescales. The Chief Executive welcomed the attention of the Committee on audit and research which he suggested could be featured more prominently in the business of the Board. It was suggested that the Council of Governors should receive a presentation on research to a future meeting and this would be suggested as part of future agenda setting for that forum.

39/23 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(i) Finance Report – month one

The Board received the report for month one of 2023/24. The Director of Finance advised that the Trust was reporting a deficit of £250k against a break-even position and he explained that this was usual at this point in the year. The remainder of the report was in line with plan. The Trust had a full capital programme which was yet to be finalised and this would be reviewed in the near future by the Capital Council which included staff representation from across the organisation. The Board welcomed the Trust's continued achievement against the Better Payment Practice Code which was currently reporting at 97% compliance. This was recognised as a whole organisational effort to ensure that invoices were processed in a timely way, and this had been consistent for the past 12 months.

(ii) Adaptive Reserve Report

The Director of Finance informed the Board that the information related to the adaptive reserve was currently still being collated and that this would be reported back to the August 2023 Board meeting. He advised that the Trust's contribution in 2022/23 was £250k and that it had received £300k which was invested in the community equipment store to support hospital discharge. The Director of Finance reported that discussions were taking place with commissioners on exploring a recurrent funding stream going forward. It was agreed that the Trust must continue to challenge the position to shift income into community from an acute focus. The Board recognised that this shift in resource was a challenge and the ability to demonstrate evidence of the benefits of the funding was important. The Chair commented that there would also be the opportunity as part of the system for organisations to think outside of their sovereignty and develop the maturity and relationships to take this forward and focus on the results for the system.

(iii) Report from the Audit Committee held on 27 April and 18 May 2023

Non-Executive Director, Tina Wilkins presented the two reports on behalf of Non-Executive Director and Audit Chair, Linda Chivers. Following a recommendation by the Audit Committee in relation to the preparation of the statutory accounts, the Board approved the acceptance of the adoption of the Going Concern basis for 2022/23. Non-Executive Director, Martyn Taylor noted that a positive statement had been relayed from auditors concerning the Value for Money Statement which had not been included within the report. The Director of Finance informed the Board that there had been no concerns raised on any matters by the auditors since the 18 May Audit Committee took place.

(iv) Report from the Finance and Performance Committee held on 5 May and 18 May 2023

The Board received reports from the Finance and Performance Committee meetings held during May 2023 from Non-Executive Director and Committee Chair, Tina Wilkins.

One point of clarification was noted; the Chief Nurse advised that under the digital section of the report, the Clinical Nursing Information Officer should read Clinical Safety Officer. The Medical Director also clarified that there was no risk to existing systems. He explained that the Clinical Safety Officer would sign off any IT aspect with a clinical element and this would be related to new systems being implemented or changes to existing ones. The Director of Finance added that in the event of any issues or concerns or delays to schemes, this would be addressed on a case by case basis. In addition support was available from an external source and so there was a mitigation in place.

The Medical Director confirmed to Non-Executive Director, Martyn Taylor that there was a person in post for the Clinical Safety Officer role and was being trained. This would take approximately three months with the mitigation in place if needed.

40/23 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

(i) Integration and Collaboration Update

The Board noted a report presented by the Chief Operating Officer which provided an update on Place and the Provider Collaborative.

(ii) ICB Joint Forward Plans

The Board received a paper on the draft Joint Forward Plan for Cheshire and Merseyside. The document described how the ICB, and partner trusts intend to arrange/provide NHS services to meet the needs of their populations. Any comments on the document would be fed back from Board members to the Trust Secretary or Programme Director of Integration and Collaboration. The final document would be publicised on 30 June 2023. The Board recognised that the paper highlighted the close alignment of the Trust's strategy with the objectives of the ICB.

(iii) Communities Matter – Trust Strategy Update

The Chief Executive presented the report which gave an update and assurance on the progress with the delivery of the new Communities Matter Trust Strategy. This included an update related to the development of annual delivery plans, measuring and monitoring the delivery and impact of the new strategy and the engagement plans and approach. The report also included an update on the quality visits, supporting the focus on continuous improvement in patient outcomes, increasing patient satisfaction and staff experience. The visits would be supportive and enable services to showcase themselves. The programme would include all services across the Trust including clinical and corporate. The Board noted and supported the content of this report.

41/23 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

(i) Report from the People Committee held on 10 May 2023

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

(ii) Update on Industrial Action and Pay Deal

The Deputy Director of Communications and Engagement reported that the Trust was advised on 18 April 2023 that RCN industrial action (IA) would take place from 8pm on Sunday 30 April to 8am Tuesday 2 May. This encompassed overnight hours and a bank holiday Monday. Originally IA was planned to continue up to 8pm on 2 May but this was changed following a successful legal challenge. The Trust's IA Task and Finish group was mobilised to plan and co-ordinate the response to the IA. Four out of five previously derogated services (District Nursing, UCR, IV therapy, Padgate House) were staffed to minimum agreed levels. One service, the Urgent Treatment Centre (UTC), received a critical mitigation derogation but still could not be staffed safely and was therefore closed. The Trust cancelled 215 appointments, and 48 shifts were not filled due to strike action. On the 2 May, the NHS Staff Council convened and formally agreed the pay deal which the majority of Agenda for Change Trade Unions accepted. Agenda for Change colleagues would now receive additional payments in relation to last year and a minimum 5% uplift for this financial year, however the pay deal did not include doctors or dentists. The implementation would take place in June 2023.

(iii) Statutory and Mandatory Training and PPDR Action Plans

The Board noted the current position concerning compliance with statutory and mandatory training leading up to the deadline of 31 July 2023 for all staff to be compliant. The Board would consider a set of principles for managing non-compliance after this date during its closed session. The Board agreed that all training must be appropriate to individual staff roles and this must be ensured prior to any consequences being introduced for non-compliance. Non-Executive Director, Elaine Inglesby asked if data was available for areas of non-compliance along with support for those areas. The Chief Operating Officer confirmed that the data was available and conversations would take place with staff to support them to understand the importance of completing their training and ensuring they took the time away from their roles to do this. Non-Executive Director, Abdul Siddique advised that there would be a breakdown of training compliance by directorate presented to the People Committee in July 2023.

(iv) NHS Staff Survey Update

The Board received the report which outlined a further update on how responses to key staff survey questions had compared between 2021 and 2022. Further information was awaited concerning the comparator group that the Trust currently sat within. The Board agreed that it would be important to ensure that the Trust was on a continuous improvement journey as a result of the feedback.

(v) Freedom to Speak Up (FTSU) Annual Report

The Board received the Annual Report summarising the FTSU activity during 2022/23. The Head of Human Resources reported that the Trust's FTSU self-assessment was underway, and the final results and plans would be presented to the August Board meeting. The Board agreed that it was of key importance to ensure that the Trust was demonstrating that it was listening to the experiences of staff who had been through the FTSU process. FTSU is a key part of Just Culture for the organisation. **It was agreed that the right way for this to be taken through to the Board would be considered and this would be decided following the conclusion of the self-assessment process,** ensuring that individuals were protected, with learning to be extracted but anonymised, as the organisation was open to sharing learning in the public domain. It would be important to consider the wishes of those who had spoken up and how they would like their stories to be shared.

42/23 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Well-Led Report

The Chief Executive introduced the final well led report that had been reviewed at a recent Board time out session in May 2023. The Board welcomed the position set out within the report and acknowledged the significant improvement journey of the Trust since its 2018 CQC inspection, around leadership and governance, whilst recognising that there was further work and actions still to be undertaken. An action plan would be taken forwards by the Executive Management Team, and this would be overseen by the Audit Committee. It was agreed that the final report would be published on the Trust's website and shared with the CQC as an indication of the work that the Trust would undertake to address any areas.

(ii) Fit and Proper Annual Review

The Trust Secretary presented a report to provide assurance that the Board members and those regularly attending and advising the Board remained as Fit and Proper Persons. The report detailed the checks that had been made against individuals to ensure that they met the required criteria.

It was clarified that those Board members who were also members of professional regulatory bodies would need to be checked against their registers i.e., Nursing and Midwifery Council/British Medical Association and others. **This would be undertaken following the meeting.**

(iii) NHS Provider Licence Self Certification

The Board approved the annual self-certification noting that there were no material risks or areas of concern identified. The document would be authorised following the meeting by the Chair and the Chief Executive.

43/23 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

There were no further items to be included within the Board Assurance Framework from discussions during the meeting.

44/23 OPPORTUNITY FOR QUESTIONS TO THE BOARD FROM STAFF, MEDIA OR MEMBERS OF THE PUBLIC AT THE DISCRETION OF THE TRUST CHAIR

The Chief Operating Officer confirmed to Public Governor, Peter Hollett, that there were clinical harms reviews undertaken for dental long waiters and that the Trust was continuing its focus on this issue.

It was also noted that all current vacant seats on the Council of Governors would be recruited to as part of the imminent elections during July and August 2023.

DATE AND 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.

Bridgewater Community Healthcare NHS Foundation Trust

Unapproved Minutes from an Extraordinary Board Meeting
Held on Wednesday 28 June 2023, 11.30am
Virtual meeting held via Microsoft Teams

Present
Karen Bliss, Chair
Linda Chivers, Non-Executive Director
Gail Briers, Non-Executive Director
Elaine Inglesby, Non-Executive Director
Tina Wilkins, Non-Executive Director
Martyn Taylor, Non-Executive Director
Colin Scales, Chief Executive
Nick Gallagher, Director of Finance
Lynne Carter, Chief Nurse
Paula Woods, Director of People
Sarah Brennan, Chief Operating Officer

In Attendance
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

45/23 Apologies for Absence
Abdul Siddique, Non-Executive Director

Quoracy Statement

The Chair confirmed that the meeting was quorate

46/23 Declarations of Interest in items on the agenda

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

47/23 ANY URGENT MATTERS WITH AGREEMENT OF THE CHAIR

The Chair confirmed that there were no urgent items of business to be taken.

48/23 (i) 2022/23 Annual Accounts

The Board approved the annual accounts noting that the accounts had been received and recommended to the Board by the Audit Committee and three minor amendments were to be made to the document. The Board noted that the Trust had achieved all key targets and were reporting a surplus.

Non-Executive Director and Audit Chair, Linda Chivers provided a verbal update on the considerations of the Audit Committee on the annual accounts. She confirmed that that the Trust had received a Head of Internal Audit Opinion of substantial assurance. There had also

been four timelines extended for some particular audits which had been agreed by the Audit Committee. She reported that KPMG had given an unmodified audit opinion on the accounts with their work now concluded with no further queries. The Trust had also received a clean Value for Money opinion. Whilst there were some recommendations in relation to ISA260, these were not of a high risk nature and work was ongoing with reporting and monitoring being taken through the Finance and Performance Committee.

The Board extended its thanks to all staff involved in the work on and the completion of the annual accounts, particularly around IRFS16.

The Board also approved the Management Letter of Representation. This referenced some IFRS16 leases that had not been signed to date, however this was reflective of a similar position across the NHS and was not a concern.

(ii) 2022/23 Annual Report and Annual Governance Statement

The Board approved the Annual Report and acknowledged that an extra paragraph had been included to recognise the contributions from two public governors, Diane McCormick and Paul Mendeika who had both recently passed away.

49/23 REVIEW OF ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

It was agreed that the Board Assurance Framework would be updated to reflect the clean audit opinion as described above.

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	Completion Date	
					Due Date/BRAG Status	Comments/Further Action
04.08.22	55/22	Board Assurance Framework	**Board session to review the BAF to be scheduled with support from GGI. Any further work following the development of an ICS BAF would be considered subsequently.**	Jan McCartney	**GREEN August 2023**	June 2023: Following the Board time out session on 11 May which considered risk appetite, a review of the Board Assurance Framework would be undertaken following this and the new strategic objectives. The Trust Secretary would take this forwards and review with the Executive Management Team and this would then be presented back to the Board. The Board agreed that the blue rating for this action would be turned to green until the updated Board Assurance Framework was presented. An update paper will be included on the agenda.

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
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: Chair to hold a discussion regarding Non-Executive engagement with Provider Collaborative Director with a view to an event taking place involving all Non-Executive Directors from each of the nine Provider Collaborative member organisations. Non-Executives to forward any suggestions for the discussion to the Chair. Verbal update to be provided by the Chair.
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	**BLUE**	Board session took place on 11 May 2023. This will be reflected within the new BAF.

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	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 August 2023**	June 2023: Information will be included in the IQPR report. A new format will be presented back to the Board in August 2023.
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: The Board agreed that this action needed to be refined: This should be focussed on standardising the reports that were being brought forward through the Councils into the Board Committees and providing support to the Chairs of the Councils which would be a one-off piece of work and not ongoing. It was agreed that this would be the role of the lead Executive Director rather than the Committee Chairs.

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	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: This work has now been paused until the implementation of the Patient Safety Incident Response Framework (PSIRF). This matter will be taken forwards by the Quality and Safety Committee.
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.**	Ted Adams	**GREEN**	June 2023: Feedback has been provided to the report author. Work is ongoing to refine the report. Further discussion would take place on this matter in June at the Quality and Safety Committee.
06.04.23	24/23i	Finance Report – month nine	**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.

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	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	**BLUE**	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. July 2023: As per June Board, the Trust's Deputy Director of Communication & Engagement explored comparators for the 2023 Staff Survey with Quality Health to see if the Trust can benchmark against Acute Trusts for the 2023 Survey. This is not possible as per there being a Community Trust specific benchmarking group.

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	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	**BLUE**	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.

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
01.06.23	41/23v	Freedom to Speak Up Annual Report (FTSU)	**The Board agreed that it was of key importance to ensure that the Trust was demonstrating that it was listening to the experiences of staff who had been through the FTSU process. It was agreed that the right way for this to be taken through to the Board would be considered and this would be decided following the conclusion of the self-assessment process.**		**GREEN August 2023**	The self-assessment report will be presented to the August Board meeting.
01.06.23	42/23ii	Fit and Proper Annual Review	**It was clarified that those Board members who were also members of professional regulatory bodies would need to be checked against their registers i.e., Nursing and Midwifery Council/British Medical Association and others. This would be undertaken.**	Jan McCartney	**GREEN**	Update to be provided to confirm this action is completed and no issues have been identified.
28.06.23	49/23	Items to be added to the Board Assurance Framework	**It was agreed that the Board Assurance Framework would be updated to reflect the clean audit opinion as described above.**	Jan McCartney	**GREEN**	

Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3 August 2023**
Agenda Item	**55/23**		
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	3 August 2023
Agenda Item	55/23		
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 June and 6 July 2023. The following amends are recommended following the sign off of the accounts and annual report.

a) An update to show 2022/23 Heads of Audit opinion as substantial assurance.

b) An update to acknowledge the updated 2023 well led review

c) An update to show 2022/23 audit and VFM opinion

d) Internal Audit plan agreed for 2023/24

e) DSPT Audit – substantial / moderate assurance 2022/23

This BAF risk rating remains at target.

2.2 BAF2 – Failure to deliver safe and effective patient care

The Quality & Safety Committee met on 22 June 2023 where no changes were recommended, with no change to the risk rating.

2.3 BAF3 – Managing demand and capacity

The Quality & Safety Committee met on 22 June 2023 where no changes were recommended which no change to the risk rating.

2.4 BAF4 – Financial sustainability

The Finance & Performance Committee met on 20 July 2023 and asked the Director of Finance to update the Gaps in Control section to reflect the challenges with CIP and agency spend targets. This change has been made.

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

2.5 BAF5 – Staff engagement and morale

The People Committee met on 12 July 2023 where the Committee recommended:

a) Under the Assurance section, update on the increase in the milage payments
b) Pay deal updated to reflect this is complete for AfC staff
c) Payroll Feeder System Review Audit, substantial assurance, added to internal audits

The Committee then has a discussion on whether the risk rating should be reduced, after considering the fact that the threat of industrial action is now significantly reduced, that compliance with mandatory training has increase and hoe the staff networks are becoming embedded, the Committee agreed to reduce the likelihood score to 3. The recommended change is to reduce the risk from 4x4=16 (significant) to 4x3=12 (high).

2.6 BAF6 – Staffing levels

The Quality & Safety Committee met on 22 June 2023 and did not ask for any changes to be made.

The People Committee met on 12 July 2023 and notes that no gaps in assurance are recorded despite the risks and significant pressures around workload, complexity, staffing levels and sick absence. The Committee have requested that the Q&S Committee review the risk score and rationale.

Neither Committee recommended a change in the current risk rating.

2.7 BAF7 – Strategy and organisational sustainability

The Finance & Performance Committee met on 20 July 2023, no changes were recommended to this BAF and the risk rating remains on target.

2.8 BAF8 – Digital Services

The Finance & Performance Committee met on 20 July 2023. The only update recommended was to record and update the DPST toolkit rating. The risk rating remains on target.

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) remain at target.

Appendix A – Board assurance framework

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 21 July 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** Current risk rating 4(C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2(L) = 8, **medium**	Inherent risk rating 5(C) x 5 (L) = 25, **significant** Current risk rating 5 (C) x 3 (L) = 15, **significant** Target risk rating 5(C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 4 (L) = 16, **significant** Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 3 (L) = 12, **high** Target risk rating 4(C) x 1 (L) = 4, **low**	Inherent risk rating 5(C) x 4 (L) = 20, **significant** Current risk rating 5 (C) x 3 (L) = 15, **significant** Target risk rating 5 (C) x 2 (L) = 10, **high**	Inherent risk rating 4(C) x 3 (L) = 12, **high** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4 (C) x 2 (L) = 8, **medium**	Inherent risk rating 4(C) x 4 (L) = 16, **significant** Current risk rating 4 (C) x 2 (L) = 8, **medium** Target risk rating 4(C) x 2 (L) = 8, **medium**

Board Assurance Framework (BAF) August 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: July 2023 Audit Committee Last reviewed: July 2023 Risk Ratings reviewed: July 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 202/23 2023 Well Led report and recommendations accepted	**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 2022/23 • Board, committees (Quality & Safety, Finance & Performance, and People) • Trust continuous improvement plan in place • Internal Audit Plan agreed for 23/24 • External independent 2023 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 (2022/23)

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

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

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

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Chief Nurse / Deputy CEO / Last reviewed: June 2023 Quality & Safety Committee Last reviewed: June 2023 Risk Ratings reviewed: June 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 BAF3) 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) August 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: June 2023 Quality & Safety Committee last reviewed: June 2023 Risk Ratings reviewed: June 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) August 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: July 2023 Finance & Performance Committee last reviewed: July 2023 Risk Ratings reviewed: July 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 2023/24 Trust plan reflects challenging CIP and reduction in agency spend targets. The Trust is focussing on supporting all teams to deliver the planned savings and spend reductions and support and advice sessions will be included in the Senior Leadership Team meeting.

Board Assurance Framework (BAF) August 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 3(L) = 12, **high** Target risk rating: 4(C) x 1 (L) = 4, **very low**	**RISK APPETITE:** **OPEN**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Director of People and OD Last reviewed: July 2023 People Committee Last reviewed: July 2023 Risk Ratings reviewed: July 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, national increases now in place **Internal Audit MIAA Substantial Assurance** • Freedom to Speak Up (2020/21) • Induction (2020/21) • Payroll Feeder System Review (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) August 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: July 2022 Quality & Safety Committee Last review: June 2022 People Committee: July 2023 Risk Ratings reviewed: July 2022	**Staffing levels** If the Trust fails to have an appropriately resourced, focused, resilient workforce in place that meets service requirements; Caused by an inability to recruit, retain and/or appropriately deploy a workforce with the necessary skills and experience; or caused by organisational change; It may result in extended unplanned service closure and disruption to services, leading to poor clinical outcomes & experience for large numbers of patients; unmanageable staff workloads; and increased costs **Risks on register 15 plus** No risks at this level	Robust operational management structures in place. Adverse impacts to consider include: winter pressures, system wide incentives causing instability in recruitment and retention, potential for industrial action. (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) August 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 2 (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: July 2023 Executive Team July 2023 F&P Committee Last reviewed: July 2023 Risk Ratings reviewed: July 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. **Risks on register 15 plus** 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) August 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: July 2023 F&P Committee Last reviewed: July 2023 Risk Ratings reviewed: July 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 (2022/23)

Gaps in controls and assurance: (and mitigating actions)

Digital Services team capacity

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

No.	Risk Title	Inherent Score			Target Score			Q3 Oct-Dec			Q4 Jan-Mar			Q1 Apr-Jun			Q2 Jul-Sep			Target Date	Change	Impact on Objectives					
		C	L	S	C	L	S	C	L	S	C	L	S	C	L	S	C	L	S			Equity, Diversity & Inclusion	Health Equity	Partnerships	Quality	Resources	Staff
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	2	8	4	2	8	4	2	8	4	2	8	TBC	→		✓	✓	✓		
BAF 5	Staff engagement and morale	4	4	16	4	1	4	4	4	16	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	2	8	4	2	8	TBC	→		✓	✓	✓	✓	✓
BAF 8	Digital services	4	4	16	4	2	8	4	3	12	4	2	8	4	2	8	4	2	8	TBC	→	✓	✓	✓	✓	✓	✓

Board Assurance Framework (BAF) August 2023 – V0.1 Board Final
Appendix 2: Risk grading criteria

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

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

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

Board Assurance Framework (BAF) August 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

Bridgewater Community Healthcare NHS Foundation Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3 August 2023**
Agenda Item	**56/23**		
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**	**3 August 2023**
Agenda Item	**56/23**		
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 several meetings outlined below:

- Community Trust Chairs' Network meeting on 22 May.
- NHS Provider Community Network meeting on 6 June.
- Cheshire & Merseyside Chairs' Network on 7 June, which was chaired by Raj Jain, ICB Chair.
- NHS Confederation Expo conference in Manchester on 15 June.
- the NHS Providers North West Regional meeting for Chairs and Chief Executives on 4 July held at the Wrightington Country Club.

Karen also attended the following webinars:

- 5 June - facilitated by the NHS North West Regional Team "Attracting, recruiting and developing our Chair and Non-Executive Talent" and one facilitated by NHS Providers "Race Equality and Health Inequalities: taking a community driven approach to addressing health inequalities.
- 3 July – NHSE facilitated a session on the NHS Long Term Workforce Plan.

Karen had a 1-1 meeting with Eileen Fairhurst, Chair of the Northern Care Alliance on 8 June. Karen also had a 1-1 meeting with Rob Foster, Programme Director of Collaboration and Integration on 29 June.

Karen accompanied the Chief Executive on the Time to Talk session with the Dental Admin Hub in Rochdale on 31 May.

As part of the Trusts appraisal process, Karen undertook appraisal meetings with all the Non-Executive Directors, as well as the Chief Executive and the Trust Secretary.

1.2 Non-Executive Director, Linda Chivers attended a number of meetings since the last Board meeting, as follows:

- Rest of England Governor's meeting.
- Council of Governors meeting.
- Council of Governors Development session.
- Monthly catch-up meetings with Mersey Internal Audit and also attended the Mersey Internal Audit Chairs session.
- Met with the two Governor Observers on Audit Committee to discuss the July Audit Committee.
- Met privately on a number of occasions with KMPG to discuss the External Audit progress.
- Meeting to discuss the process for undertaking Procurement of External Audit for 2023/24 onwards.
- Attended the NHS Leadership Academy Non Executive Directors Networking events.

Linda also had a 1-1 meeting with the Director of People & OD as part of the buddying arrangement and participated in her annual appraisal with the Trust Chair.

1.3 Non-Executive Director, Martyn Taylor attended numerous meetings, namely:

- Informal H&W Governors meeting on 25 May.
- NHSP Webinar regarding Talent Recruitment on 5 June.
- Governor Rem Com meeting on 6 June.
- Time to Shine meeting on 9 June.
- Meeting with Public Governor Andrew Mortimer, the Trust Chair and Trust Secretary on 27 June.
- Chairs appraisal meeting on 30 May.
- 1-1 meeting with the Trust Chair on 22 May.
- 1-1 meeting with the Chief Executive on 22 May.

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

- A meeting held by the Audit Committee Chair to discuss the process to procure External Auditors on 13 June 2023.
- Time to Talk Session on 19 July with the LTC Nursing Team Warrington.
- As part of the buddying arrangements, met with the Chief Nurse on 10 July.
- Attended the Northwest Non-Executive Director (NED) Network Event on 19 July 2023.
- Time to Shine meeting on 9 June.
- The Voice of the Child forum held on 4 July.
- Met with the Deputy Chief Operating Officer to discuss the Cost Improvement Programme (CIP) on 14 July 2023.

1.5 Non-Executive Director, Abdul Siddique attended the Reciprocal Mentoring briefing day on 12 June and is taking part in this programme.

1.6 Non-Executive Director, Gail Briers accompanied the Chief Operating Officer on the Time to Talk session with the Nye Bevan House Dental Team on 13 June. As part of the buddying arrangements, Gail also held two 1-1 sessions with the Chief Operating Officer. On 20 June, Gail met with Helen Young, Freedom to Speak Up Guardian.

2. EXECUTIVE UPDATES

2.1 The Executive Team appraisal process took place during the months of June and July and the 2023/24 Executive Team and individual objectives were set. These were presented to the Nominations & Remuneration Committee on Thursday, 13 July.

2.2 The Chief Executive and Director of Finance met with the Chief Executive of Norfolk Community Health & Care NHS Trust on Monday, 10 July to share Bridgewater's experiences and the learning from our digital journey so far.

2.3 On Wednesday, 19 July the Chief Executive and Medical Director met with members of the leadership team from the University of Central Lancashire (UCLan) to discuss partnership opportunities.

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:

- On 31 May, the Chief Executive met with the Dental Admin Hub, based at Brook House in Oldham. The Trust Chair accompanied the Chief Executive on this visit.

- On 13 June, the Chief Operating Officer met with the Dental Nye Bevan House Team via teams.

- On 5 July, The Trust Secretary visited the Halton Speech and Language Therapy team and was able to celebrate the NHS 75th Birthday with the team.

- The Executive Medical Director met with the team based at Padgate House on 6 July.

2.5 Board Sessions/Events

2.5.1 An Extra-ordinary Board meeting took place on 28 June to sign off the annual report and 2022/23 Accounts.

2.5.2 A Board Time-Out session took place on 13 July. The following topics were discussed:

- Dental Strategy
- Children's Transformation
- Strategy Update

3. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

3.1 Monthly feedback from the Time to Talk sessions is collated and an example of feedback is provided below:

"Really coherent team. Felt that there was a good sense of team. Team leader knew her team really well and where they all wanted to be and their interests."

4. OTHER TRUST NEWS

4.1 **NHS 75th Birthday – Westminster Abbey Service**

On Wednesday 5th July, Bridgewater staff attended a service at Westminster Abbey celebrating 75 years of the NHS.

Speakers included Prime Minister Rishi Sunak, Leader of the Opposition Keir Starmer and Chief Executive Officer of NHS England Amanda Pritchard.

Staff invited were Beth Johnson, Health Care Support Worker, Katie Adams, Business Administration Apprentice, Lisa Williams, Childhood Immunisation and Vaccination Team Leader and Emma Smith, Lead Nurse, Children in Care, Halton.

In acknowledgement of the way in which Bridgewater services are developed using feedback from the local community, Michael Gee, a care leaver who has worked to help shape the delivery of the dedicated Child in Care Nursing Team, was also invited to the service.

The group had a wonderful day, with Lisa Williams stating: "I feel so proud to be a nurse in the NHS and I'm honoured to be representing our incredible Trust in this way."

4.2 **NHS Long Term Workforce Plan**

The NHS Long Term Workforce Plan was published on the 30th of June 2023. It sets out how the NHS will address existing and future workforce challenges by recruiting and retaining thousands more staff over a 15-year period, and working in new ways to improve staff experience and patient care. Commissioned and accepted by the government, it provides a costed plan for how the NHS will develop to meet existing and future demand and challenges, and support population health and wellbeing. Over £2.4 billion has been committed to fund additional education and training places over the next five years, on top of existing funding commitments.

The plan sets out the strategic direction over the long term as well as short to medium term actions to be undertaken locally, regionally and nationally. Those actions fall into three priority areas: Train, retain and reform. The Trust's assessment of the Workforce Plan is on the Trust Board agenda.

4.3 **PPDR, Statutory and Mandatory Training Compliance**

Over the last twelve months, the Trust has been focused on ensuring the appropriate compliance with statutory and mandatory training and PPDRs. Numerous communications have gone out to staff regarding full compliance being required by the 31st of July. Support to create the right conditions and environment to undertake training and conduct meaningful PPDRs has been provided and this has been enhanced by way of extra face to face training sessions, along with uncapped attendance on training delivered virtually via Microsoft Teams.

The Director of People & Organisational Development and I met with Associate Borough Directors and Corporate Services Deputies on Tuesday 18th of July. This meeting took place face to face and involved a review of compliance reports and plans to meet the end of July deadline. There was also ample opportunity provided at this meeting to flag any issues and consider any further support required. There are plans in place to achieve compliance and this will be assessed when Month 4 reports are generated in August. Any non-compliance will be dealt with in line with the partnership principles that have agreed with our Staff-side Colleagues and endorsed by Trust Board.

4.4 **Executive Team Meetings**

The executive team has refreshed how it conducts their weekly team meetings. One meeting per month will be held as a 'Business Meeting' which takes formal decisions on reports on subjects already discussed and will be formally minuted. Other meetings, known as 'Development Meetings', will provide an opportunity for the team to focus on emerging issues/risks and develop thinking around strategic matters, and will encourage frank and open exchange. Actions will be captured but no decisions made. This new way of conducting executive team meetings started in July and will be reviewed in 3 months to assess their efficacy. Fewer decision meetings support the devolved autonomy of the Directorates as the Directorate Leadership Teams take increased operational responsibility.

5. EXTERNAL PUBLICATIONS AND REPORTS

5.1 **UK COVID – 19 INQUIRY** – The inquiry has started requesting and hearing evidence for module 1. This module examines government planning and preparedness in the period between June 2009 and 21 January 2020
NHS Providers are providing regular updates on the inquiry - COVID-19 public inquiry - NHS Providers
The UK Covid 19 Inquiry website - Every Story Matters - UK Covid-19 Inquiry (covid19.public-inquiry.uk)

5.2 **HFMA Briefing – Health Inequalities, establishing the case for change**
This is the first introductory briefing on health inequalities produced by the HFMA working with NHS England. It is aimed at raising awareness and providing a useful background on why health inequalities are important, and how finance staff can support

the case for change (both within their organisation and across the local system) hfma-health-inequalities-establishing-the-case-for-change-may-2023.pdf

5.3 **Review Body on Doctors' and Dentists' Remuneration 51st Report: 2023**
On 13 July the government accepted the recommendations outlined in the Remuneration report.
Review Body on Doctors' and Dentists' Remuneration 51st Report: 2023 - GOV.UK (www.gov.uk)
The full details of the announcement is available in the Secretary of State's ministerial statement. Written statements - Written questions, answers and statements - UK Parliament

6. RECOMMENDATIONS

6.1 The Board is asked to note the report.

Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3rd August 2023**
Agenda Item	**57/23i**		
Report Title	**INTEGRATED QUALITY AND PERFORMANCE REPORT (IQPR) NEW FORMAT**		
Executive Lead	Sarah Brennan, Chief Operating Officer		
Report Author	Sarah Brennan, Chief Operating Officer		
Presented by	Sarah Brennan, Chief Operating Officer		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

Following a Board Development Session led by the Good Governance Institute on 28th February 2023, it was agreed that a revised format of the IQPR would be developed. The current IQPR document was refreshed in its layout and presentation in 2021, however the indicators contained in the document were not refreshed at this point.

Several indicators in the current version of the IQPR needed to be reviewed and some of the indicators needed to be refined to be more focused. A number of metrics also needed to be incorporated from the System Oversight Framework (SOF) Metrics 2022/23.

Each domain of the IQPR – Operations, Quality, People and Finance has been reviewed and indicators to be removed and added have been proposed.

The Finance and Performance Committee recommend to the Board that the Indicators proposed are approved and that a revised format of the IQPR is brought to the Finance and Performance Committee in September and onward to Board in October. The Finance and Performance Committee recommend that the People indicators are taken to People Committee review and that the Quality indicators are taken to Quality and Safety Committee.

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 REPORT

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3RD AUGUST 2023**
Agenda Item	**57/23i**		
Report Title	**IQPR NEW FORMAT**		
Report Author	Sarah Brennan, Chief Operating Officer		
Purpose	To propose the new indicators for the revised IQPR.		

1. INTRODUCTION

1.1 Following a Board Development Session led by the Good Governance Institute on 28th February 2023, it was agreed that a revised format of the IQPR would be developed.

1.2 The current IQPR document was refreshed in its layout and presentation in 2021, however the indicators contained in the document were not refreshed at this point.

1.3 A number of indicators in the current version of the IQPR required reviewing as the way in which they are measured by clinical systems means that they will always be outside of the target, such as cancellations by service where the movement of an appointment from one clinician to another results in a cancellation. Some of the indicators required making more focused as by just indicating a number they did not inform the Committees or Board of any areas of risk or challenge.

1.4 Several metrics also needed to be incorporated from the System Oversight Framework (SOF) Metrics 2022/23.

1.5 It was agreed at the Board Development Session that the IQPR would become a more iterative document where indicators could be added/removed more routinely following the appropriate governance process so that the IQPR was reflective of performance against targets that the Board and Committees needed to be sighted on.

1.6 It was also agreed that once the core metrics were agreed, additional metrics would be added to evidence the delivery of the Trusts new strategy ‘Communities Matter’ and that all indicators would align to the strategic objectives.

2. PROCESS

2.1 Following the Board Development Session in February, a task and finish group meeting was arranged with Executive and Non-Executive representatives with support from the business intelligence team. It was however decided at the session that the work of the task and finish group should be to review a more finished product such as a list of indicators for the IQPR or Directorate Scorecard.

2.2 The Chief Operating Officer and the Assistant Director of Transformation supported by the Head of Information met with leads for the Quality, Finance and People Indicators and developed a set of draft indicators.

2.3 The draft indicators were reviewed by each of the Executive Leads and a final proposal for a new set of indicators was developed.

3. OPERATIONS

3.1 Following a review of the current indicators and the SOF metrics the following set of metrics is proposed for the Operations Section of the IQPR:

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Comments	Frequency
Operations	Responsive	OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	Already in IQPR		Monthly
Operations	Responsive	OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	Already in IQPR		Monthly
Operations	Responsive	OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	Already in IQPR		Monthly
Operations	Responsive	OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	Already in IQPR		Monthly
Operations	Responsive	OP22	28 day faster diagnosis	Already in IQPR	This is the only indicator included within22/23 SOF for Cancer	Monthly
Operations	Responsive	OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	Already in IQPR		Monthly
Operations	Responsive	OP12	Total time in A&E - 95th Percentile (Mins)	Already in IQPR		Monthly
Operations	Responsive		Total time in A&E - Median (Mins)	New	Included in National Dashboard	Monthly
Operations	Responsive	OP13	A&E Time to treatment decision (median) <=60 mins (Mins)	Already in IQPR		Monthly
Operations	Responsive		A&E Time to treatment decision 95th percentile <=60 mins (Mins)	New	Included in National Dashboard	Monthly
Operations	Responsive	OP14	A&E Unplanned re-attendance rate <=5%	Already in IQPR		Monthly
Operations	Responsive	OP15	A&E left without being seen <=5% (left before trx completed)	Already in IQPR		Monthly
Operations	Responsive		percentage referred onto A+E (UTC)	New	Not in National dashboard but local interest	Monthly
Operations	Well led	OP17	Data Quality Maturity Index (DQMI) (monthly internal reporting)	Already in IQPR	There will be differences between Monthly and Quarterly data due to refresh submissions.	Monthly
Operations	Well led		Data Quality Maturity index (DQMI) Quarterly published score (2 months in arears)	New	Obtain from National Dashboard	Quarterly
Operations	Well led		Unfinished Activity (appointments/visits that remain in " booked" status with past date)	New		Monthly
Operations	Responsive		Cancellations by Patient not rescheduled with 10 working days	New		Monthly
Operations	Responsive		Cancellations by service not rescheduled with 10 working days	New		Monthly
Operations	Responsive		Percentage of DNAs/Was not brought	New		Monthly
Operations	Responsive		Proportion of Urgent Community Response referrals reached within two hours	New		Monthly
Operations	Responsive	OP16	Audiology - Number of 6 weeks diagnostic breaches	Already in IQPR	(remove Warrington from description)	Monthly
Operations	Responsive	OP06	Referrals to plan	Already in IQPR	Hidden in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Referrals to plan - Dental	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		Referrals to plan - Childrens	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		Referrals to plan - Warrington Adults	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		Referrals to plan - Halton Adults	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive	OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	Already in IQPR		Monthly
Operations	Responsive		% of waiters over 52 weeks - consultant Led	New		Monthly
Operations	Responsive		% of waiters over 78 weeks -consultant Led	New		Monthly
Operations	Responsive		% of waiters over 104 weeks-consultant Led	New		Monthly
Operations	Responsive		All waiters - % waiting over 52 weeks (also include Dental)	New	Difficulty level of 2 because of Dental data	Monthly
Operations	Responsive		All waiters - % waiting under 18 weeks(also include Dental)	New	Difficulty level of 2 because of Dental data	Monthly
Operations	Responsive		Dental Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Warrington Adults Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Warrington Childrens Activity	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Halton Adults Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Halton Childrens Activity	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Avaialable Virtual Ward Capacity per 100,000 head of population	New		Monthly

3.2 The indicators that are proposed to be removed are:

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Comments	Frequency
Operations	Responsive	OP07	Cancellations by service	Remove from IQPR		Monthly
Operations	Responsive	OP08	Cancellations by Patient	Remove from IQPR		Monthly
Operations	Responsive	OP19	Warrington Activity Variance	Remove from IQPR	Remove due to splitting out	Monthly
Operations	Responsive	OP20	Halton Activity Variance	Remove from IQPR	Remove due to splitting out	Monthly

This is because the cancellations indicators have been made more focused and highlight when appointments are not being rebooked following cancellation and therefore avoid the cancellations which are counted when appointments move from clinician to clinician.

Operations	Responsive		Cancellations by Patient not rescheduled with 10 working days	New		Monthly
Operations	Responsive		Cancellations by service not rescheduled with 10 working days	New		Monthly

The activity variance targets have been split into the directorates. It is proposed that these indicators will not be reported on in the IQPR until the new targets have been agreed at the Finance Activity Review Group which is chaired by the Integrated Care Board (ICB) Commissioners.

Operations	Responsive		Dental Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Warrington Adults Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Warrington Childrens Activity	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Halton Adults Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Halton Childrens Activity	New	Hide in IQPR until target reviewed at FARG	Monthly

3.4 The new indicators are as follows:

Domain	CQC	IQPR Co	KPI Name	IQPR already?	Comments	Frequen
Operations	Responsive		Total time in A&E - Median (Mins)	New	Included in National Dashboard	Monthly
Operations	Responsive		A&E Time to treatment decision 95th percentile <=60 mins (Mins)	New	Included in National Dashboard	Monthly
Operations	Responsive		percentage referred onto A+E (UTC)	New	Not in National dashboard but local interest	Monthly
Operations	Well led		Data Quality Maturity index (DQMI) Quarterly published score (2 months in arears)	New	Obtain from National Dashboard	Quarterly
Operations	Well led		Unfinished Activity (appointments/visits that remain in " booked" status with past date)	New		Monthly
Operations	Responsive		Cancellations by Patient not rescheduled with 10 working days	New		Monthly
Operations	Responsive		Cancellations by service not rescheduled with 10 working days	New		Monthly
Operations	Responsive		Percentage of DNAs/Was not brought	New		Monthly
Operations	Responsive		Proportion of Urgent Community Response referrals reached within two hours	New		Monthly
Operations	Responsive		Referrals to plan - Dental	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		Referrals to plan - Childrens	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		Referrals to plan - Warrington Adults	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		Referrals to plan - Halton Adults	New	Difficulty level 2 as needs review at FARG	Monthly
Operations	Responsive		% of waiters over 52 weeks - consultant Led	New		Monthly
Operations	Responsive		% of waiters over 78 weeks -consultant Led	New		Monthly
Operations	Responsive		% of waiters over 104 weeks-consultant Led	New		Monthly
Operations	Responsive		All waiters - % waiting over 52 weeks (also include Dental)	New	Difficulty level of 2 because of Dental data	Monthly
Operations	Responsive		All waiters - % waiting under 18 weeks(also include Dental)	New	Difficulty level of 2 because of Dental data	Monthly
Operations	Responsive		Dental Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Warrington Adults Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Warrington Childrens Activity	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Halton Adults Activity Variance	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Halton Childrens Activity	New	Hide in IQPR until target reviewed at FARG	Monthly
Operations	Responsive		Available Virtual Ward Capacity per 100,000 head of population	New		Monthly

The majority are based on the SOF; however, some have been added for additional detail such as the percentage of waiters and the increased breakdown of referrals and activity.

4. QUALITY

4.1 Following a review of the current indicators and the SOF metrics the following set of metrics is proposed for the Quality Section of the IQPR:

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Frequency
Quality	Safe		% of incidents opened and managed in line with policy timescales	New	Monthly
Quality	Safe	QU01	Number of Never Events	Already in IQPR	Monthly
Quality	Safe		% of incidents opened and managed in line with policy timescales	New	Monthly
Quality	Safe		% of incidents causing harm (levels 3-5)	New	Monthly
Quality	Safe		% - Compliance with reporting time frames for StEIS within 48 hours	New	Monthly
Quality	Safe	QU07	RCA investigations compliance submitted to ICB within 60 day time frame	Already in IQPR	Monthly
Quality	Safe	QU08	DOC (Duty of Candour) - 10 day compliance (part 1)	Already in IQPR	Monthly
Quality	Safe		% of incidents that are medication incidents	New	Monthly
Quality	Safe		% of medication indications that cause harm	New	Monthly
Quality	Effective	QU13	Information Governance Training	Already in IQPR	Monthly
Quality	Effective	QU14	Safeguarding Childrens Level 1	Already in IQPR	Monthly
Quality	Effective	QU15	Safeguarding Childrens Level 2	Already in IQPR	Monthly
Quality	Effective	QU16	Safeguarding Childrens Level 3	Already in IQPR	Monthly
Quality	Effective	QU17	Safeguarding Adults Level 1	Already in IQPR	Monthly
Quality	Effective	QU18	Safeguarding Adults Level 2	Already in IQPR	Monthly
Quality	Effective	QU19	Safeguarding Adults Level 3	Already in IQPR	Monthly
Quality	Well led		% of risks managed in line with policy	New	Monthly
Quality	Well led		Percentage of risks identified as 12 or above	New	Monthly
Quality	Safe		% of falls identified as serious	New	Monthly
Quality	Safe	QU28	Falls per 1,000 bed days - bed based	Already in IQPR	Monthly
Quality	Safe		Total number of pressure ulcers	New	Monthly
Quality	Safe		% of Category 4 Pressure Ulcers acquired in Bridgewater	New	Monthly
Quality	Safe		% of Cat 3 & Unstageable Pressure Ulcers acquired in Bridgewater	New	Monthly
Quality	Safe	QU36	MRSA - Total Number of outbreaks (Community)	Already in IQPR	Monthly
Quality	Safe	QU37	C.Diff - Total Number of outbreaks (Community)	Already in IQPR	Monthly
Quality	Safe		E-E Coli- Total Number of incidents (Community)	New	Monthly
Quality	Safe	QU38	Bacteraemia - Total Number of outbreaks	Already in IQPR	Monthly
Quality	Well led		Complaints that are managed within the policy timelines	New	Monthly
Quality	Well led		National Patient Safety Alerts opened and managed in line with policy timescales	New	Monthly
Quality	Well led		Clinical harms reviews managed within policy guidelines	New	Monthly
Quality	Well led		% of policies within review date	New	Monthly
Quality	Safe		IPC assurance audit compliance	New	Monthly
Quality	Safe		Record keeping Audit completion compliance	New	Monthly
Quality	Safe		CQUINS compliance	New	Monthly
Quality	Safe		% of Patients asked about smoking	New	Monthly
Quality	Safe		% of Patients asked about Alcohol	New	Monthly
Quality	Safe		% of Patients asked about exercise	New	Monthly
Quality	Safe		Consistency of reporting patient safety incidents	New	Yearly
Quality	All		Overall CQC rating	New	Yearly
Quality	Safe		Acting to improve safety - safety culture theme in the NHS staff survey	New	Yearly

4.2 The following indicators are proposed to be removed from the Quality Section:

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Frequency
Quality	Safe	QU02	Number of patient safety incidents reported	Remove from IQPR	Monthly
Quality	Safe	QU03	% of incidents High impact Level 3-5	Remove from IQPR	Monthly
Quality	Safe	QU04	% Of Incidents Low impact Level 1-2	Remove from IQPR	Monthly
Quality	Safe	QU05	Number of Serious Incidents Reported	Remove from IQPR	Monthly
Quality	Safe	QU06	Percentage of Serious Incidents Reported - Compliance with reporting time fr	Remove from IQPR	Monthly
Quality	Safe	QU09	CAS Alert Compliance	Remove from IQPR	Monthly
Quality	Safe	QU10	Total Number of Medication Errors	Remove from IQPR	Monthly
Quality	Safe	QU11	Medication Errors That Caused Harm	Remove from IQPR	Monthly
Quality	Safe	QU12	Medical Device Incidents	Remove from IQPR	Monthly
Quality	Well led	QU20	Total Number of risks	Remove from IQPR	Monthly
Quality	Well led	QU21	Total Number of risks identified as High	Remove from IQPR	Monthly
Quality	Well led	QU22	Percentage of risks identified as High	Remove from IQPR	Monthly
Quality	Well led	QU23	Total Number of risks identified as High 12	Remove from IQPR	Monthly
Quality	Well led	QU24	Percentage of risks identified as High 12	Remove from IQPR	Monthly
Quality	Well led	QU25	Total Number of risks identified as Extreme	Remove from IQPR	Monthly
Quality	Well led	QU52	Percentage of risks identified as Extreme	Remove from IQPR	Monthly
Quality	Safe	QU26	Total Number of falls	Remove from IQPR	Monthly
Quality	Safe	QU27	Total Number of falls identified as Catastrophic	Remove from IQPR	Monthly
Quality	Safe	QU29	Percentage of overall falls that are bed based	Remove from IQPR	Monthly
Quality	Safe	QU30	Total Number of Community Falls	Remove from IQPR	Monthly
Quality	Safe	QU31	Percentage of overall falls that are community falls	Remove from IQPR	Monthly
Quality	Safe	QU32	Total Number of Category 2 Pressure Ulcers acquired in Bridgewater	Remove from IQPR	Monthly
Quality	Safe	QU33	Total Number of Category 3 Pressure Ulcers acquired in Bridgewater	Remove from IQPR	Monthly
Quality	Safe	QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater	Remove from IQPR	Monthly
Quality	Safe	QU35	Total Number of Unstageable Pressure Ulcers acquired in Bridgewater	Remove from IQPR	Monthly
Quality	Safe	QU40	VTE - Bed Based - % of patients risk assessed	Remove from IQPR	Monthly
Quality	Safe	QU41	Friends and Family Test	Remove from IQPR	Monthly
Quality	Safe	QU42	Number of Complaints	Remove from IQPR	Monthly
Quality	Well led	QU44	Patient Experience - Dignity and Respect	Remove from IQPR	Monthly
Quality	Well led	QU45	Patient Experience - Information / Communication	Remove from IQPR	Monthly
Quality	Well led	QU46	Patient Experience - Access/Waiting Time	Remove from IQPR	Monthly
Quality	Well led	QU47	FFT (Staff)	Remove from IQPR	Monthly

All the indicators that have been proposed to be reviewed have been replaced with smarter more target focused indicators or have been removed based on updated guidance in the SOF or because they are duplicated i.e., number and then also articulated as a percentage.

4.3 The following metrics are added as new metrics:

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Frequency
Quality	Safe		% of incidents opened and managed in line with policy timescales	New	Monthly
Quality	Safe		% of incidents opened and managed in line with policy timescales	New	Monthly
Quality	Safe		% of incidents causing harm (levels 3-5)	New	Monthly
Quality	Safe		% - Compliance with reporting time frames for StEIS within 48 hours	New	Monthly
Quality	Safe		% of incidents that are medication incidents	New	Monthly
Quality	Safe		% of medication indications that cause harm	New	Monthly
Quality	Well led		% of risks managed in line with policy	New	Monthly
Quality	Well led		Percentage of risks identified as 12 or above	New	Monthly
Quality	Safe		% of falls identified as serious	New	Monthly
Quality	Safe		Total number of pressure ulcers	New	Monthly
Quality	Safe		% of Category 4 Pressure Ulcers acquired in Bridgewater	New	Monthly
Quality	Safe		% of Cat 3 & Unstageable Pressure Ulcers acquired in Bridgewater	New	Monthly
Quality	Safe		E-E Coli- Total Number of incidents (Community)	New	Monthly
Quality	Well led		Complaints that are managed within the policy timelines	New	Monthly
Quality	Well led		National Patient Safety Alerts opened and managed in line with policy timescales	New	Monthly
Quality	Well led		Clinical harms reviews managed within policy guidelines	New	Monthly
Quality	Well led		% of policies within review date	New	Monthly
Quality	Safe		IPC assurance audit compliance	New	Monthly
Quality	Safe		Record keeping Audit completion compliance	New	Monthly
Quality	Safe		CQUINS compliance	New	Monthly
Quality	Safe		% of Patients asked about smoking	New	Monthly
Quality	Safe		% of Patients asked about Alcohol	New	Monthly
Quality	Safe		% of Patients asked about exercise	New	Monthly
Quality	Safe		Consistency of reporting patient safety incidents	New	Yearly
Quality	All		Overall CQC rating	New	Yearly
Quality	Safe		Acting to improve safety - safety culture theme in the NHS staff survey	New	Yearly

5. PEOPLE

5.1 Following a review of the current indicators and the SOF metrics the following set of metrics is proposed for the People Section of the IQPR:

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Frequency
People	Well led	PO01	% Headcount of new starters attending induction programme	Already in IQPR	Monthly
People	Well led	PO02	Staff turnover (rolling)	Already in IQPR	Monthly
People	Well led	PO03	% Overall Organisation Sickness rate (rolling)	Already in IQPR	Monthly
People	Well led	PO04	Sickness absence rate (Actual)	Already in IQPR	Monthly
People	Well led	PO05	% of staff with a current PDR	Already in IQPR	Monthly
People	Well led		% Long Term Absence	New	Monthly
People	Well led		% Short Term Absence	New	Monthly
People	Well led		Aggregate score for NHS staff survey questions that measure perception of leadership culture	New	Yearly
People	Well led		CQC Well Led Rating	New	Yearly
People	Well led		Proportion of staff in Band 8a roles or above that have a BME background	New	Yearly
People	Well led		Proportion of staff in Band 8a roles or above that are women	New	Yearly

5.2 There are no indicators that will be removed from the People Section.

5.3 The new IQPR indicators are largely from the SOF driven by the staff survey and the long term and short-term absence help to break down the sickness indicators.

Doma	CQC	IQPR Co	KPI Name	IQPR already	Frequen
People	Well led		% Long Term Absence	New	Monthly
People	Well led		% Short Term Absence	New	Monthly
People	Well led		Aggregate score for NHS staff survey questions that measure perception of leadership culture	New	Yearly
People	Well led		CQC Well Led Rating	New	Yearly
People	Well led		Proportion of staff in Band 8a roles or above that have a BME background	New	Yearly
People	Well led		Proportion of staff in Band 8a roles or above that are women	New	Yearly

6. FINANCE

6.1 Finance has not had bespoke indicators in the IQPR previously – a separate finance section has previously been included. This has been revised and finance will now have its own indicators.

Domain	CQC	IQPR Code	KPI Name	IQPR already?	Frequency
Finance	Well Led		CIP in month against plan	New	Monthly
Finance	Well Led		Capital in month against plan	New	Monthly
Finance	Well Led		Agency costs as a percentage of turnover	New	Monthly
Finance	Well Led		Adjusted Net surplus or deficit	New	Monthly
Finance	Well Led		Cash	New	Monthly
Finance	Well Led		Better Payment Practice Code	New	Monthly

7. NEXT STEPS

7.1 Collection of the required information to enable the indicators to be reported on will now be progressed.

7.2 It is anticipated that the majority of the indicators will be reported to the next meeting of the Finance and Performance Committee in September and onward to Board in October.

7.3 There maybe a small number of indicators which we are unable to report on in September as we haven't been able to collect the data.

7.4 This paper was received at Finance and Performance Committee and it is recommended that the People Committee received the People indicators and the Quality and Safety Committee receive the Quality indicators.

8. RECOMMENDATIONS

8.1 The Board of Directors are asked:

- To note the work that has been done to revise the indicators.
- To approve the changes to the IQPR indicators.
- To receive the IQPR with the updated metrics in October.

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team
Reporting Period: May 2023 (Month 2)

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 May 2023.

Within this Report

1. KPI Amendments

KPI	Change	Rationale

2. Recommendations:

The Finance & Performance committee are asked to:

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

Trust Overview

Executive Summary

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

Responsive (Operations)

There are 13 green indicators and 6 red indictors in month 2. There is one new red indicator this month pertaining to the ‘Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery’ indicator.

4 of the 6 red indicators have shown an improvement in month, with only the audiology breaches showing a decrease in performance in month. This is not unexpected as the service are managing a number of competing challenges. The most significant improvement in month is with the % of patients waiting under 18 weeks.

All indicators are reviewed and discussed at the Performance Council.

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 40 green indicators in month 2 and 5 red indicators. There are two new red indicators pertaining to ‘DOC (Duty of Candour) - 10 day compliance’ and ‘Percentage of risks identified as High’.

The 3 other red indicators have shown an improvement in month, particularly in relation to Safeguarding Adults Level 3.

People

4 out of the 5 people indicators are red in month 2. 3 of the 4 red indicators have shown an improvement in month with only 1 indicator showing a decline in month.

Making Good Use of Resources (Finance)

There are a number of indicators reporting an adverse variance in month which has resulted in a deficit of £0.6m against a breakeven position.

Operations

Executive Summary

Of the 19 Operations indicators which are reported; six are red and thirteen are green.

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

- Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery – New red indicator in month
- Referrals to plan – improvement in month
- Cancellations by service – improvement in month
- Percentage of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway) – improvement in month
- Warrington Audiology - Number of 6 weeks diagnostic breaches – decline in month
- Warrington Activity Variance – improvement in month

Overall, there is an improvement in the majority of the red indicators. The new red indicator is due to a small number of breaches in performance some of which relate to patient choice.

Operations

Actions

Indicator	Action	Target date	Responsible Committee
% of patients waiting under 18 weeks	There are three services impacting the performance in relation to the 18 week RTT. These are: • Dermatology • Community Paediatrics – Halton • Community Paediatrics – Warrington The dermatology service is expected to have no over 18 week waits by August. The Community Paediatrics services are more challenged and although there is additional resources in place current	Action plans are in place to manage the Community Paediatrics Services and it is anticipated that if we continue with the current rates of locum use we would be able to address the waiting list by approximately May 2024. Discussions are progressing with ICB Commissioners to see if there are any resources available to accelerate the waiting list management position.	Chief Operating Officer / Finance and Performance Committee

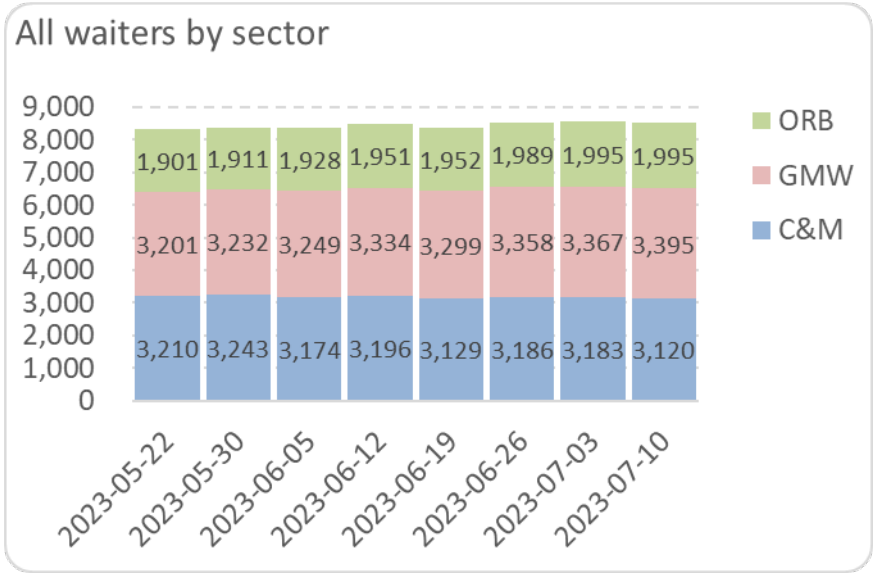
Operations

Trust Scorecard

Operations																
Code	KPI Name	Target	Trend Line	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
OP01	KPIs / Achievements Locally agreed KPIs	100.00%														
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93.00%		94.03% (▲)	95.76% (▲)	93.19% (▼)	91.34% (▼)	93.93% (▲)	31.25% (▼)	92.34% (▲)	94.39% (▲)	98.84% (▲)	99.55% (▲)	98.16% (▼)	96.82% (▼)	97.78% (▲)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94.00%		100% (▲)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	83.33% (▼)	100% (▲)	75% (▼)	100% (▲)	100% (►)	71.43% (▼)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96.00%		100% (▲)	80% (▼)	100% (▲)	92.86% (▼)	100% (▲)	80% (▼)	100% (▲)	100% (►)	100% (►)	83.33% (▼)	100% (▲)	100% (►)	100% (►)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85.00%		96.97% (▲)	100% (▲)	85.71% (▼)	87.5% (▲)	92.31% (▲)	100% (▲)	100% (►)	100% (►)	93.33% (▼)	87.5% (▼)	75% (▼)	77.27% (▲)	86.67% (▲)
OP22	28 day faster diagnosis	75.00%		66.5% (▼)	71.92% (▲)	72.73% (▲)	68.67% (▼)	75.19% (▲)	79.17% (▲)	73.02% (▼)	75.29% (▲)	75.95% (▲)	81.14% (▲)	91.01% (▲)	86.96% (▼)	82.91% (▼)
OP06	Referrals to plan	95.00%		94.12% (▲)	89.86% (▼)	87.27% (▼)	87.03% (▼)	84.88% (▼)	95.85% (▲)	90.53% (▼)	75.66% (▼)	91.08% (▲)	81.22% (▼)	85.83% (▲)	83.5% (▼)	91.01% (▲)
OP07	Cancellations by service	5.00%		11.58% (▲)	11.29% (▲)	12.43% (▼)	11.67% (▲)	12.56% (▼)	10.61% (▲)	10.56% (▲)	12.22% (▼)	10.89% (▲)	11.16% (▼)	10.77% (▲)	13.71% (▼)	12.27% (▲)
OP08	Cancellations by Patient	5.00%		4.5% (▲)	5.28% (▼)	6.32% (▼)	5.16% (▲)	5.3% (▼)	5.81% (▼)	5.66% (▲)	5.73% (▼)	5.39% (▲)	5.22% (▲)	5.79% (▼)	4.98% (▲)	4.87% (▲)
OP09	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92.00%		61.03% (▲)	59.48% (▼)	59.05% (▼)	53.34% (▼)	43.21% (▼)	39.74% (▼)	35.29% (▼)	34.75% (▼)	39.76% (▲)	41.49% (▲)	57.99% (▲)	58.67% (▲)	67.55% (▲)
OP11	A&E: Total time in A&E (% of pts who have waited <= 4hrs)	95%		98.38% (▲)	96.6% (▼)	96.3% (▼)	98.66% (▲)	96.48% (▼)	92.66% (▼)	87.43% (▼)	82.48% (▼)	93.72% (▲)	96.01% (▲)	98.1% (▲)	96.8% (▼)	97.53% (▲)
OP12	Total time in A&E - 95th Percentile	4 Hrs		03:35 (▲)	03:54 (▼)	03:56 (▼)	03:32 (▲)	03:55 (▼)	04:31 (▼)	05:11 (▼)	06:06 (▼)	04:27 (▲)	03:57 (▲)	03:31 (▲)	03:51 (▼)	03:52 (▼)
OP13	A&E Time to treatment decision (median) <=60 mins	60 Mins		00:09 (▼)	00:11 (▼)	00:10 (▲)	00:09 (▲)	00:09 (▼)	00:10 (▼)	00:12 (▼)	00:14 (▼)	00:10 (▲)	00:08 (▲)	00:08 (▼)	00:09 (▼)	00:09 (▲)
OP14	A&E Unplanned re-attendance rate <=5%	5%		0% (▲)	0% (►)	0.03% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.03% (▼)
OP15	A&E left without being seen <=5%	5%		0.41% (▼)	0.13% (▲)	0.28% (▼)	0.44% (▼)	0.23% (▲)	0.08% (▲)	0.27% (▼)	0.89% (▼)	0.13% (▲)	0.03% (▲)	0.09% (▼)	0.09% (▼)	0.18% (▼)
OP16	Warrington Audiology - Number of 6 weeks diagnostic breaches	0		0 (▲)	5 (▼)	1 (▲)	0 (▲)	3 (▼)	2 (▲)	4 (▼)	4 (►)	1 (▲)	5 (▼)	9 (▼)	67 (▼)	85 (▼)
OP17	Data Quality Maturity Index (DQMI) MHSDS quarterly score	95%		99.68% (►)	99.76% (▲)	99.8% (▲)	99.77% (▼)	95.36% (▼)	99.83% (▲)	99.83% (►)	99.82% (▼)	99.71% (▼)	99.71% (►)	99.73% (▲)	99.73% (►)	99.7% (▼)
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%		-20.85% (▲)	-19.14% (▲)	-16.68% (▲)	-17.26% (▼)	-17.81% (▼)	-16.77% (▲)	-16.37% (▲)	-17.02% (▼)	-16.95% (▲)	-17.1% (▼)	-17.28% (▼)	-21.99% (▼)	-18.25% (▲)
OP20	Halton Activity Variance	3%		17.05% (▼)	14.07% (▲)	17.27% (▼)	17.39% (▼)	15.15% (▲)	13.85% (▲)	12.36% (▲)	11.08% (▲)	10.92% (▲)	10.36% (▲)	9.18% (▲)	0.31% (▲)	2.16% (▼)

Operations: Exception Reporting

Chart



Issue

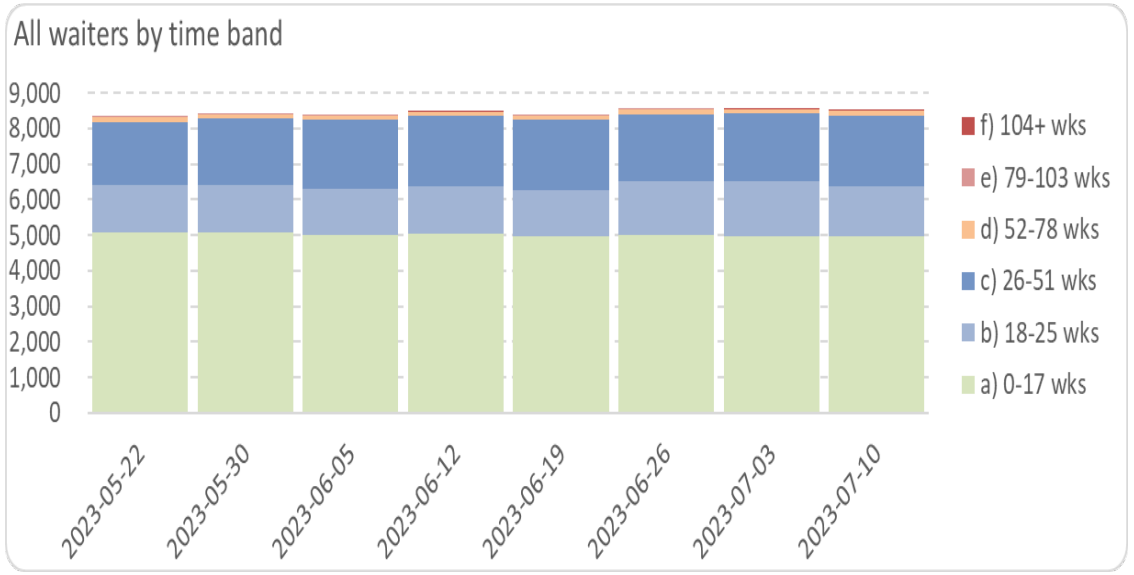
Dental - Patients waiting by Sector

The number of patients waiting for dental treatment has increased in ORB and GMW and has fallen slightly in C&M.

A Quality Summit has been held and task and finish groups have been put in place to undertake a number of actions to drive forward service efficiencies and to highlight pressures to commissioners.

Operations: Exception Reporting

Chart



Issue

Dental – Waiters by time band

The number of patients waiting over 78 weeks has increased to 4. These patients have been scheduled for appointments and there have been cancellations by the patient and the service.

Patients waiting over 52 weeks are being closely monitored in order to ensure achievement against the target of having no waiters over 65 weeks by April 2024

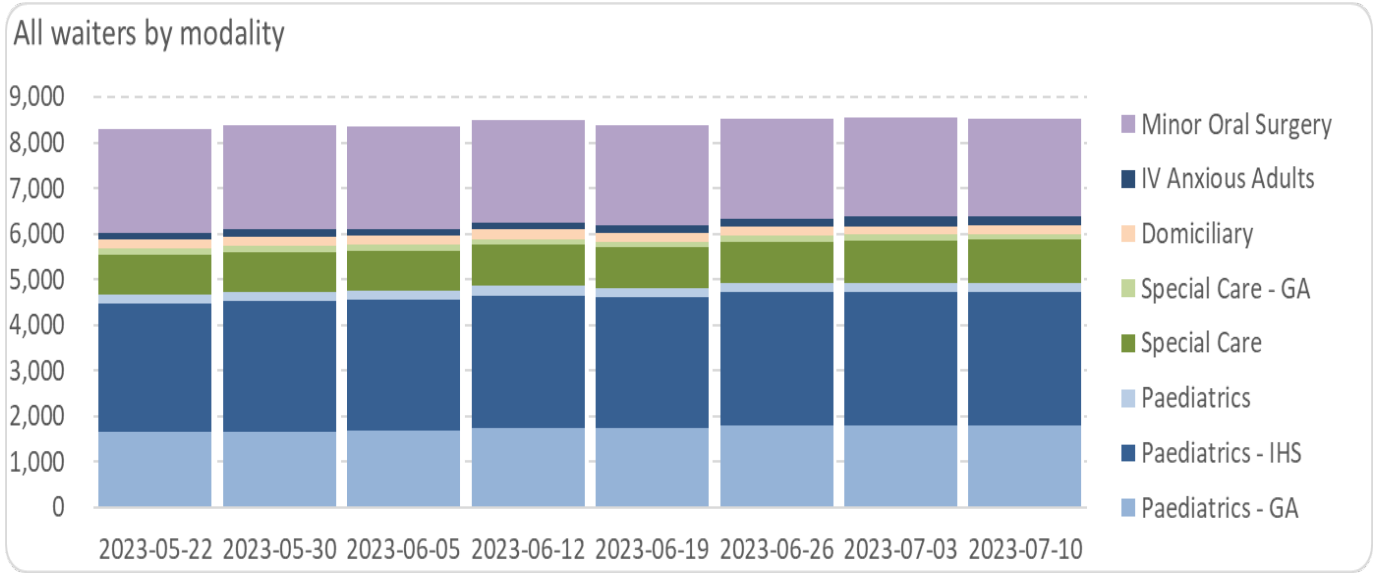
Operations: Exception Reporting

Dental – Waiters by time band

Date	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2023-05-22	5,080	1,349	1,766	114	3	0
2023-05-30	5,066	1,336	1,879	104	1	0
2023-06-05	5,016	1,288	1,941	104	2	0
2023-06-12	5,034	1,349	1,992	102	2	2
2023-06-19	4,965	1,314	1,986	110	5	0
2023-06-26	5,021	1,488	1,900	119	5	0
2023-07-03	4,984	1,522	1,915	118	3	3
2023-07-10	4,966	1,414	1,992	134	3	1

Operations: Exception Reporting

Chart



Issue

Dental - Patients waiting by treatment

Waiters in Special Care GA, Domiciliary and Minor Oral Surgery have fallen in month.

Particular attention is being focused on the minor oral surgery and paediatric GA and IHS pathways to reduce the number of waiters.

Quality

Executive Summary

There are 5 Quality indicators reporting as red and 40 green indicators in May 2023.

The 5 indicators which were red in May are as follows:

- % Of Incidents Low impact Level 1-2 – Improvement in month
- DOC (Duty of Candour) - 10-day compliance – New in month
- Information Governance – Improvement in month
- Safeguarding Adults Level 3 Training – Improvement in month
- Percentage of risks identified as High - New in month

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 • Regular reminders at Daily Ops Huddle • Education and Training team sharing regular lists of staff who are compliant and non compliant • Meetings to take place with Chief Executive in July to discuss reasons for non compliance with training	• Children's Level 3 is now compliant **TARGET DATE 31st July 2023**	Associate Directors / Director of Nursing and Operational Managers

Quality: Exception Reporting

Trust Scorecard

Quality																	
Code	KPI Name	Target		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Incidents																	
QU01	Number of Never Events	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU02	Number of patient safety incidents reported	97-217		133 (▼)	137 (▼)	102 (▲)	139 (▼)	140 (▼)	148 (▼)	156 (▼)	112 (▲)	128 (▼)	128 (►)	138 (▼)	109 (▲)	128 (▼)
QU03	% of incidents High impact Level 3-5	7.88%		3.01% (▼)	0.73% (▲)	4.9% (▼)	3.6% (▲)	5% (▼)	3.38% (▲)	3.85% (▼)	4.46% (▼)	5.47% (▼)	6.25% (▼)	6.52% (▼)	1.83% (▲)	1.56% (▲)
QU04	% Of Incidents Low impact Level 1-2	68.97%		89.47% (▼)	85.4% (▲)	86.27% (▼)	87.77% (▼)	91.43% (▼)	85.81% (▲)	81.41% (▲)	84.82% (▼)	88.28% (▼)	86.72% (▲)	84.78% (▲)	88.07% (▼)	86.72% (▲)
QU05	Number of Serious Incidents Reported	9		5 (▼)	3 (▲)	8 (▼)	4 (▲)	9 (▼)	3 (▲)	8 (▼)	6 (▲)	5 (▲)	11 (▼)	2 (▲)	4 (▼)	1 (▲)
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% (►)	88.89% (▼)	100% (▲)	100% (►)	75% (▼)	75% (►)	100% (▲)	100% (►)	100% (►)	100% (►)	50% (▼)
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		13 (▼)	15 (▼)	7 (▲)	12 (▼)	12 (►)	18 (▼)	12 (▲)	9 (▲)	8 (▲)	9 (▼)	9 (►)	9 (►)	11 (▼)
QU11	Medication Errors That Caused Harm	6		1 (▼)	0 (▲)	1 (▼)	0 (▲)	0 (►)	2 (▼)	1 (▲)	0 (▲)	1 (▼)	1 (►)	1 (►)	1 (►)	2 (▼)
QU12	Medical Device Incidents	14		4 (▲)	3 (▲)	9 (▼)	6 (▲)	5 (▲)	13 (▼)	6 (▲)	4 (▲)	6 (▼)	3 (▲)	6 (▼)	7 (▼)	8 (▼)
Training Compliance																	
QU13	Information Governance	95.00%		87.22% (▲)	94.7% (▲)	95.5% (▲)	93.94% (▼)	92.67% (▼)	92.37% (▼)	91.21% (▼)	91.47% (▲)	90.79% (▼)	88.59% (▼)	89.31% (▲)	88.86% (▼)	90.23% (▲)
QU14	Safeguarding Childrens Level 1	85.00%		87.86% (▲)	86.61% (▼)	89.07% (▲)	90.45% (▲)	90.85% (▲)	92.04% (▲)	92.55% (▲)	92.32% (▼)	92.68% (▲)	93.76% (▲)	93.99% (▲)	92.69% (▼)	93.89% (▲)
QU15	Safeguarding Childrens Level 2	85.00%		75.57% (▲)	77.42% (▲)	80.84% (▲)	85.4% (▲)	85.3% (▼)	85.96% (▲)	84.87% (▼)	85.94% (▲)	87.15% (▲)	89.61% (▲)	91.23% (▲)	89.97% (▼)	91.8% (▲)
QU16	Safeguarding Childrens Level 3	85.00%		83.74% (▼)	80.27% (▼)	85.86% (▲)	85.08% (▼)	82.84% (▼)	83.44% (▲)	83.77% (▲)	89.37% (▲)	86.44% (▼)	89.19% (▲)	93.13% (▲)	93.84% (▲)	94.6% (▲)
QU17	Safeguarding Adults Level 1	85.00%		88.57% (▲)	88.18% (▼)	88.95% (▲)	90.07% (▲)	89.72% (▼)	92.45% (▲)	92.9% (▲)	92.87% (▼)	93.49% (▲)	94.43% (▲)	94.79% (▲)	93.57% (▼)	94.82% (▲)
QU18	Safeguarding Adults Level 2	85.00%		73.63% (▲)	74.15% (▲)	76.27% (▲)	81.83% (▲)	71.19% (▼)	76.22% (▲)	77.18% (▲)	80.67% (▲)	83.45% (▲)	86.47% (▲)	88.86% (▲)	88.79% (▼)	90.83% (▲)
QU19	Safeguarding Adults Level 3	85.00%		53.91% (▲)	56.98% (▲)	58.88% (▲)	65.79% (▲)	67.24% (▲)	69.36% (▲)	69.21% (▼)	77.16% (▲)	76.26% (▼)	78.45% (▲)	76.09% (▼)	79.72% (▲)	83.6% (▲)
Risks																	
QU20	Total Number of risks	258		181 (▲)	184 (▼)	187 (▼)	177 (▲)	164 (▲)	145 (▲)	147 (▼)	151 (▼)	157 (▼)	165 (▼)	171 (▼)	173 (▼)	181 (▼)
QU21	Total Number of risks identified as High	111		88 (▲)	87 (▲)	92 (▼)	85 (▲)	73 (▲)	71 (▲)	62 (▲)	65 (▼)	71 (▼)	75 (▼)	79 (▼)	75 (▲)	83 (▼)
QU22	Percentage of risks identified as High	44.02%		48.62% (▲)	47.28% (▲)	49.2% (▼)	48.02% (▲)	44.51% (▲)	48.97% (▼)	42.18% (▲)	43.05% (▼)	45.22% (▼)	45.45% (▼)	46.2% (▼)	43.35% (▲)	45.86% (▼)
QU23	Total Number of risks identified as High 12	57		22 (▼)	23 (▼)	22 (▲)	22 (►)	20 (▲)	16 (▲)	22 (▼)	22 (►)	15 (▲)	16 (▼)	19 (▼)	26 (▼)	24 (▲)
QU24	Percentage of risks identified as High 12	15.17%		12.15% (▼)	12.5% (▼)	11.76% (▲)	12.43% (▼)	12.2% (▲)	11.03% (▲)	14.97% (▼)	14.57% (▲)	9.55% (▲)	9.7% (▼)	11.11% (▼)	15.03% (▼)	13.26% (▲)
QU25	Total Number of risks identified as Extreme	21		1 (▲)	2 (▼)	3 (▼)	1 (▲)	2 (▼)	1 (▲)	3 (▼)	3 (►)	5 (▼)	3 (▲)	3 (►)	2 (▲)	2 (►)
QU52	Percentage of risks identified as Extreme	4.69%		0.55% (▲)	1.09% (▼)	1.6% (▼)	0.56% (▲)	1.22% (▼)	0.69% (▲)	2.04% (▼)	1.99% (▲)	3.18% (▼)	1.82% (▲)	1.75% (▲)	1.16% (▲)	1.1% (▲)

Quality: Exception Reporting

Trust Scorecard

Quality																	
Code	KPI Name	Target		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Falls (Bridgewater)																	
QU26	Total Number of falls	23		15 (▼)	18 (▼)	9 (▲)	13 (▼)	13 (►)	18 (▼)	14 (▲)	14 (►)	20 (▼)	25 (▼)	21 (▲)	24 (▼)	13 (▲)
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		10.34 (▲)	16.29 (▼)	4.49 (▲)	9.42 (▼)	10.13 (▼)	14.61 (▼)	11.72 (▲)	11.39 (▲)	8.65 (▲)	11.63 (▼)	6.7 (▲)	12.66 (▼)	5.71 (▲)
QU29	Percentage of overall falls that are bed based	88.28%		73.33% (▲)	88.89% (▼)	44.44% (▲)	76.92% (▼)	76.92% (►)	83.33% (▼)	85.71% (▼)	85.71% (►)	45% (▲)	44% (▲)	33.33% (▲)	54.17% (▼)	46.15% (▲)
QU30	Total Number of Community Falls	11		4 (▼)	2 (▲)	5 (▼)	3 (▲)	3 (►)	3 (►)	2 (▲)	2 (►)	11 (▼)	14 (▼)	14 (►)	11 (▲)	7 (▲)
QU31	Percentage of overall falls that are community falls	55.01%		26.67% (▼)	11.11% (▲)	55.56% (▼)	23.08% (▲)	23.08% (►)	16.67% (▲)	14.29% (▲)	14.29% (►)	55% (▼)	56% (▼)	66.67% (▼)	45.83% (▲)	53.85% (▼)
Pressure Ulcers																	
QU32	Total Number of Category 2 Pressure Ulcers acquired in Bridgewater	44		31 (▼)	14 (▲)	12 (▲)	30 (▼)	23 (▲)	14 (▲)	23 (▼)	19 (▲)	25 (▼)	23 (▲)	26 (▼)	14 (▲)	28 (▼)
QU33	Total Number of Category 3 Pressure Ulcers acquired in Bridgewater	5		0 (►)	0 (►)	2 (▼)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	1 (▼)	0 (▲)
QU34	Total Number of Category 4 Pressure Ulcers acquired in Bridgewater	2		0 (►)	0 (►)	2 (▼)	0 (▲)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU35	Total Number of Unstageable Pressure Ulcers acquired in Bridgewater	3		2 (▼)	2 (►)	3 (▼)	3 (►)	6 (▼)	4 (▲)	6 (▼)	5 (▲)	6 (▼)	5 (▲)	7 (▼)	0 (▲)	0 (►)

Quality																	
Code	KPI Name	Target	Trend Line	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-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%		99.03% (▲)	99.11% (▲)	99% (▼)	98.01% (▼)	98.97% (▲)	98.98% (▲)	98.06% (▼)	98.94% (▲)	99.03% (▲)	99.38% (▲)	98.97% (▼)	98.95% (▼)	99.01% (▲)
QU42	Number of Complaints	9		0 (▲)	5 (▼)	4 (▲)	5 (▼)	6 (▼)	6 (►)	6 (►)	2 (▲)	0 (▲)	6 (▼)	3 (▲)	6 (▼)	4 (▲)
QU44	Patient Experience - Dignity and Respect	95.00%		100% (▲)	100% (►)	100% (►)	99.01% (▼)	100% (▲)	98.98% (▼)	98.97% (▼)	100% (▲)	100% (►)	100% (►)	100% (►)	100% (►)	99.01% (▼)
QU45	Patient Experience - Information / Communication	95.00%		99.03% (▲)	99.11% (▲)	99% (▼)	98.01% (▼)	98.97% (▲)	98.98% (▲)	98.97% (▼)	100% (▲)	100% (►)	100% (►)	98.97% (▼)	98.95% (▼)	99.01% (▲)
QU46	Patient Experience - Access/Waiting Time	95.00%		94.05% (▼)	93.96% (▼)	96% (▲)	95.03% (▼)	98.01% (▲)	97.03% (▼)	96% (▼)	95.98% (▼)	95.99% (▲)	96.02% (▲)	97.05% (▲)	98.04% (▲)	96.06% (▼)

People

Executive Summary

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

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

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

People

Actions

Indicator	Action	Target date	Responsible Committee

People

Trust Scorecard

People															
Code	KPI Name	Target		May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
PO01	% Headcount of new starters attending induction programme	95.00%		99.6% (▲)	99.54% (▼)	99.54% (▼)	99.4% (▼)	99.4% (▲)	99.47% (▲)	99.34% (▼)	99.74% (▲)	99.6% (▼)	99.8% (▲)	99.61% (▼)	99.36% (▼)	99.29% (▼)
PO02	Staff turnover (rolling)	8.00%		31.35% (▼)	32.37% (▼)	32.62% (▼)	37.05% (▼)	33.57% (▲)	28.67% (▲)	28.47% (▲)	28.54% (▼)	27.91% (▲)	27.61% (▲)	13.25% (▲)	12.66% (▲)	14.67% (▼)
PO03	% Overall Organisation Sickness rate (rolling)	4.80%		7.01% (▼)	7.02% (▼)	7.05% (▼)	6.99% (▲)	6.96% (▲)	6.88% (▲)	6.81% (▲)	6.75% (▲)	6.52% (▲)	6.41% (▲)	6.3% (▲)	6.07% (▲)	5.9% (▲)
PO04	Sickness absence rate (Actual)	4.80%		7.02% (▼)	6.31% (▲)	7.16% (▼)	5.28% (▲)	5.77% (▼)	5.81% (▼)	6.1% (▼)	7.11% (▼)	6.19% (▲)	5.26% (▲)	5.5% (▼)	5.16% (▲)	5.06% (▲)
PO05	% of staff with a current PDR	85.00%		57% (▲)	58.96% (▲)	58.45% (▼)	63.59% (▲)	67.42% (▲)	63.71% (▼)	67.44% (▲)	66.09% (▼)	70.13% (▲)	72.57% (▲)	70.56% (▼)	71.62% (▲)	72.85% (▲)

Finance

Month Two 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 May 2023 (Month 02).

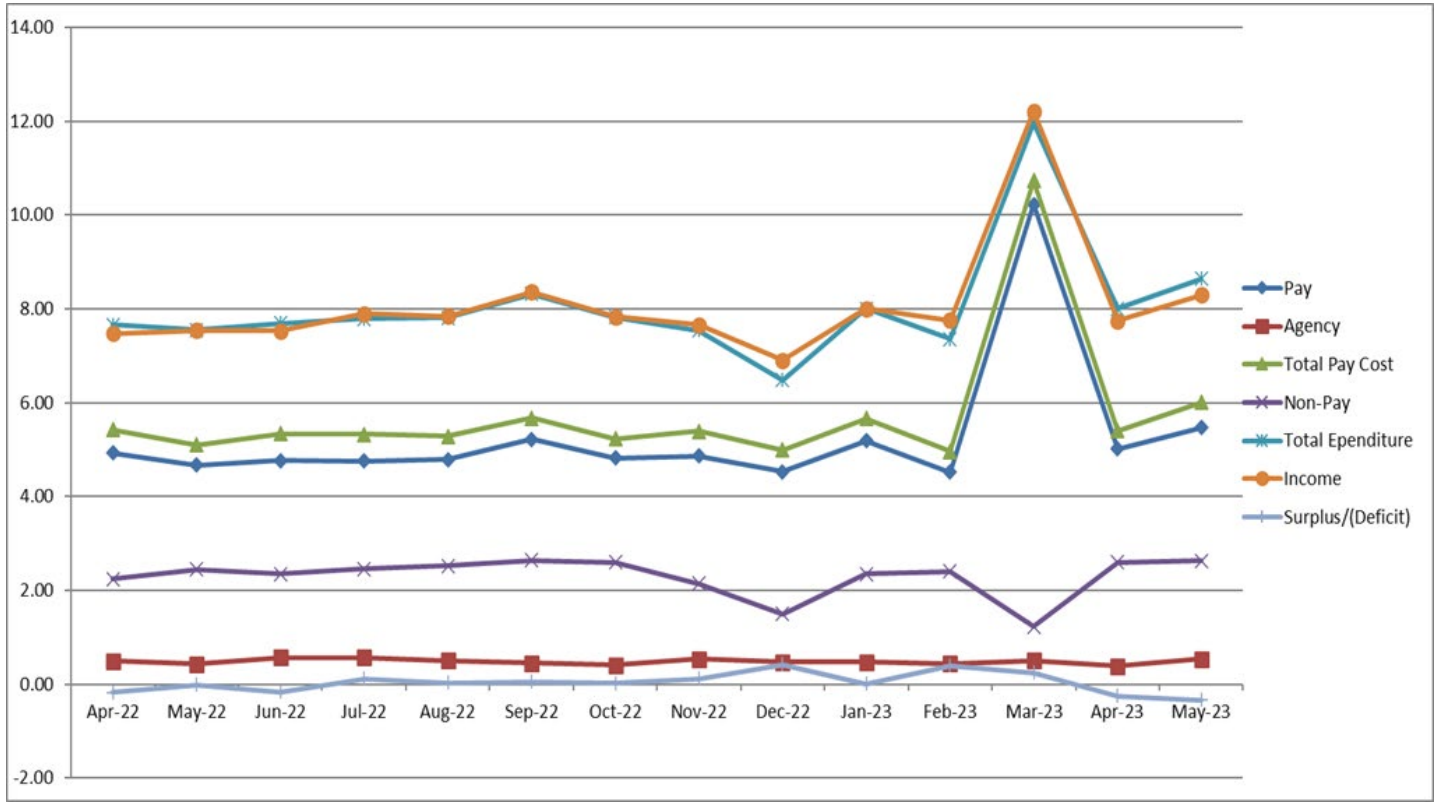
Summary Performance Month 02 2023-24	Month 2 Plan (£M)	Month 2 Actual (£M)	Month 2 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.00)	(8.30)	0.30	(15.84)	(16.06)	0.21	(95.83)	(95.83)
Expenditure - Pay	5.34	5.47	(0.13)	10.53	10.49	0.04	63.95	63.95
Expenditure - Agency	0.35	0.54	(0.19)	0.70	0.93	(0.22)	4.22	4.22
Expenditure - Non Pay	2.26	2.60	(0.34)	4.51	5.29	(0.78)	27.10	27.10
EBITDA	(0.05)	0.32	(0.37)	(0.09)	0.65	(0.74)	(0.55)	(0.55)
Financing	0.05	0.03	0.01	0.09	(0.06)	0.15	0.55	0.55
Normalised (Surplus)/Deficit	(0.00)	0.35	(0.36)	(0.00)	0.60	(0.60)	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)	0.35	(0.36)	(0.00)	0.60	(0.60)	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)	0.35	(0.36)	(0.00)	0.60	(0.60)	0.00	0.00
CIP	0.43	0.43	0.00	0.86	0.43	(0.43)	5.15	5.15
Capital	0.91	0.33	0.58	0.91	0.33	0.58	2.10	2.10
Cash	24.31	20.65	(3.66)	24.31	20.65	(3.66)	24.65	24.65
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 2022/23 to 2023/24



Finance

CUMULATIVE PERFORMANCE AGAINST NHSE/I PLAN – BREAKEVEN FOR THE YEAR

2.1 The key headlines for month two are as follows:

- The Trust is reporting a deficit of £0.60m, against a plan position of breakeven.
- The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.
- The Trust is reporting a year-to-date achievement of £0.43m against a plan of £0.86m.
- Income is £16.06m for the year-to-date against a plan of £15.84m.
- Expenditure is £16.65m against a plan of £15,.84m.
- Pay is £10.49m against a plan of £10.53m.
- Agency spend £0.93m against a plan of £0.70m.

Finance

CUMULATIVE PERFORMANCE AGAINST NHSE/I PLAN – BREAKEVEN FOR THE YEAR (continued)

- Non pay expenditure is £5.29m against a plan of £4.51m.
- Capital charges are £0.15m below plan.
- Capital expenditure is £0.33m at month two, £0.58m behind plan.
- Cash is £20.65m.

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.

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NHS Oversight Framework

File created on: 21/06/2023 10:30

NHS Oversight Framework - Organisation Detail

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
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S035a: Overall CQC rating	Month	2023 05	- Requires Improvemer					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 05	- Requires Improvemer					55/69
	MH Provider	S060a: Aggregate score for NHS staff survey questions that measure perception of leadership culture	Annual; calendar year	2022	7.15/10	6.94/10		↓		68/71
	MH Provider	S063a: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from managers	Annual; calendar year	2022	7.28%	11.1%		↑		23/71
	MH Provider	S063b: Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from other colleagues	Annual; calendar year	2022	13.4%	20%		↓		28/71
	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	2022	22.8%	27.8%		↑		18/71
	MH Provider	S067a: Leaver rate	Month	2023 03	10%	8.55%		↓		60/71
	MH Provider	S068a: Sickness absence rate	Month	2023 01	6.26%	5.4%		↓		55/71
	MH Provider	S069a: Staff survey engagement theme score	Annual; calendar year	2022	7.18/10	6.79/10		↑		24/71
	MH Provider	S071a: Proportion of staff in senior leadership roles who are from a BME background	Annual; calendar year	2022	10.7%		12%	↑	↑	28/69
	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	2022	61.3%	56%		↑		25/71
	MH Provider	S121a: NHS Staff Survey compassionate culture people promise element sub-score	Annual; calendar year	2022	7.41/10	6.98/10		↑		22/71
	MH Provider	S121b: NHS Staff Survey raising concerns people promise element sub-score	Annual; calendar year	2022	6.96/10	6.43/10		↓		23/71

Org Type MHPRV

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile

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Thank You


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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**57/23iii**		
Report Title	**FREEDOM TO SPEAK UP REPORT**		
Executive Lead	Lynne Carter, Deputy CEO/Chief Nurse		
Report Author	Helen Young, Lead FTSU Guardian/Tania Strong, FTSU Guardian		
Presented by	Tania Strong, FTSU Guardian		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

This report:

- Provides an overview of the current Freedom to Speak Up (FTSU) provision, activity and learning.
- Includes information on the Freedom to Speak Up self-reflection and planning tool, which will evaluate the current baseline and identify actions to inform an improvement and development plan spanning the next 6-24 months.
- Provides an overview of learning and future development.
- Seeks engagement from the Board as part of this process to ensure the organisation's ongoing commitment to Speaking Up.

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**	**03 August 2023**
Agenda Item	**57/23iii**		
Report Title	**FREEDOM TO SPEAK UP REPORT**		
Report Author	Helen Young, Lead Freedom to Speak Up Guardian/Tania Strong, Freedom to Speak Up Guardian		
Purpose	To make the Board aware of current Freedom to Speak Up provision, and to appraise of plans to support a Freedom to Speak Up improvement and development plan.		

SCOPE

1.1 To provide the Board with details of the current Freedom to Speak Up (FTSU) provision and activity.

1.2 To present the outcome of the reflection and planning tool, which will evaluate the current baseline and identify actions to inform an improvement and development plan spanning the next 6-24 months.

FREEDOM TO SPEAK UP ACTIVITY AND BENCHMARKING

2.1 Concerns being raised remain relatively low and during 2022/23 a total of 13 concerns were raised with the FTSU Guardian, compared to 3 in 2021/22. For the year 2023/24 to date a further 3 concerns have been raised, taking the rolling total to 16. A breakdown of FTSU concerns raised by Directorate/Network can be found in the latest People Committee Report which can be seen at appendix 1.

2.2 On a quarterly basis, Freedom to Speak Up Guardians are expected to share non identifiable information with the National Guardian's Office (NGO) about speaking up. This data repository can be accessed and includes details from other healthcare organisations in England. Bridgewater is classed as a small NHS Trust (less than 5000 employees). Our most similar regional Trust comparator in headcount and function is Wirral Community NHS Trust – our numbers whilst lower are comparable – full detail is provided in the People Committee Report for benchmarking purposes (appendix 1). Next steps will involve further research on the systems, resources and number of Guardians within these Trusts to see whether this can inform better delivery within our own Trust.

SELF REFLECTION TOOL AND ACTION PLAN

3.1 **Freedom to Speak Up: a reflection and planning tool** - The NGO has developed an improvement tool designed to help identify strengths in FTSU Guardians, Trust leadership teams and organisational culture and systems, with a resulting action plan to address any gaps that require work. The improvement tool will demonstrate to our senior leadership team, our Board, or any oversight organisation the progress we have made developing our Freedom to Speak Up arrangements.

3.2 The final assessment and accompanying action plan spanning the next 6 – 24 months can be found in appendix 2.

3.3 The self-reflection tool is set out in three stages: - **Stage 1:** sets out statements for reflection under the eight principles. **Stage 2:** involves summarising our high-level actions will take over the next 6–24 months to develop our Freedom to Speak Up arrangements. **Stage 3:** Summarise the high-level actions we need to take to share and promote our strengths. The NGO suggest Boards should repeat this self-reflection exercise at least every two years once agreed.

3.4 The scoring scheme ranges from 1 to 5, with level 1 indicating a significant concern and level 5 indicating confidence that the organisation is operating at best practice level. For those areas of the self assessment scoring level 1 and 2, these should become priority areas of focus for the Trust over the coming weeks, although as part of our continual plans for improvement a range of actions have also been identified across those principles scoring levels 3 to 5. Actions to support any priority action areas are highlighted in Table 1/section 3.9.

The principles behind the self assessment include:

- **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
- **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
- **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.
- **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.
- **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.
- **Principle 6: Support guardians to fulfil their role in a way that meets workers' needs and National Guardian's Office requirements**
- **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
- **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

3.5 Senior Leaders (The Executive Team) were asked to contribute to the self assessment against **Principle 2: Role-model speaking up and set a healthy Freedom to Speak up culture** which featured the following questions and responses:

3.6 Named input from the Lead for Organisational Development (Director of People and OD) and the Non Executive Director for FTSU is also incorporated into the self assessment and their individual contributions can be seen within the full self assessment at appendix 2. The remainder of the self assessment was completed by the Senior Lead for FTSU (Executive Lead) with input from the Guardians.

Statements about assurance	**Range of scores**
The whole leadership team has bought into Freedom to Speak Up.	Consensus at 5
We regularly and clearly articulate our vision for speaking up.	Consensus at 4

We can evidence how we demonstrate that we welcome speaking up.	Consensus at 3 / 4
We can evidence how we have communicated that we will not accept detriment.	Consensus at 3 / 4
We are confident that we have clear processes for identifying and addressing detriment.	Scores range from 3 - 5
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up.	Consensus at 3 / 4
We regular discuss speaking-up matters in detail.	Consensus at 3 / 4

3.7 All proposed actions from the self assessment are included in appendix 2 – this will be developed further with agreed milestones, and monitored via People Committee with a further update provided to Board by January 2024. A further review will take place in 2025 as part of the 2 year review cycle. Since the time of completion of the self-assessment, work has already commenced to address some of the areas for improvement, and developments will continue to be reported to People Committee and onwards to the Board.

3.8 Priority actions for are detailed in table 1. These are predominantly linked to those statements that have scored a level 1 or 2. Particular attention should be given to the following action which requires consideration:

> Action: Propose for the Board to consider whether FTSU e-learning should be mandatory, or whether this learning should be completed by the Board and/or for key personnel, or whether this remains non-mandatory

3.9 This relates to plans for training and development, with a recommendation for adoption of the FTSU E-learning as essential for certain categories of workers.

Table 1

Principle 3	**Statements about how speaking up is promoted**	**Score 1–5 or yes/no**
	We measure the effectiveness of our communications strategy for Freedom to Speak Up.	2
	ACTION: Media action plan in place to promote Freedom to Speak Up and the role of the Guardian – to be executed throughout 2023.	
	ACTION: To develop a freedom to speak up newsletter (how often to be determined) re lessons learnt etc.	
Principle 4	**Statements about training**	**Score 1–5 or yes/no**
	We have mandated the National Guardian's Office and Health Education England training.	1
	ACTION: Propose for the Board to consider whether FTSU e-learning should be mandatory, or whether this learning should be completed by the Board and/or for key personnel, or whether this remains non-mandatory.	
	Statements about support for managers within teams or directorates	**Score 1–5 or yes/no**
	All managers and senior leaders have received training on Freedom to Speak Up.	1
	We have enabled managers to respond to speaking-up matters in a timely way.	2

	We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture.	1
	ACTION: Develop a trust-wide training delivery plan for FTSU, subject to Board discussions.	
	ACTION: To incorporate a learning review with the managers involved in a selection of speaking up cases, to ascertain what learning took place and how they can take steps to improving their environments to ensure a safe speaking up culture.	
Principle 5	**Statements about learning for improvement**	**Score 1–5 or yes/no**
	Statements about learning for improvement - We regularly identify good practice from others – for example, through self-assessment or gap analysis.	3
	We use this information to add to our Freedom to Speak Up improvement plan.	2
	ACTION: Utilise media action plan to incorporate opportunities for sharing learning (both internal and external) via newsletter.	
	ACTION: Regularly include updates to People Committee on lessons learned in terms of how the improvement plan adapts and adjusts to incorporate these.	
Principle 7	**Statements about barriers**	**Score 1–5 or yes/no**
	We have identified the barriers that exist for people in our organisation.	2
	We know who isn't speaking up and why.	2
	We are confident that our Freedom to Speak Up champions are clear on their role.	3
	We have evaluated the impact of actions taken to reduce barriers?	2
	ACTION: Meeting to be held with the champions to discuss their role and to identify any actions, including a focus on identification of barriers to speaking up.	
	ACTION: Data triangulation to take place/new report template to be developed to analyse any potential local intelligence in relation to barriers to speaking up.	
	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.	2
	ACTION: Policy adaptation to make NED involvement in allegations of detriment explicit, including a prescribed process.	
Principle 8	**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.	1
	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.	1
	We routinely evaluate the Freedom to Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation.	1
	Our improvement plan is up to date and on track.	1
	ACTION: To update the Freedom to Speak Up Strategy/Plan.	
	ACTION: To develop an improvement plan as a result of this self assessment tool.	

ACTION: To develop a revised reporting template that incorporates the data sources listed in the improvement guide, incorporating a range of quantitative/qualitative reporting measures.	
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.	3
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach.	1
Our speaking-up arrangements have been evaluated within the last two years.	1
ACTION: Utilise staff survey metrics to identify how confident staff feel in speaking up, and develop an attached improvement plan that has been developed with input from the Lead Executive and Head of OD.	

High level analysis of the self assessment can be seen within section 4 of this report.

HIGHLIGHTS - ANALYSIS OF SELF ASSESSMENT

4.1 Through engaging and evaluating the information provided by Senior Leaders within Bridgewater (the Executive Team) as part of this self assessment, the Senior Lead (Lead Executive) responsible for Freedom to Speak Up can evidence that we are operating to best practice to meet **Principle 1 –** that we value speaking up.

4.2 Scoring on the whole across the statements within Principle 1 has been identified at levels 4 and 5 which indicates high levels of knowledge and confidence in our operation of Freedom to Speak Up by our Executive Team. The level 4 score awarded relates to assurance that our Guardian(s) have sufficient ringfenced time to fulfil all aspects of the guardian job description. This will be monitored as part of the identified action plan, and as can be seen with appendix 2, the FTSU report to people Committee has started to report on actions in relation to benchmarking and will provide some insight into how Freedom to Speak Up operates within other small organisations regionally.

4.3 Our assessment as completed by our Senior Leads against **Principle 2 – Role modelling speaking up** can be seen in section 3.6 – there is broad consistency and consensus in scoring across the range of statements, with the statement 'The whole leadership team has bought into Freedom to Speak Up' being assessed consistently as an area of strength and level 5. The remaining questions score between a level 3-4, with some assessments believing that 'We are confident that we have clear processes for identifying and addressing detriment' should be scored at level 5 also. All factors will be incorporated into the ongoing improvement action plan.

4.4 We can evidence that Bridgewater's speaking-up policy reflects the 2022 update (level 5) and as recommended by the NGO, but to be confident that staff know about the policy and to meet **Principle 3: Make sure workers know how to speak up and feel safe and encouraged to do so**) a refreshed internal survey has recently been executed to test the current awareness of staff (currently scored at level 3) and details are included in section 6 of this report. Growth of a wider network of FTSU champions especially considering the geographical size of Bridgewater would also be beneficial and may improve awareness of the policy and this has been incorporated into the improvement plan actions for 2023/24.

4.5 In order to evidence that we are confident that we can meet **Principle 4 - When someone speaks up, thank them, listen and follow up** we have actions that we need to be considered

as per the point at 3.8. In order to address this particular standard within the self assessment further consideration is needed regarding the FTSU E-learning modules and whether this is to be made mandatory, which it is not at present. Our HR and OD teams can measure the impact of speaking-up training and FTSU currently features in the corporate induction and the first line managers programme and work is underway to have it included in local team-based inductions. As discussed above a wider conversation is needed in relation to e-learning or dedicated FTSU training as an agreed training or e-learning strategy for all staff.

4.6 The stand alone FTSU report as submitted to People Committee will continue to develop and will increase the early identification of themes and areas of concern and address any gap analysis - this will contribute to **Principle 5 - Use speaking up as an opportunity to learn and improve**, an identified action to which work is already underway is to develop a new report template for People Committee which incorporates better data triangulation. Scores in this areas are 2-3 and form part of our priority areas for action. This will include liaison with the Head of Risk and Patient Safety and attend quality and safety meetings for early identification of concerns – the new requirements of PSIRF will also be incorporated. Lead Guardian will continue to attend the North West FTSU Guardian Network meetings where good practice and learning is shared, with contributions from Bridgewater, and qualitative and quantitative data sets will be developed.

4.7 **Principle 6 - Support Guardians to fulfil their role** scored at levels 4-5 and will continue to be reviewed via the existing support systems in place. We can evidence this as a strength and confident that we are operating at best practice. We have identification an alternative Lead Executive in case of absence, and we are in the process of formalising a schedule of 1:1s between the Lead Guardian and Lead Executive/Lead NED.

4.8 **Principle 7 - Identify and tackle barriers to speaking up and Principle 8 - Continually improve our speaking up culture** will be a priority within the improvement plan and will be monitored closely (scoring mainly levels 1-2 and summary detail is provided at Table 1). We have identified that we have concerns or risks which require addressing within weeks and which warrant discussion to evaluate and consider options. We also have areas that we are generally applying well, but we are aware of room for improvement.

4.9 The Board is asked to endorse the self assessment and action plan, and to consider the proposal for the FTSU E-learning to be identified as essential learning within the Trust.

5. STAFF STORIES – LIVED EXPERIENCE AND LESSONS LEARNED

5.1 As part of using qualitative feedback in the form of staff stories, we have sought to evaluate people's experiences of speaking up, and through this that the organisation itself welcomes 'speaking up' and feedback.

5.2 All staff who submitted a 'speaking up' concern between 2022/23, both those with concerns concluded and those ongoing, were contacted directly by the Guardian with the invite to share their stories and review their experience of speaking up. Alternative routes were also offered should staff have felt that providing feedback directly to the Guardian was a barrier to doing so honestly and without impediment.

5.3 Of the 13 staff who were contacted, 3 came forward and agreed to their stories being written up into case studies. Staff were asked what they felt worked well and what could be improved, and what leaning could be taken away from this regarding both the process of speaking up or the concern that was raised. The case studies have also been shared with the relevant managerial lead in terms of feedback on lessons learned, where appropriate.

5.4 Individuals were invited to share their first-hand experiences of speaking up and were offered the opportunity to attend in person at Trust Board, or via their story being re-told on their behalf - the level of involvement was dictated by the member of staff. The case studies produced can be seen at appendices 3-5.

5.5 This feedback loop supports future work that will fall out of the Trust's FTSU improvement plan around detriment, evaluation and continuous improvement.

5.6 Key learning themes that will be incorporated into the corporate FTSU workstream includes training or awareness raising for managers regarding how to handle concerns being raised by staff to create the best environment for this to flourish, including steps to promote active listening.

5.7 Case studies 2 and 3 do detail some wider cultural issues which have impacted on the individuals' psychological safety, and these have been raised with the relevant Executive and HR/OD for wider address – the staff experiences are powerful and further support the need for effective training for managers on FTSU and Civility and Respect.

6. INTERNAL ANONYMOUS SURVEY RESULTS

6.1 The whole organisation was surveyed for 4 weeks during June and July 2023. The method included a link to a TEAMs questionnaire promoted via the Bulletin and Team Brief. In total 105 staff responded to the survey and of the 105 respondents 89 staff had heard of FTSU and 16 had not. When asked if they knew Bridgewater has a FTSU Guardian 82 staff did know and 23 did not.

6.2 Of the respondents 76% knew how to raise a concern.

6.3 When asked if there are any barriers that would prevent you from speaking up and what are they, 86 staff responded but when collating the results, some staff had left the question blank. 50 staff however did comment. Some of the free text comments received include:

"Being critical of more senior leaders can often lead you to be exposed and vulnerable. Difficult to keep anonymity, potentially as well"

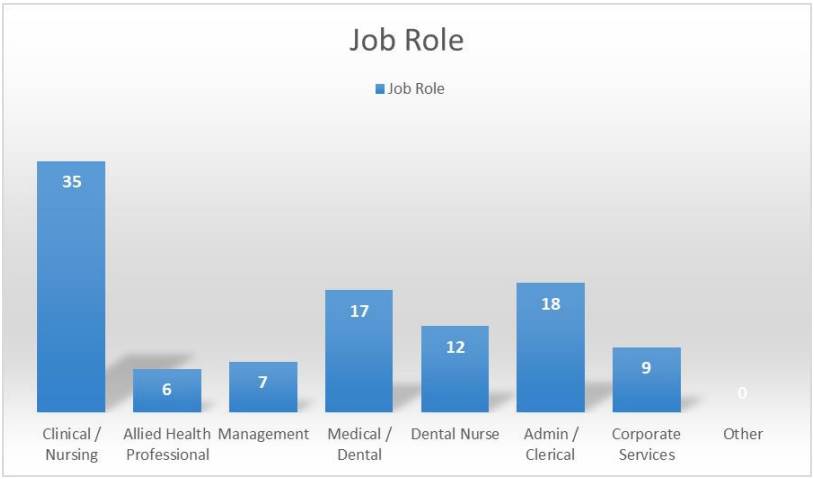
"Sometimes, fear of recriminations, other peoples view of you / where will it all lead for you if you spoke up"

"*I would be concerned that speaking up would not change anything as I know this has happened to colleagues in the past"*

6.4 Those staff who identified a barrier to speaking up, the majority of respondents commented that they were concerned about repercussions if they spoke up, or that nothing happens when they do. These are key and commonly identified barriers to speaking up. Of the 50 respondents, 27 indicated that there weren't any barriers to speaking up so the picture is

varied. Further analysis will be undertaken of the survey results and a review of proposed suggestions for improvement will be used to inform developments going forward.

6.5 Response results by job role.



6.6 **Conclusion –** The aim of the survey was to find out what Bridgewater staff know about Freedom to Speak Up and whether there are any barriers to speaking up – whilst roughly 50% of a small survey sample stated that no barriers existed, for those who do believe barriers exist, these appear to be cultural or related to fear of detriment. Barriers still appear to exist and when taken alongside some of the staff stories shared with Board within this paper will require further work.

6.7 Compared to the total number of Bridgewater staff, numbers responding to the survey were relatively low, yet staff have indicated that there are still barriers to speaking up. In March 2023 the results for the 2022 staff survey were released and feeling secure about raising a concern about clinical practice and feeling confident that it would be addressed showed a deterioration of 4.9% and 3.3% respectively from the 2021/22 results. Bridgewater results mirror the national results as found by the NGO and that workers still feel there is a barrier to 'speaking up' and therefore more work need to be done. The focus on this years FTSU month is 'breaking down barriers'.

6.8 In June 2021 a similar internal survey was carried out – this was sent directly to all staff email inboxes and a higher response rate of 291 was achieved. Of those who responded, awareness of FTSU sat at 63% and knowledge of how to raise concerns sat at 43%. There may be merit in surveying further once the Guardian has been in post for a period of time, and direct surveys have provided a higher response level so will be used going forward.

6.9 As forementioned the improvement/action plan includes making identifying and tackling barriers to speaking up a priority and progress will be monitored.

7. CONTINUOUS IMPROVEMENT AND FUTURE ACTIVITY

7.1 At a recent Race Inclusion Network meeting feedback was received by a member of staff. They suggested that to help oversees members of staff settle into their new job role that it would be good for them to be provided with a "buddy" (longer term if needed).

7.2 As a result of this feedback, it has been added to the action plan and raised at regional EDI meeting. In the interest of cultural sensitivity this was discussed with workforce and HR who feel that this is something that can be implemented and will be discussed further.

7.3 Feedback about the quality visits has recently been received. Concerns were raised at the visit, but no feedback was received, and staff felt let down by the process. This was fed back to the Deputy Chief Nurse who has taken this feedback on board. The quality visits are to be relaunched and reassurance has been given that a feedback mechanism will be included.

7.4 Raising awareness activities will all lead up to October 2023 which is Freedom to Speak Up Month and the theme this year is 'breaking barriers'. There will be a focus on removing the barriers that can stop workers from speaking up. The FTSU Champions will be fully briefed so that they can also disseminate information on removing barriers.

8. RECOMMENDATIONS

7.1 That the Board notes the current provision and assurance mechanisms.

7.2 That the Board notes the self assessment and accepts the proposed improvement plan which will be subject to ongoing review, and specifically considers the requirement for FTSU E-learning as essential learning.

Bridgewater Community Healthcare NHS Foundation Trust

PEOPLE COMMITTEE

Title of Meeting	**PEOPLE COMMITTEE**	**Date**	**12 July 2023**
Agenda Item	**00/23**		
Report Title	**FREEDOM TO SPEAK UP REPORT**		
Executive Lead	Lynne Carter - Chief Nurse/Deputy CEO		
Report Author	Helen Young - Freedom to Speak Up Guardian		
Presented by	Helen Young - Freedom to Speak Up Guardian		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Purpose

This report provides the Committee with details of current Freedom to Speak Up activity and updates.

Executive Summary

Speaking Up activity has increased since May 2023, however overall numbers remain low.

A FTSU media plan is in place to further grow the FTSU agenda.

The National Guardians Office (NGO) have produced a report analysing the 2022 staff survey called 'Fear and futility: what does the staff survey tell us about speaking up in the NHS?' The results show a fall in NHS workers' confidence to speak up. Of particular concern is the marked fall in how safe people feel to raise a clinical concern.

Previously considered by:

☐ **Flu Group**	☐ **Freedom to Speak Up Guardian Group**
☐ **Medical & Dental Professional Governance**	☐ **PEOPLE HUB**

Strategic Objectives

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

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

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

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

PEOPLE COMMITTEE REPORT

Title of Meeting	**PEOPLE COMMITEE**	**Date**	**12 July 2023**
Agenda Item	**00/23**		
Report Title	**FREEDOM TO SPEAK UP REPORT**		
Report Author	Helen Young - Freedom to Speak Up Guardian		
Purpose	To provide an overview of Freedom to Speak Up activity and updates.		

1. SCOPE

1.1 This report provides a summary of the FTSU activity during the first quarter of 2023/24.

1.2 This report also provides:

- An overview of developments including current mechanisms for 'Speaking Up'
- Details of recent promotion activity undertaken
- Provides the number and type of cases raised via 'Speaking Up' processes.
- Provides details of the NGO national staff survey results relevant to 'Speaking Up'.

2. RECENT INTERNAL DEVELOPMENTS

2.1 *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. To ensure that staff are aware of FTSU and to build on the work that has already been done, the Lead FTSU Guardian has developed a media plan to promote FTSU and to ensure that FTSU information is available to all staff within Bridgewater.* Please also see 4.2.

2.2 *To discover what staff already know about FTSU an anonymous survey has gone out to staff via the bridgewater bulletin and team brief and will close on the 14th July 2023. This short survey aims to understand if staff already know about FTSU and to also identify if staff feel there are any barriers to speaking up. Staff are also being asked which borough/network or directorate they work in which will identify any disparities. When the survey has closed, the analysis and results will be shared with the Committee.*

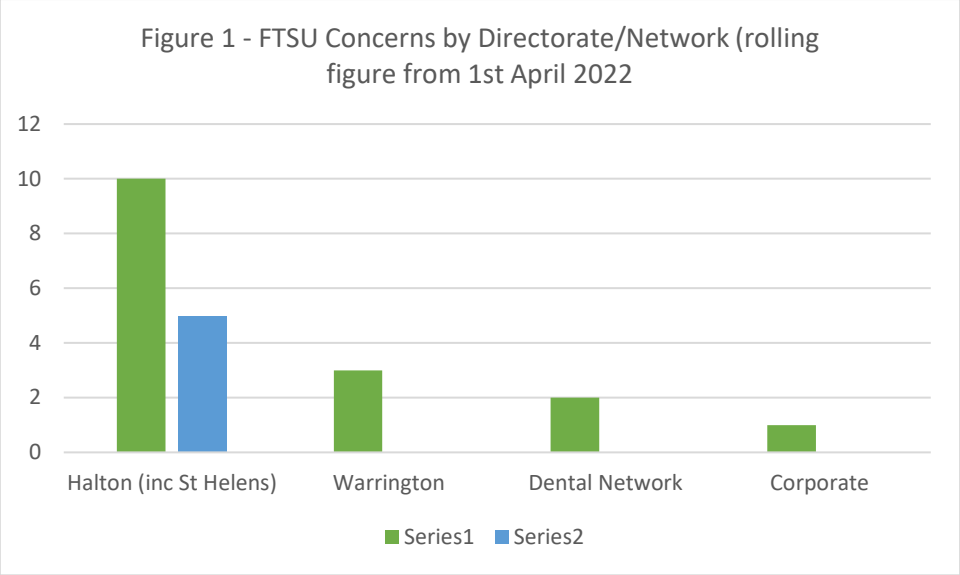
2.3 The FTSU page on the intranet is currently under review to make it easier to navigate and more employee-centric. Existing content and contact details for both the Guardian(s) and Champions remain on the intranet so staff know how to contact them.

2.4 *This is the first regular standalone report presented to People Committee, and will continue to develop. Employee Relation Cases will be reported separately however data will be triangulated to identify any 'hotspots' correlate with FTSU concerns. Freedom to Speak Up activity, themes and trends of concerns raised to the FTSU Guardians will continue to be reported to the Trust Board, bi-monthly to the People Committee and quarterly to the National Guardian's Office.*

2.5 ***Freedom to Speak Up: a reflection and planning tool -*** *The National Guardian's Office (NGO) has developed an improvement tool designed to help identify strengths in FTSU Guardians, Trust leadership teams and organisational culture and systems, with a resulting action plan to address any gaps that require work. Completing the improvement tool will demonstrate to our senior leadership team, our Board, or any oversight organisation the progress we have made developing our Freedom to Speak Up arrangements. At present the self reflection tool is being completed individually by Trust Executives so that their individual scores and any reflections can be captured. The final assessment and accompanying action plan spanning the next 6-24 months will be presented to Trust Board in August 2023. Following this a progress update will be supplied as per the NGO mandate before January 2024.*

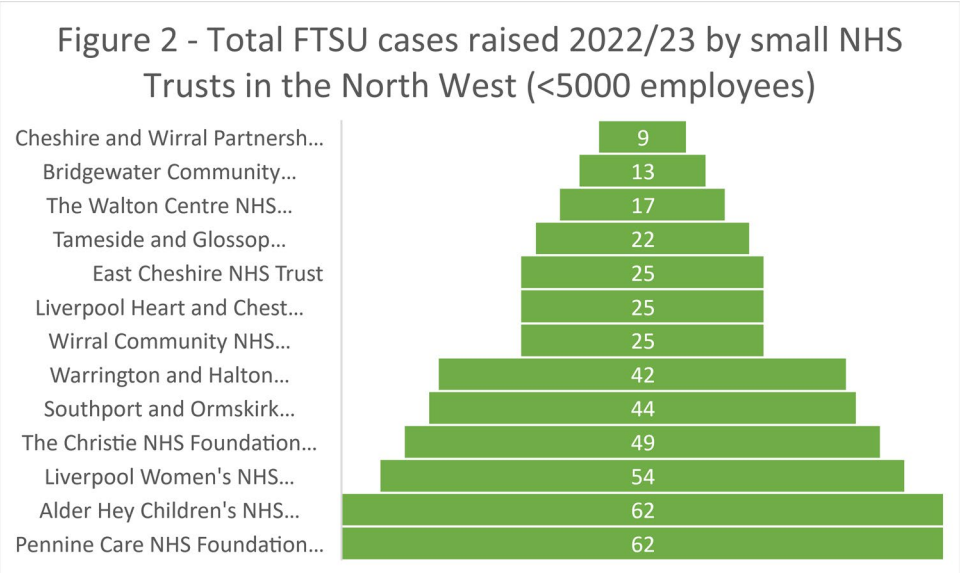
3. ACTIVITY OVERVIEW & BENCHMARKING

3.1 *Concerns being raised remain relatively low and during 2022/23 a total of 13 concerns were raised with the FTSU Guardian, compared to 3 in 2021/22. For the year 2023/24 to date a further 3 concerns have been raised, taking the rolling total to 16. A breakdown of FTSU concerns raised by Directorate/Network can be see a Figure 1. The higher number of concerns in Halton and St Helens should be considered with some context – of the 10 concerns raised since 2022/23, 5 relate to a common issue raised by a team (please see series 1 vs series 2) – our reporting guidance from the NGO requires the Trust to log these as individual contacts rather than collectively as one.*



3.2 On a quarterly basis, Freedom to Speak Up Guardians are expected to share non-identifiable information with the National Guardian's Office about the speaking up cases raised with them. This information provides invaluable insight into the implementation of Freedom to Speak Up.

3.3 This data repository can be accessed including detail from other healthcare organisations in England. Bridgewater is classed as a small NHS Trust (less than 5000 employees) – comparators and highlight data in this category of Trust from the North West can be seen at figure 2. The most similar Trust in headcount and function (community Trust of circa 1900 employees) is Wirral Community NHS Trust, who had 25 concerns raised during 22/23. Further benchmarking will take place and be reported back to the Committee in future reports.



3.4 Within Bridgewater, of those concerns raised, and the recent concerns within quarter 1, the majority focused on Patient Safety and Quality however the concerns are multi factorial in nature.

3.5 From a worker category perspective, the main professional group reporting concerns continues to be registered nurses.

4. STAFF SURVEY

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 National Guardians Office (NGO) have produced a report analysing the 2022 staff survey called 'Fear and futility: what does the staff survey tell us about speaking up in the NHS?'. This can be accessed at: https://nationalguardian.org.uk/2023/06/08/fear-and-futility/

4.3 They have found that while the results have improved since Freedom to Speak Up guardians were first implemented, the results show a fall in NHS workers' confidence to speak up. Of particular concern is the marked fall in how safe people feel to raise a clinical concern.

4.4 Bridgewater's staff survey results mirror the national picture and only question 23f had a higher response rate than 2021 as the other 3 questions were lower than the 2021 staff survey. This will be scoped further and question 5 in the anonymous internal survey that is currently underway asks, "Are there any barriers that would prevent you from speaking up and what are they?". This will give us some insight into what staff feel are the barriers to speaking up, and identify any actions that need taking to address these.

4.5 In their report the NGO concluded that there is still so much more to be done to ensure that all workers feel it is safe to speak up about clinical concerns or anything that gets in the way of them doing their role. More work is needed to improve the confidence of people who experience racism, as well as others who face barriers to speaking up. The NGO have identified that speaking up continues to be seen as a risky thing to do and the two main reasons that people don't speak up is because they fear the consequences or believe that nothing will be done as a result.

4.6 Understanding the barriers to speaking up and how they can be overcome, will be a core focus of both the National Guardian's Office, and of Freedom to Speak Up guardians locally. The NGO's analysis with also be shared with the CQC and NHS England as their role as regulators in vital in supporting improvement in speak up culture.

5. AWARENESS RAISING AND PROMOTION

5.1 *As mentioned in 2.1 a media plan is in place to promote FTSU. The Lead Guardian plans to be more visible across the Trust and posters and business cards have been printed and will be disseminated in staff areas.*

5.2 Raising awareness activities will all lead up to October 2023 which is Freedom to Speak Up Month and the theme this year is 'breaking barriers'. There will be a focus on removing the barriers that can stop workers from speaking up. The FTSU Champions will be fully briefed so that they can also disseminate information on removing barriers.

5.3 FTSU month also coincides with Black History month and the Health & Wellbeing Fortnight which will run from 9th to the 20th October. Plans are in place to:

- Hold a marketplace event in Spencer House Boardroom on the 9th and 19th October, creating a space for staff to visit, ask questions, take information away, join in on activities/workshops.
- Attendance at staff network group to raise awareness.
- To arrange attendance at a variety of service team meetings throughout October.
- FTSU promotion via staff networks and also Team Brief and staff bulletin.

5.4 FTSU Guardian continues to deliver a bespoke session at the Trust's corporate induction and continues to receive positive feedback, e.g. "Good to know and that is important to everyone" and "Informative and easy to understand".

6. LOCAL LEARNING & IMPROVEMENT

6.1 **Racial Discrimination & Speaking Up -** As forementioned the NGO have already stated that more work is needed to improve the confidence of people who experience racism. Recently a Northwest nurse won a landmark case against NHS England and Improvement (NHSE&I) for racial discrimination. Michelle Cox a senior nurse who was the victim of racial discrimination at work received a written apology from NHS England's chief executive following a landmark legal win re racial discrimination and whistle blowing detriment. It was ruled in a judgement that Ms Cox was treated unfavourably by her employer because of her race and because of her willingness to speak out. In light of this case we will review our speaking up processes to identify any learning and if any changes need to be made.

6.2 Currently Bridgewater has a small number of staff from ethnic minority groups. From a FTSU point of view and to be assured that staff within Bridgewater have the confidence to speak up, attendance at the Race Equality meeting will continue. The Guardian will also be more visible in the different localities to be more accessible to all hard to reach groups of staff.

6.3 As previously mentioned, the number of staff raising concerns via the FTSU process remains relatively low, but this does not capture the local issues that may be being raised with managers and other routes that demonstrates a healthy Speaking Up culture. Opportunities for how this might be captured will be scoped further, and any themes or opportunities for further learning identified.

6.4 In discussions with the Chief Nurse, we are going to look at the FTSU feedback evaluation form, once someone has raised a concern. This is to make sure that it is fit for purpose and to ensure that it captures the important information about people's experiences of speaking up including any barriers, and to learn from this.

6.5 **International Recruitment -** In May 2023 the NMC contacted the Trust about an important issue that may affect some of our nursing and midwifery staff. Internationally educated professionals must take a two-part test of competence before joining the NMC's register and usually sat in their home country, and a practical test (OSCE) in the UK. This is to ensure they have the right knowledge and skills to join our register. The NMC were alerted by their provider re some concerning data at CBT test centres in Ibadan and Nigeria, which raises serious concerns about the integrity of the tests taken at this centre. A total of 512 people on the register took their CBT at this test centre. This is being investigated by the NMC.

For context, the number of registered nurses and midwives who went through this test site represents around five percent of all Nigeria-educated professionals on the register. Additional controls are in place before registering:

- passing the practical OSCE exam, in person, in the UK
- completing in-person identity and documentation verification
- completing English language checks.

if someone has gained entry to the register incorrectly or fraudulently then the NMC have said they will take action. The NMC have written to us to tell us what has happened for awareness only.

From a Freedom to Speak Up point of view, staff effected may raise concerns about:

- racism and discrimination they experience as a result
- employers taking unnecessary steps, like invoking an internal disciplinary procedure

6.6 Being made aware of issue like this is important to ensure that we have processes in place to support staff.

6.7 At a recent Race Equality meeting feedback was received by a member of staff. They suggested that to help oversees members of staff settle into their new job role that it would be good for them to be provided with a "buddy" (long term if needed).

6.8 As a result of this feedback, it has been added to the action plan and raised at regional EDI meeting. In the interest of cultural sensitivity this was discussed with workforce and HR who feel that this is something that can be implemented and will be discussed further.

6.9 Feedback about the quality visits has recently been received. Concerns were raised at the visit, but no feedback was received and staff felt let down by the process. This was fed back to the Acting Chief Nurse who has taken this feedback on board. The quality visits are to be relaunched and reassurance has been given that a feedback mechanism will be included.

6.10 **Speaking Up Support Scheme** - For anyone who has spoken up and experienced an adverse effect NHS England have developed a support scheme called the Speaking Up Support Scheme for 2023-24.

The scheme provides a range of practical support for past and present NHS workers who have experienced a significant adverse impact following a formal speak up process. This information went out to staff in the bulletin on the 5th June 2023.

6.11 CQC Inspections - The FTSU Guardian has been attending FTSU regional meetings and changes to how the CQC monitor trusts and what they will be looking for has been high on the agenda. There's a new approach to CQC assessment and inspections and it replaces the four existing assessment frameworks with one single assessment framework.

6.12 The single assessment framework emphasises the need to create cultures that learns, improves and sets expectations for how services and providers need to work together (and within systems) to plan and deliver safe, person-centred care.

6.13 Some neighbouring trusts have already been inspected and they have feedback to the group.

The main areas identified are:

- Interview with senior managers and board members and FTSU lead.
- Equality strategy.
- WRES data and analysis.
- WDES data and analysis.
- Staff handbook and corporate induction.
- Staff complaints procedures and policies.
- Freedom to Speak Up Policy.
- Performance management framework and disciplinary procedure.
- Staff surveys and in particular looking for trends in survey re bullying and harassment.

7. CONCLUSION

7.1 The People Committee is asked to note the contents of this report.

National Guardian
Freedom to Speak Up

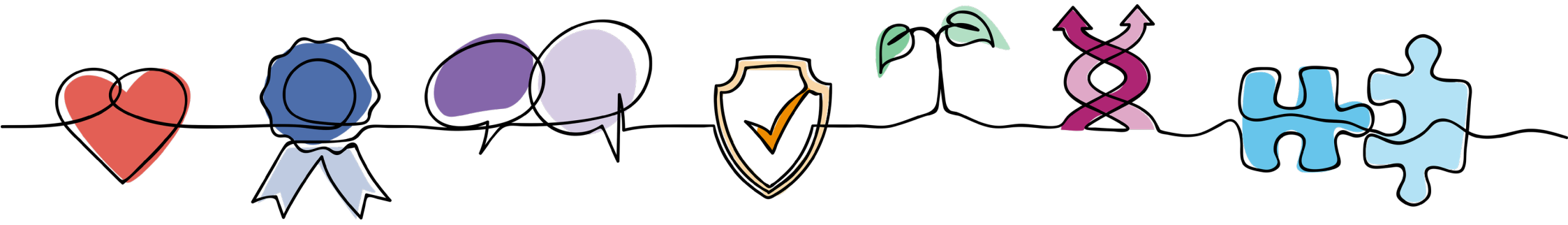
NHS

Freedom to Speak up

A reflection and planning tool

Bridgewater Community Healthcare NHS Foundation Trust

July 2023



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 othersin 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	5
I have led a review of our speaking-up arrangements at least every two years (ACTION)	4
I am assured that our guardian(s) was recruited through fair and open competition	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description	4
I am regularly briefed by our guardian(s)	5
I provide effective support to our guardian(s)	5

Enter summarised commentary to support your score.

The Lead Executive oversees the FTSU Guardian.

Network meetings are held on a quarterly basis including the FTSU Champions.

Update reports are sent to Board meetings (twice yearly going forwards) and People Committee – bi-monthly.

26.10.2022: Lead FTSU Guardian post recruited to.

The first dedicated Lead FTSU Guardian (ringfenced time) in situ from January 2023 (0.4 wte) and all HR and recruitment processes followed via fair and transparent recruitment process, however onboarding not completed – review capacity and time requirements to fulfil the Lead `Guardian role after 12 months. Resource supplemented by an additional Guardian at 1.0 wte (time not ring fenced) for cross cover where necessary.

Through line management and leadership arrangements.

Executive and non-executive leads are aware of guidance from the National Guardian's Office, however this could be further improved upon – this review will activate this. Last review of speaking up arrangements was undertaken in 2018 and further review paused due to the Pandemic – reinstated in line with National Guardian's Office Guidance for completion before January 2024.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 In the absence of the Lead Executive for FTSU – identification of an alternative Lead Executive
2 Completion of Speak Up, Listen Up, Follow Up e-learning by Board to further knowledge of Speaking Up/lead by example.
3 Review capacity and time requirement for Lead Guardian role after 12 months in post.
4 Executive and non-executive leads are aware of guidance from the National Guardian's Office, however this could be further improved upon

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.	5
I am confident that the board displays behaviours that help, rather than hinder, speaking up.	5
I effectively monitor progress in board-level engagement with the speaking-up agenda.	3
I challenge the board to develop and improve its speaking-up arrangements.	3
I am confident that our guardian(s) is recruited through an open selection process.	5
I am assured that our guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description.	5
I am involved in overseeing investigations that relate to the board.	4

I provide effective support to our guardian(s).	3
Enter summarised evidence to support your score. I have previous experience managing the FTSU agenda. I have discussed the FTSU agenda at board and board committees. I have advocated for a defined FTSU role which we now have.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Regular reporting and updates on FTSU to come directly to board.	
2 Regular meetings between Guardian and NED lead now established.	

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.	All 5's
We regularly and clearly articulate our vision for speaking up.	All 4's
We can evidence how we demonstrate that we welcome speaking up.	3,4,4,4,4

We can evidence how we have communicated that we will not accept detriment.	3,4,4,3,4
We are confident that we have clear processes for identifying and addressing detriment.	3,4,5,5,4
We can evidence feedback from staff that shows we are role-modelling the behaviours that encourage people to speak up.	3,4,4,4,4
We regular discuss speaking-up matters in detail.	3,4,4,3,4

Enter summarised evidence to support your score.

Comprehensive reports provided and feedback received and comments from board members / relevant meetings attended.

Regular meetings held with the NED and Chief Nurse.

All NGO advised processes are followed and information maintained in folders that only the Guardians can access. Concerns are documented as open/confidential with details of whom the concern can be shared with.

Information shared via staff bulletin and monthly briefings and newsletter in development.

Regular review of the FTSU webpage to provide information and feedback.

High-level actions needed to bring about improvement (focus on scores 1 ,2 and 3)

1 Policy adaptation to make NED involvement in allegations of detriment explicit, including a prescribed process.

2 Identify a mechanism for evaluation of speaking up experiences, including detriment.

3 Currently reviewing higher profile reviews / reporting and evidence at board level.

Statements for the person responsible for organisational development	**Score 1–5 or yes/no**
I am knowledgeable about Freedom to Speak Up.	5

We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans.	5
We have adapted our organisational culture so that it becomes a just and learning culture for our workers.	5
We support our guardian(s) to make effective links with our staff networks.	5
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture.	4

Enter summarised evidence to support your score.

FTSU Guardian attends our staff events, which includes, but is not limited to: Leader in Me, Annual Members Meeting/Staff Awards, Time to Shine, team meetings and training events.

Bridgewater has a People Strategy (2022-2025) which sets out a firm commitment to developing and supporting people so that they are equipped with the right knowledge and skills to continuously improve the quality of care for patients and service users. The Strategy incorporate the NHS People Plan and its 7 People Promises which are measured by the annual NHS Staff Survey. One of the promises refers to 'we each have a voice that counts'.

From December 2022 FTSU was further enhanced at Corporate Induction, including the presence of the FTSU Guardian - complementing the Director of People & OD presentation to staff regarding values and behaviours. The half our session that follows an introduction from the Chief Executive, places emphasis on how to manage and handle situation that may arise during employment that are unplanned and/or are unexpected. The session also encourages the reporting of incidents and making suggestions for improvements.

A behavioural toolkit is under development as referenced in a blog issued by the Director of People & OD (June 23). This has links to the FTSU agendas.

Connections have been established between the FTSU Guardians and the Trust's Head of Organisational Development to establish opportunities for FTSU to form part of the wider culture and leadership plans for the Trust. For example, our First Line Manager and Operational Manager training programmes.

Guardians work closely with the Trust's Equality and Inclusion Manager for worker intelligence and to gain access to hard to reach groups and have connections with the established Staff Networks. The latter are now becoming embedded and engrained and regular updates on progress and outputs are reported to various forums and Committees.

Bridgewater has implemented a just and learning culture in conjunction with NHS Mersey Care and Northumbria University, which is focused on fairness and learning. The Freedom to Speak Up Guardians, HR Team and Staff-side colleagues, have implemented this since June 2022 – the Disciplinary Policy was reviewed and realigned to Just and Learning Culture and launched in April 2023. We have Executive Sponsorship for our Just & Learning Culture Journey which is via the Deputy Chief Executive/Chief Nurse and Director of People & Organisational Development.

All work plans relating to Culture & Leadership are routed via the Culture & Leadership POD – the Lead Guardian is now included in the membership.

Bridgewater has a variety of strategies and apart from the People Strategy, FTSU is not mentioned – consider future review of strategies to incorporate this element where appropriate going forward.

Activity relating to speaking up is low (13 cases in the last 12 months) – learning from speaking up needs to be increased and communicated across the Trust to further influence our speaking up culture.

FTSU reports are tabled at the Trust's People Committee and ultimately Trust Board. A report of employee relations activity also features, which indicates the positive trends in reduction of cases as per the Just & Learning Culture Journey and its ongoing programme of initiatives, measures etc.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 For the Lead Guardian to engage with the FTSU champions to support the embedding of the speaking up ethos.
2 To ensure that 'Freedom to speak up' is embedded throughout all relevant Bridgewater policies / strategies.
3 Focus on dissemination of learning from FTSU concerns raised.
4 Focus on themes emerging to inform further action and programmes of work.

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.	4
We have reviewed the ringfenced time our Guardian has in light of any significant events.	4
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s).	5
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians.	5
Enter summarised evidence to support your score. The Lead Guardian has 15 hours a week (0.4 WTE) dedicated time for the role, but this will need to be reviewed on an ongoing basis if there is an increase in speaking up cases etc and to be able to fulfil the role effectively. This is the first post of its nature, whereby there is dedicated time for a stand alone role, so the efficacy of the arrangements will need to be reviewed after they have had the opportunity to embed after 12 months.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 To review the working hours of the Lead FTSU Guardian on a regular basis / annual My Plan.	

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.	5
We can evidence that our staff know how to find the speaking-up policy.	3

Enter summarised evidence to support your score.

How to find policies is clearly identified on the Bridgwater Hub, however our staff would need to know that there is a speaking up policy. Information does go out in the bulletin and also in team brief which is cascaded to staff. Information is included in the corporate induction for new starters to the Trust.

Following a MIAA Audit in 2020, a survey was undertaken in June 2021 asking about awareness of speaking up - results are detailed below.

Staff awareness of Freedom to Speak Up

A refreshed survey would test the current awareness and will form part of actions for 2023/24.

A small network of FTSU champions exists consisting of two staff, and access to a wider network of Engagement Champions can also be called upon – however for the geographical size of the organisation, further Champions may improve awareness of the policy and speaking up.

A revised Intranet platform is being commissioned and the number of 'hits' to the FTSU Intranet pages should be able to evidence how many staff have frequented the area.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To conduct a staff survey about Freedom to speak up to ascertain what staff know.
2 To grow and develop the network of FTSU champions as part of a tool to promote awareness of Speaking Up and the FTSU policy.

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).	4
We have an annual plan to raise the profile of Freedom to Speak Up.	3
We tell positive stories about speaking up and the changes it can bring.	3
We measure the effectiveness of our communications strategy for Freedom to Speak Up.	2

Enter summarised evidence to support your score.

A new Lead Guardian came into post in January 2023 and we have a media plan in place to promote the role and to promote freedom to speak up. This will include information in the staff bulletin on a rolling programme leading to speaking up month in October 2023.

This assessment tool will generate actions which will form a plan to raise the profile of the Lead Guardian.

There are already processes in place for lessons learnt but the Lead Guardian could produce a newsletter to inform staff about speaking up and the changes it can bring.

The Freedom to Speak up strategy produced in 2020 incorporated a work plan which has now been superseded by the action plan outputs as part of this self assessment, and so will be removed and an updated Speaking Up Plan will be produced.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Media action plan in place to promote Freedom to Speak Up and the role of the Guardian – to be executed throughout 2023.
2 To develop a freedom to speak up newsletter (how often to be determined) re lessons learnt etc.
3 To replace the Freedom to Speak Up Strategy (last updated July 2020) and replace with a 12 month Freedom to Speak Up Plan incorporating actions from this self-assessment.

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.	1
Freedom to Speak Up features in the corporate induction as well as local team-based inductions.	3
Our HR and OD teams measure the impact of speaking-up training.	3
Enter summarised evidence to support your score. Staff can access the eLearning training but this has not been mandated. FTSU Guardians and Champions are expected to complete the relevant parts of the training. There is a dedicated monthly slot on the corporate induction for the FTSUG to attend where the e-learning is also promoted.	

Freedom to speak up is not currently included in the local teams based induction paperwork.

FTSU E-learning will form part of the 1st Line Manager and Operational Manager Training programme in 2023.

Evaluations of the Corporate Induction are given and suggestions for improvement taken on board (currently very positive feedback to date) – evaluations of the training package for the 1st Line Managers programme and Operational Managers programmes will be factored in but is currently pending – score of level 3 until training delivered and evaluations completed/fully consolidated.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To work with Education & Professional Development Team to include freedom to speak up information in the local induction paperwork that is sent to managers to complete with new starters.
2 Propose for the Board to consider whether FTSU e-learning should be mandatory, or whether this learning should be completed by the Board and/or for key personnel, or whether this remains non-mandatory.

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.	3
All managers and senior leaders have received training on Freedom to Speak Up.	1
We have enabled managers to respond to speaking-up matters in a timely way.	2
We are confident that our managers are learning from speaking up and adapting their environments to ensure a safe speaking-up culture.	1

Enter summarised evidence to support your score.

In principle the messages in relation to FTSU are there, and anyone coming into contact with a Guardian directly will experience this message about learning and that it shouldn't be feared, however if e-learning or other learning opportunities are not widely accessed then for those unaware of FTSU, they may find when presented with someone raising a concern, their reaction is defensive. Anecdotally messages may be there but we do not have the evidence to support this.

In relation to e-learning or dedicated FTSU training, this is not mandated at present – a wider conversation is needed to determine an agreed training or e-learning strategy for all staff. Agreement in place to deliver a Board development session in 2023 in relation to Speaking Up.

A manager's ability to respond to speaking up concerns varies widely based on operational pressures. FTSU promotes the view that staff concerns form part of the core element of a managerial role as part of promoting a positive speaking up culture – one where staff feel encouraged to speak up, and not dissuaded by their manager by e.g. being too busy. Resource is available for concerns that warrant more formal Investigation where appropriate (patient safety, HR etc).

More time must be spent working with managers around promoting a positive Freedom to Speak Up culture.

There are always communication opportunities to deliver key messages e.g. Team Brief, staff meetings, the Trust Bulletin, our intranet and staff App, Twitter etc.

There is a dedicated webpage that all staff can access on the hub re speaking up and the processes involved etc.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Develop a trust-wide training delivery plan for FTSU, subject to Board discussions.

2 To incorporate a learning review with the managers involved in a selection of speaking up cases, to ascertain what learning took place and how they can take steps to improving their environments to ensure a safe speaking up culture.

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.

We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them.	4
We use triangulated data to inform our overall cultural and safety improvement programmes.	3

Enter summarised evidence to support your score.

Information is available where areas of concern have been identified and to liaise with the Head of Risk and Patient Safety / attend quality and safety meetings for early identification of concerns.

Triangulation of Employee Relations information is accessible.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 To liaise with the Head of Risk and Patient Safety / attend quality and safety meetings for early identification of concerns.

2 To develop a new report template for People Committee which incorporates better data triangulation.

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.	3
We use this information to add to our Freedom to Speak Up improvement plan.	2
We share the good practice we have generated both internally and externally to enable others to learn.	3

Enter summarised evidence to support your score.
Lead Guardian attends the North West FTSU Guardian Network meetings where good practice and learning is shared, with contributions from Bridgewater. Self-assessment is being undertaken to identify improvements and work plan going forward, this will happen every two years, however more frequent review of learning outcomes via the National Guardian's Office need to be incorporated on a rolling basis and incorporated into the FTSU improvement plan. Media action plan to introduce a newsletter will incorporate learning (both local and national).
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Utilise media action plan to incorporate opportunities for sharing learning (both internal and external) via newsletter.
2 Regularly include updates to People Committee on lessons learned in terms of how the improvement plan adapts and adjusts to incorporate these.

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.	5
Our guardian(s) has been trained and registered with the National Guardian Office.	5

Enter summarised evidence to support your score.
All HR and recruitment processes where followed and as advised by the NGO for recruitment to the Lead FTSU Guardian. All Guardians have completed the relevant training and are registered with the NGO. Their details / profile can be found on the NGO webpage.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

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.	5
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders.	4
Our guardian(s) has access to a confidential source of emotional support or supervision.	5
There is an effective plan in place to cover the guardian's absence.	5
Our guardian(s) provides data quarterly to the National Guardian's Office.	5

Enter summarised evidence to support your score.

Direction is taken from the NGO.

The Guardian will receive an annual 'My Plan' which includes performance and development objectives.

The Lead Guardian has support from another Guardian within Bridgewater to provide cover during absence, and also a named 'Buddy' Freedom to Speak Up Guardian from another Trust. Bridgewater offer a range of health and wellbeing support / resources if required.

Peer support in place via Lead Guardian/Guardian close working. The FTSU Lead Guardian has access to all the senior leaders who provide support. The FTSU Lead Guardian has support from the regional network and attends network meetings. Quarterly data is uploaded to the NGO portal within timescales – both Lead Guardian and Guardian have access to the portal.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Identification of alternative Lead Executive in case of absence.
2 Formalise the schedule of 1:1s between Lead Guardian and Lead Executive/Lead NED (not regularly established as yet due to recency of appointment).

Statements about our speaking up process	**Score 1–5 or yes/no**
Our speaking-up case-handling procedures are documented.	5
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases.	5
We are assured that confidentiality is maintained effectively.	5
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for.	5
We are confident that if people speak up within the teams or directorates we are responsible for, they will have a consistently positive experience.	4

Enter summarised evidence to support your score.
All NGO advised processes are followed and information maintained in folders that only the Guardians can access. Concerns are documented as open/confidential with details of whom the concern can be shared with. Training for staff is not mandated but senior leads within services should complete the training to ensure that they understand that speaking up is a positive experience and that it is a learning experience. Managers are provided with guidance as to their role via the Guardian if they have not had experience of speaking up previously, or have not accessed training. The issue of negative experience or detriment is not well documented – many staff have not engaged after their concern was resolved/closed as to whether they have felt they have experienced a detriment for speaking up – a better mechanism for feedback is needed, which can then be evaluated.
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Identify a mechanism for evaluation of speaking up experiences, including detriment.

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.	2
We know who isn't speaking up and why.	2
We are confident that our Freedom to Speak Up champions are clear on their role.	3

We have evaluated the impact of actions taken to reduce barriers?	2

Enter summarised evidence to support your score.

Anecdotally based on the national picture, we are aware of the typical barriers that staff face in relation to speaking up (for example ethnicity, disability, new starters, low levels of psychological safety). Our 2022 staff survey identified a deterioration in the confidence levels for staff speaking up about clinical issues which requires further exploration. Triangulation of data and building a more comprehensive reporting template with accompanying analysis may provide further insight into potential barriers to speaking up at a local level within the Trust – this work has been identified as necessary.

Employees are directed to the local Staff Networks within the FTSU policy, and connections have been made with the leads for the staff networks in terms of speaking up and gathering any local intelligence on barriers to speaking up.

Quarterly meetings are held with the champions, but an extraordinary meeting is to be held with the Champions due to the Lead Guardian now being in post, to scope what role they have been playing and identify any actions to improve and enhanced the champion role, and the support offer they receive. A key focus will also be utilising their local intelligence to support the identification of potential barriers to staff speaking up.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 Meeting to be held with the champions to discuss their role and to identify any actions, including a focus on identification of barriers to speaking up.
2 Data triangulation to take place/new report template to be developed to analyse any potential local intelligence in relation to barriers to speaking up.

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.	2
We monitor whether workers feel they have suffered detriment after they have spoken up.	3

We are confident that we have a robust process in place for looking into instances where a worker has felt they have suffered detriment.	3
Our non-executive director for Freedom to Speak Up is involved in overseeing how allegations of detriment are reviewed.	3

Enter summarised evidence to support your score.

The FTSU Policy describes the actions that will be taken if staff have been victimised as a result of speaking up.

For anyone who has spoken up we ask for an evaluation and this would identify if they have suffered detriment – however to date, take up has been low and the reasons for this need to be further explored.

The Trust has mechanisms in place to receive feedback from all members of staff such as Listening Events, Pulse Checks, Conferences, staff surveys, staff governors.

The NED for FTSU is not currently prescribed in being involved with any cases of allegations of detriment, this would need updating within the current policy.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)

1 Policy adaptation to make NED involvement in allegations of detriment explicit, including a prescribed process.

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.	1
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.	1
We routinely evaluate the Freedom to Speak Up strategy, using a range of qualitative and quantitative measures, and provide updates to our organisation.	1
Our improvement plan is up to date and on track.	1

Enter summarised evidence to support your score.

Current FTSU Strategy is reflective of previous actions which have now been completed – a revised and refreshed strategy or plan is required in relation to speaking up, taking into account the results of the self-assessment and overall People Strategy within the Trust.

Metrics and measures attached to the strategy should be used to measure it's effectiveness, with monitoring in place via bi-monthly reports to People Committee and twice yearly reports to Board. A new report template incorporating different triangulation data points will be developed to provide updates to the organisation.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To update the Freedom to Speak Up Strategy (already an action).
2 To develop an improvement plan as a result of this self assessment tool.

3 To develop a revised reporting template that incorporates the data sources listed in the improvement guide, incorporating a range of quantitative/qualitative reporting measures.

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.	3
Our plan follows a recognised 'plan, do, study, act' or other quality improvement approach.	1
Our speaking-up arrangements have been evaluated within the last two years.	1
Enter summarised evidence to support your score. Staff survey results provide a metric as to how confident staff feel about speaking up. 2022 Staff Survey results indicate this metric has deteriorated from 2021 in relation to clinical concerns, non-clinical concerns have remained broadly static in terms of confidence levels (see 2022 FTSU Annual report). Work is underway and steps have been taken by the Lead Executive/Lead Guardian/ Head of OD to identify an appropriate improvement methodology in relation to this piece of work. Last review of speaking up arrangements was undertaken in 2019 and further review was paused due to the Pandemic – reinstated in line with National Guardian's Office Guidance for completion before January 2024.	
High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)	
1 Utilise staff survey metrics to identify how confident staff feel in speaking up, and develop an attached improvement plan that has been developed with input from the Lead Executive and Head of OD.	

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.	3
We have we evaluated the content of our guardian report against the suggestions in the guide.	3
Our guardian(s) provides us with a report in person at least twice a year.	3
We receive a variety of assurance that relates to speaking up.	3
We seek and receive assurance from the relevant executives/senior leaders that speaking up results in learning and improvement.	3

Enter summarised evidence to support your score.

Discussions about report content have taken place within People Committee and feedback given to the Guardians, with steps agreed to implement a stand alone report which will include a greater focus on data triangulation based on the data sources listed in the improvement guide to provide greater assurance – this will be implemented as part of the improvement plan in 2023.

Reports have/are being submitted to Board in February and June 2023, with a further date in 2023 to be identified. Twice yearly reporting to Board will then be updated within the Business Cycle.

Feedback loops are in situ for when a member of staff speaks up, and any learning from cases is reported to People Committee bi-monthly, however wider dissemination of learning needs improvement.

High-level actions needed to bring about improvement (focus on scores 1, 2 and 3)
1 To develop a revised reporting template that incorporates the data sources listed in the improvement guide.
2 To identify a mechanism for wider cascade of learning relating to speaking up cases, using the existing Trust communications channels and/or newsletter – to be incorporated into the Media Plan.

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	To replace the Freedom to Speak Up Strategy and replace with a 12 month Freedom to Speak Up Plan incorporating actions from this self-assessment.	31.08.2023	FTSUG
2	Firm up our commitment to review our speaking-up arrangements at least every two years.	30.11.2023	FTSUG & Board members and senior leads
3	Current review / agreement of reporting arrangements to board to ensure they are kept updated and fully briefed.	30.11.2023	FTSUG
4	Completion of Speak Up, Listen Up, Follow Up e-learning by Board to further knowledge of Speaking Up/lead by example.	29.02.2024	Board Members
5	Propose for the Board to consider whether FTSU e-learning should be mandatory for all staff, or whether this learning should be completed by key personnel, or whether this remains non-mandatory.	29.02.2024	FTSUG & Board Members
6	Develop a trust-wide training delivery plan for FTSU, subject to Board discussions.	29.02.2024	FTSUG & Board Members
7	Review capacity and time requirement for Lead Guardian role after 12 months in post - ongoing support via 1:1s and PPDR.	30.04.2024	Chief Nurse
8	Executive and non-executive leads are aware of guidance from the National Guardian's Office, however this could be further improved upon.	29.02.2024	FTSUG
9	Identify a mechanism for evaluation of speaking up experiences, including detriment.	30.11.2023	FTSUG
10	Policy adaptation to make NED involvement in allegations of detriment explicit, including a prescribed process.	29.02.2024	FTSUG

11	Regular review and updates on the FTSU webpage to provide information and feedback to staff.	30.11.2023	FTSUG
12	To work with Education & Professional Development Team to include freedom to speak up information in the local induction paperwork that is sent to managers to complete with new starters.	31.10.2023	FTSUG
13	For the Lead Guardian to engage with the current FTSU champions to support the embedding of the speaking up ethos - meeting to be held with the champions to discuss their role and to identify any actions, including a focus on identification of barriers to speaking up. To grow and develop the network of FTSU champions as part of a tool to promote awareness of Speaking Up and the FTSU policy.	31.10.2023	FTSUG
14	Guardian support: Formalise the schedule of 1:1s between Lead Guardian and Lead Executive/Lead NED (not regularly established as yet due to recency of appointment) and identification of alternative Lead Executive in case of absence.	31.08.2023	FTSUG & Chief Nurse & NED
15	To conduct a staff survey about Freedom to speak up to ascertain what staff know.	31.08.2023	FTSUG
16	Media action plan in place to promote Freedom to Speak Up and the role of the Guardian, to include a mechanism for wider cascade of learning relating to speaking up cases (both internal and external) – to be executed throughout 2023. Incorporate development of a freedom to speak up newsletter and dissemination of learning from FTSU concerns raised.	31.10.2023	FTSUG
17	To develop a revised reporting template that incorporates the data sources listed in the improvement guide, incorporating a range of quantitative/qualitative reporting measures, including analysis any potential local intelligence in relation to barriers to speaking up.	31.10.2023	FTSUG
18	To develop a new report template for People Committee which incorporates better data triangulation and lessons learned in terms of how the improvement plan adapts and adjusts to incorporate these.	31.08.2023	FTSUG
19	To liaise with the Head of Risk and Patient Safety / attend quality and safety meetings for early identification of concerns.	31.08.2023	FTSUG
20	Policy adaptation to make NED involvement in allegations of detriment explicit, including a prescribed process.	31.10.2023	FTSUG
21	To incorporate a learning review with the managers involved in a selection of speaking up cases, to ascertain what learning took place and how they can take steps to improving their environments to ensure a safe speaking up culture.	31.10.2023	FTSUG
22	To review the current mechanism for evaluation of speaking up experiences, including detriment, and identify where any improvements might be made.	30.11.2023	FTSUG

	Development areas to address in the next 12–24 months	Target date	Action owner
23	To ensure that ‘Freedom to speak up’ is embedded throughout all relevant Bridgewater policies / strategies.	29.02.2024	FTSUG
24	Continue to regularly include updates to People Committee/Board on lessons learned in terms of how the improvement plan adapts and adjusts to incorporate these and to ensure they are kept updated and fully briefed.	29.02.2024	FTSUG
25	Utilise staff survey metrics to identify how confident staff feel in speaking up and develop an attached improvement plan that has been developed with input from the Lead Executive and Head of OD.	29.02.2024	FTSUG
26	Focus on themes emerging to inform further action and programmes of work.	29.02.2024	FTSUG
27	To continue to attend regional FTSU meetings to enable identifying good practice from others e.g. through self-assessment or gap analysis and to share this good practice internally and externally to enable others to learn.	31.08.2023	FTSUG

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
The majority of Bridgewater's senior leads (execs) are knowledgeable about Freedom to Speak Up	31.07.2024	FTSU Guardian
The majority of Bridgewater's senior leads (execs) are assured that Bridgewater's guardian(s) was recruited through fair and open competition	31.01.2024	FTSU Guardian
The majority of senior leads feel they are regularly briefed by our guardian(s)	31.07.2024	FTSU Guardian
Senior leads provide effective support to our guardian(s)	31.07.2024	FTSU Guardian & Senior Leads
Our NED is knowledgeable about Freedom to Speak Up.	31.08.23	FTSU Guardian & NED
Our NED is confident that the board displays behaviours that help, rather than hinder, speaking up.	31.01.2024	NED
Our NED is confident that our guardian(s) is recruited through an open selection process.	31.08.23	FTSU Guardian & NED
Senior leads and NED are assured that Bridgewater's guardian(s) has sufficient ringfenced time to fulfil all aspects of the guardian job description.	31.01.2024	NED & Senior Leads
The whole leadership team has bought into Freedom to Speak Up.	31.07.2024	FTSU Guardian & Leadership Team
Our NED is involved in overseeing investigations that relate to the board (4)	31.01.2024	NED
The leadership team regularly and clearly articulate our vision for speaking up.	31.01.2024	Leadership Team
The leadership team can evidence how we demonstrate that we welcome speaking up.	31.01.2024	Leadership Team
The leadership team can evidence how we have communicated that we will not accept detriment.	31.01.2024	Leadership Team
We have included creating a speaking-up culture (separate from the Freedom to Speak Up guardian process) in our wider culture improvement plans.	31.07.2024	FTSU Guardian

We have adapted our organisational culture so that it becomes a just and learning culture for our workers.	31.07.2024	FTSU Guardian & Senior Leads
We support our guardian(s) to make effective links with our staff networks.	31.01.2024	Leadership Team
The whole senior team or board has been in discussions about the amount of ringfenced time needed for our guardian(s).	31.01.2024	NED & Senior Leads
We are confident that we have appropriate financial investment in place for the speaking-up programme and for recruiting guardians.	31.01.2024	NED & Senior Leads
We use Freedom to Speak Up intelligence and data to influence our speaking-up culture (4).	31.01.2024	NED & Senior Leads
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 (4)	31.01.2024	NED & Senior Leads
We have reviewed the ringfenced time our Guardian has in light of any significant events (4)	31.01.2024	NED & Senior Leads
Our organisation's speaking-up policy reflects the 2022 update	31.08.2023	FTSU Guardian
We have used clear and effective communications to publicise our guardian(s) (4)	31.08.2023	FTSU
We have supported our guardian(s) to effectively identify potential areas of concern and to follow up on them (4)	31.01.2024	NED & Senior Leads
Our guardian(s) was appointed in a fair and transparent way	31.08.2023	Senior Leads
Our guardian(s) has been trained and registered with the National Guardian Office	31.08.2023	FTSU Guardian
Our guardian(s) has performance and development objectives in place	30.09.2023	
Our guardian(s) receives sufficient one-to-one support from the senior lead and other relevant executives or senior leaders (4)	31.01.2024	NED & Senior Leads
Our guardian(s) has access to a confidential source of emotional support or supervision	31.08.2023	FTSU Guardian
There is an effective plan in place to cover the guardian's absence	31.08.2023	FTSU Guardian
Our guardian(s) provides data quarterly to the National Guardian's Office	31.08.2023	FTSU Guardian
Our speaking-up case-handling procedures are documented	31.08.2023	FTSU Guardian
We have engaged with managers and other key stakeholders on the role they play in handling speaking-up cases	31.01.2024	FTSU Guardian

We are assured that confidentiality is maintained effectively	31.01.2024	FTSU Guardian
We ensure that speaking-up cases are progressed in a timely manner within the teams or directorates we are responsible for	31.01.2024	FTSU Guardian
We are confident that if people speak up within the teams or directorates, we are responsible for, they will have a consistently positive experience (4)	31.01.2024	FTSU Guardian

Case study 1

A concern was raised in relation to behaviors and interactions with senior colleagues by a member of a clinical team. The matter was referred to a Senior Leader to address – they did not meet with the employee face to face as requested (by the employee) but via TEAMs to talk about the issue and put forward some solutions. The environment has now improved due to change in personnel and is generally more pleasant.

Personal reflections from the employee:

'There were pros and cons to speaking up – even if there wasn't much that could be done, or was done about the issue I'd raised, it helped clear my mind and avoided a deterioration in my mental health. It was a difficult decision to speak up – these days there are more layers to go through just to get things done in terms of hierarchy. Meeting face to face with the helped – I think that meetings over TEAMs distances people for these sorts of issues and isn't as helpful. Speaking up wasn't a full solution for me – there was some culture change due to change in personnel and this helped a lot with my interactions afterwards – the change in personnel refocused and repurposed things for the better and things became less 'gladiatorial' - but things also became better because I'm also more wary to challenge, and I shy away more from conflict – from a personal reflection point of view I feel I've swerved the problem rather than fully tackled it.

Generally speaking, I think there still needs to be more input/engagement with services – they're redesigning our service but there have been poor communications with where we're up to with this, staff seem to be the last ones to input into the changes.

Would you speak up again? Yes – because if I hadn't it would have continued to affect my mental health, and the behavior would have continued as it was.

Do you feel you've suffered a detriment after speaking up? Not so far, but time will tell.

Would you like to give any further feedback on the process more generally?

It's really important for these sorts of issues for people to sit face to face and take time to really listen, and this helped even if the outcome wasn't exactly what I'd wanted.

I still felt there was a degree of defensiveness when I was raising the issues with the Senior Leader, which is understandable/it's human nature, but it's something to note in terms of how we portray ourselves as managers.

Generally speaking, my view is that I think we lose the line of sight of the front line sometimes, and there's a lack of acknowledgement of the operational impact of governance – sometimes we do it for the governance teams sake, and not for making things better for the patient.'

Learning Identified: Face to face interaction is important from an engagement perspective. Communication can always be improved in terms of service changes. Creating and portraying the right environment for staff to speak up is equally as important as the actual output, as sometimes all changes may not be able to be accommodated.

Case study 2

A member of staff was concerned about the physical safety of the building they were working in, which had been raised repeatedly as an issue. This related to concerns that patients and clients being able to access staff areas which were not secure, especially when reception cover was not available. The issue was raised with the Deputy Director of Estates and Borough Director to address. Assessments were made to the building and electronic fob access was introduced. The member of staff has also agreed to become a FTSU champion following their experience of the process.

Personal reflections from the employee:

It's taken a considerable amount of time to get the issue resolved – nearly a year in total – but all of my concerns have been resolved from a building safety point of view. All staff in the building thought that we'd only get something done once something 'bad' happened to prompt the changes that were needed, but this hasn't been the case. There are still sometimes issues with reception cover but this has improved and there is signage in place to help patients contact the right people when reception isn't open, and the fob access means that people aren't wandering around the building anymore so we feel safe now.

It was great to have a neutral body (the Guardian) to be able to go to and this worked well in terms of being a point of access to escalate things.

Would you speak up again? Yes – my advice to someone else considering speaking up would be to not be afraid to do it, you won't get 'told off' or anything like this.

Do you feel you've suffered a detriment after speaking up? Absolutely not.

Would you like to give any further feedback on the process more generally? General feedback on the process is that there could have been some better communication about the plans that estates had and some expectations management in terms of how long things would take. The FTSU process in itself has been fantastic.

Learning identified: better communication around estates plans and timescales is needed so that staff are aware of plans that are underway.

Case Study 3

A member of staff raised a concern anonymously about leadership and behaviours within their area of work, this was prompted by a particular member of staff leaving – they were concerned that behaviours had led to this, and would lead to more departures.

The concern related to third party issues reported to the person speaking up, there has been no direct involvement or experience of any of the issues raised by the person speaking up themselves nor did they have any concerns personally.

The member of staff was concerned that there was a pattern of behaviour demonstrated by a Leader/Manager that was leading staff to leave the Trust. The third party has raised the issue with a Senior Manager but felt nothing had substantially changed.

The person speaking up was concerned that a pattern might emerge and lead to more staff leaving.

The case was referred to Human Resources to determine the best course of action - the person speaking up was advised by the Guardian that they would feedback as much they were permitted to, noting third party confidentiality.

The third party via the inroads of an Exit Interview raised their concerns directly and independently of the FTSU concern being raised which were addressed and took the decision to continue with their resignation - but noted they would choose to work for the Trust again in the future.

Action included previous and future exit interview information held for this area of work would continue to be reviewed to identify any trends or themes regarding reasons for leaving. Referral was also made to Organisational Development for any particular interventions that may be appropriate.

A second concern was raised by the person speaking up, in relation to another staff departure – the HR team were immediately able to respond following better implementation of the revised exit interview process via ESR. Monitoring of future exit interviews had been implemented and feedback was given that the issues were not the same nor linked to the Leader/Manager concerned, but that matters would continue to be monitored by way of assurance.

Personal Reflections from Employee:

At the time of speaking up I felt empowered - there was a process that would support me to raise the issues I was concerned about, and could do so in a way that made sure I felt safe – I was worried about the ‘career limiting’ aspects of speaking up. The process was fair and I got interim updates from the Guardian on what they were doing to escalate my concern.

Would you speak up again? At the time of raising the concern, I would have said ‘yes’ I’d speak up again, but I would still do so anonymously, because at the time I would have still been afraid of suffering a detriment. My recent interactions with the Leaders/Managers within the Trust hasn’t been positive – I don’t feel valued and I wouldn’t speak up again – I think it would have a negative impact on my mental health and I don’t believe anything would

change, and doing what's right would be to my detriment. There appears to be a disconnect between what Senior Leaders say in the Trust - the Senior Leaders are people focused, but there's something that isn't filtering through to all areas in terms of culture, and this doesn't create the right environment for staff to feel confident in raising issues.

Do you feel you've suffered a detriment after speaking up? No, because I raised issues anonymously, but I felt if I had spoken up openly I would have experienced a detriment.

Learning identified: That the opportunity for HR Business Partner input worked well in triangulating exit interview information to identify if there were any themes regarding reasons for leaving. The FTSU process was fine and did its job.

The issues raised within this case study at the time of interview are being taken forward in conjunction with the HR Department, and support is being provided to the member of staff. They have requested that their identity remain anonymous but wished for their previous experience of speaking up and more recent experience of culture be shared with the Board.

Committee Chair's Report

Name of Committee/Group:	Quality and Safety Committee		**Report to:**	Board of Directors
Date of Meeting:	22 June 2023		Date of next meeting:	24 August 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 Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer	**In attendance:** Susan Burton, Deputy Chief Nurse Sue Mackie, Director of Quality Governance Amanda Gregory, HR (on behalf of Tania Strong) Andi Sizer, Principal Lead for Public Health Rachel Hall, Head of Research (from item 58/23 to 61/23) Suzanne Taylor, Clinical Audit Facilitator (for item 58/23 to 61/23) Lynda Richardson, Board and Committee Administrator **Observers**: Christine Stankus, Public Governor, Rest of England (from item 46/23)	**Key Members not present**:	**Apologies received from:** Ted Adams, Medical Director Jeanette Hogan, Deputy Chief Nurse Mark Charman, Assistant Director of Transformation Jan McCartney, Trust Secretary

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Deep Dive – District Nursing	2, 3		The Committee received a deep dive report from the Chief Operating Officer. The Committee accepted the deep dive report as assurance that there was a clear understanding of the actions that needed to be taken to address the challenges identified and recognised that the issues would require ongoing monitoring. It was therefore proposed that the Committee would receive further updates until there is an improvement in the level of risk identified in the service.	It was agreed that a report would be presented back to the Committee in October 2023 to demonstrate improvement.

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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

Serious Incidents Compliance Report	2, 3		During April and May 2023, there had been a total of five serious incidents reported with one category three pressure ulcer and four unstageable pressure ulcers. Pressure ulcers continued to be the most frequently reported serious incident within the organisation, however there had been a reduction observed over the past months due to the ongoing work by the operational delivery group focussed on pressure ulcer reduction. There were six open serious incidents reported. There had been one date extension requested for audiology related incidents due to complexity. All serious incidents continued to be reported within the required 48 working hours maintaining the 100% compliance during April and May. During this period, 14 root cause analysis reports were approved and submitted to the ICB. Five of those had been closed pending completion of the action plans, with four reports still to be taken through the ICB's serious incident review group. Feedback would be awaited from that forum. In relation to the action plans, the Trust continued to hold monthly action plan meetings to review the evidence against the actions to ensure that learning was being embedded within practice. For the remaining 17, there were some actions slightly overdue with work ongoing to support the completion of those action plans. The report also included some examples of learning from the Root Cause Analyses as well as project plan information for PSIRF as requested at the last meeting by the Committee.	The Committee noted the contents of the report, that the Trust was currently compliant with all current requirements and was assured that the systems and processes in place continued to effectively manage serious incidents reported within the Trust. A process was also in place for addressing action plans. The Committee acknowledged the progress in relation to the implementation of PSIRF.
Summary Report for Risks Relating to Quality and Safety	2, 3		During April and May 2023, there had been 17 risks in relation to quality and safety during the period. However across both months there were two risks that had passed their review dates. During April, 15 had been reviewed and were all within their dates, with two slightly outside of this and during May, there were 16 in date and one slightly exceeding the	The Committee received the report and agreed that detail should be provided in future reports to explain where risks had passed their target date.

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			review date. As of April and May, of the 17 risks, 15 had not yet reached their target dates. However during May one risk had passed its review date, therefore this would be reviewed to look at the target score and target date to see if this was appropriate. There had been three new risks identified in April: capacity within the District Nursing Service, mandatory training within the District Nursing Service and Dental Services within Greater Manchester. There had been one new risk in May 2023: a lack of assurance in relation to the management of medical gases. The report also provided detailed information in relation to the risks scoring 15 or above. Themes had also been explored in relation to risks with this information being included within the circulated paper. There had been no risks closed during April and May and all of the risks had been assigned a level of assurance. Of all of the risks identified during April and May, all risks were assigned either significant or moderate assurance. The Chief Operating Officer informed the Committee that there was a dental summit taking place on 22 June and all of the risks on the register were being reviewed in relation to dental services, particularly around the Greater Manchester pathway considering the capacity within the network.	The Committee agreed that it was assured that the risks scoring 12 plus in relation to quality and safety were being effectively managed.
Policies, Procedures and Guidelines Position Report	2,3		It was reported that there were currently 261 policies and procedures with 227 in date and 34 out of date. There were 22 out of date with an exception in place, with 12 without an exception form. An update was provided on the documents that did not have an exception in place. Meetings of the Corporate and Clinical Policy Group continued to take place monthly, with the potential to arrange additional meetings if required. The Trust was continuing to manage policies and procedures with a risk included on the risk register (currently owned by the risk team as they oversaw the process, however this would be reviewed). All of the policies, procedures and guidelines across the Trust were allocated to an	The Committee received the report and acknowledged the current position and challenges in relation to the completion of out-of-date policies, procedures and guidelines, the process that was in place to address them, being assured that actions were being undertaken to

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			author who would have responsibility for reviewing and updating any policies, procedures or guidelines. There may be occasions where a policy had not been reviewed within the timeline for a number of reasons, and should this occur, a member of staff would complete an exception report to request an extension to the deadline. As part of this process, it would be expected that a review of any evidence would be undertaken to ensure that the policy was still safe and fit for use and that there had been no changes in practice. Although a policy may lapse and be slightly out of date, the process provided the assurance that a policy was still safe to continue to use.	reduce the number that were outdated. It was agreed that going forwards, the Committee would receive updates as part of the Quality Council report.
Quality Impact Assessment (QIA) Report			During quarter four of 2022/23 there had been a total of two service QIAs undertaken and reviewed at panel. Further information had been requested in relation to both QIAs which were then scheduled for the next panels which took place in April 2023. The Committee noted that 40 schemes were currently listed and noted that it was possible for the frequency of the panels to be increased if required to ensure that the QIAs could be reviewed.	The Committee agreed that it was assured that the Trust had appropriate steps in place to safeguard the quality and safety of patient care when working within business continuity, delivering significant changes to its services by any policy, project or saving scheme that may have an impact on the quality of care provided by the Trust.
IQPR	2, 3, 6		The Committee noted that the majority of indicators were reporting as green, with four indicators reporting as red. Two were in relation to training, with extensive work in progress to improve figures and one new red indicator concerning the total number of falls largely around bed based falls. This was being picked up by patient safety reviews with incidents being monitored closely from an intermediate tier perspective. An improvement had been seen in the number of falls in month.	The Committee received the report for assurance that the quality indicators were being appropriately monitored and noted that the refreshed IQPR, which would include the

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				updated quality indicators, would be taken to the Finance and Performance Committee in July 2023. It was agreed that there was a different way of delivering the quality section of the report and it was acknowledged that this work was in train.
Report from the Quality Council	2, 3		The Committee received the report setting out the key considerations from the Quality Council meeting held in May 2023. The Committee noted that there had been a lower level of feedback from dental services in comparison to other areas and some concerns were raised in relation to this and the need for a deputy to be identified to attend Quality Council meetings. It was suggested that this Committee could receive a deep dive on quality and safety aspects in relation to dental services and clinical leadership. The current position in relation to the lone worker devices within the Trust was noted: whilst progress had been made, there was further work to be undertaken. The Quality Council was asked to continue to keep the Committee updated on the position via the estates update that it received.	The Committee received the report and accepted the update from the Quality Council.
Paediatric Audiology Incident Update	2, 3		The Committee received an update report: of the 48 joint cases between Bridgewater and Warrington and Halton Hospitals (WHH): there were 26 cases with no harms, one case with low harm, 20 cases where the harm had not yet been established and one case where harm had not been determined as the patient was deceased. In terms of the current status of the patients: 13 cases were to be recalled following failure to opt-in or	The Committee was assured in relation to the actions that were being taken to manage the incident. A further update would be provided to the Committee in August 2023.

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			previous discharge from the service, nine cases were current patients of Bridgewater and were receiving appropriate ongoing care with appointments scheduled for June/July 2023, with 22 cases in the same category but with no current appointments booked, three cases had moved out of area and would be followed up by audiology services within their area and one case as described above where the patient was deceased. Terms of reference for a service review had been approved, with the work to be begin week commencing 26 June to start the process. A high level of scrutiny was in place which included weekly meetings with WHH and internal meetings.	
Learning from Deaths	2,3		The Committee considered the content of this report and it was agreed that some further work was required to refine it.	The Committee agreed that the Executive Management Team would be asked to review the report. The Chief Nurse would take this forward and discuss this with the Medical Director.
Quality Accounts 2022/23 – Final Version			The Committee received and approved the Quality Accounts for 2022/23.	This was approved with the caveat that this was an approval of the process for this report: that the report had been taken through the right processes with the right people having had the opportunities to contribute and comment.
Dermatology Update Report	2, 3		The Committee received an update concerning the current position with the service from the Chief Operating Officer.	The Committee acknowledged that there had been significant progress made in terms of

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				recruitment, however the resilience of the service remained challenged, despite the improvements that had been made and a reduction of incidents and risks. The Committee noted that it would receive a further paper to the October Committee, following considerations to be made by the Board in August 2023.
CQC Update Report	2, 3		An update was provided to the Committee concerning the quarterly meetings that the Trust had held with the CQC Relationship Manager. The last meeting that had taken place was held on the 15 May 2023 and those regular meetings formed part of the CQC monitoring processes and provided an opportunity for the Trust to talk about successes, any issues and to provide assurances around any mitigations that were in place. The meeting in May focussed on the Trust strategy which had been approved recently by the Board, with a copy of this being shared with the CQC following the meeting. An update was also provided in relation to industrial action over the quarter, capacity and demand around nursing and actions being taken, as well as an update in relation to Warrington Children's Services. A discussion also took place regarding the new single assessment framework that would be in place later in 2023. The CQC advised that relationship meetings would continue with the Trust on a quarterly basis as ongoing monitoring. The CQC had feedback consistently that the Trust was open and transparent with its information but had also acknowledged that Bridgewater was a low risk organisation because of its transparent approach to sharing information. There were no current concerns that	The Committee received the update for assurance. It noted that the meetings were very much of a supportive and collaborative nature with the CQC.

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			had been raised and there were no current plans for an inspection to take place.	
Trust Improvement Plan Update	2, 3		The Committee noted that there were currently 28 service improvement plans that continued to be monitored and RAG rated on progress via the quality improvement programme. There were 20 new plans added during the reporting period and this followed a series of meetings with all operational leads to review their directorate annual plans and action plans that have been drawn from the 28 improvement plans. Five of the plans had demonstrated positive improvement with an increase in overall blue or green rated actions during the period. One of the plans had shown limited progress, this was due to a minor delay in the completion of a standing operating procedure. Two further plans had demonstrated some progress, but this had not been substantial enough to amend the current RAG ratings.	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.
Report from the Transformation Council			The Committee received a report in relation to the newly established Transformation Council which was currently in a development phase. It was noted that this Council had now been included as part of this Committee's Terms of Reference and Business Cycle as it would report through to this forum. A further update would be provided to the Committee in August.	It was agreed that the Committee would have sight of the terms of reference for the Transformation Council and the interdependencies, recognising that the Council would report into this Committee. This would provide an understanding from a governance perspective as to where the Council fits and the role of this Committee in providing assurance to the Board.

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Committee Chair's Report

Clinical Audit Plan Reassurance Report			The Committee received the reassurance report. This included a flowchart to demonstrate the escalation process for any clinical audits within the Trust as well as the various groups that audits were reported into and where they may be escalated from and the process for monitoring audits.	The Committee Chair asked that the flowchart also included this Committee and its reporting line through to the Audit Committee to set out its responsibilities for providing assurances regarding any quality and safety related audit matters.
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.	
Infection, Prevention and Control (IPC) Strategy	2, 3		The Committee received an update on the refreshed three-year strategy and the progress that had been made.	The Committee received the update for assurance in relation to the work that was taking place implementing the strategy and acknowledged that there was further work to take place on an ongoing basis, continuing over the next two years.
Carer's Plan			An update was received on the carer's plan which was approved last year by the Committee. The plan was a three-year strategy to be implemented and delivered against in relation to commitments to support carers within the organisation.	The Committee received the report which provided assurance that work was progressing in relation to the implementation of the carer's

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				plan. It noted progress made to date and the actions to be taken forward.
Committee Terms of Reference and Business Cycle			The Committee reviewed its Terms of Reference and a number of queries were raised. Those elements would be further considered and discussed during the Committee's pre-meet in July 2023. The Committee discussed its business cycle. It was suggested that the Committee reviewed the amount of business being taken at each meeting as there were some views that the meetings were becoming lengthy, whilst some Committee members considered the agendas to be manageable.	The Terms of Reference would then be updated and circulated via e-governance to Committee members for final approval. Following a discussion at the Committee's July pre-meet, it was agreed that the length of the agendas/meeting duration would be monitored over the next six months.
Board Assurance Framework (BAF)	2,3,6		The Committee considered the Board Assurance Framework. It agreed that there were no changes required to the scoring.	The Chief Nurse reported that she would be meeting with the Trust Secretary and the Chief Operating Officer week commencing 26 June to discuss a number of minor changes and updates required to BAF3. There was no material impact expected in relation to the scoring.
Items for Deep Dive	1, 2, 3, 6		The Committee discussed the items for future deep dive reports.	It was agreed as discussed earlier in the meeting that a report on dental services with considerations in relation to

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				quality and safety impacts would be welcomed. The Clinical Lead would be invited to attend a future meeting to present this report which should also include leadership challenges and the options/solutions for this. This deep dive would be separate to issues within dental services being considered by the Finance and Performance Committee such as waiting lists.
Items to be shared with the Board or other Committees	1		There were no other items to be shared or escalated.	
Review of meeting	1		All participants and observers were invited to comment on the meeting.	
Risks Escalated: **None from this meeting**				

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BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**58/23(i)**		
Report Title	**FINANCE REPORT – MONTH 3 (JUNE 2023)**		
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 three:

- The Trust is reporting a break even position, in line with plan.
- The Trust has a savings requirement of £5.15m (5.2%) in line with ICB instruction.
- The Trust is reporting a year to date achievement of £1.05m against a plan of £1.29m.
- Income is £24.74m year to date against a plan of £23.84m.
- Expenditure is £24.74m year to date against a plan of £23.84m.
- Pay is £15.39m against a plan of £15.88m.
- Agency spend is £1.46m against a plan of £1.06m.
- Non pay expenditure is £7.88m against a plan of £6.77m.
- Capital charges are £0.13m below plan.
- Capital expenditure is £0.27m against a plan of £0m.
- Cash is £21.30m.

The Board is requested to approve the Capital Programme for 2023/24

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	03 August 2023
Agenda Item	58/23(i)		
Report Title	FINANCE REPORT MONTH 3 (JUNE 2023)		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial position as at Month Three To request the Board to approve the Capital Programme for 2023/24		

1. SCOPE

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

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

1.2 The Board is requested to approve the Capital Programme for 2023/24.

2. FINANCIAL POSITION AS AT MONTH THREE

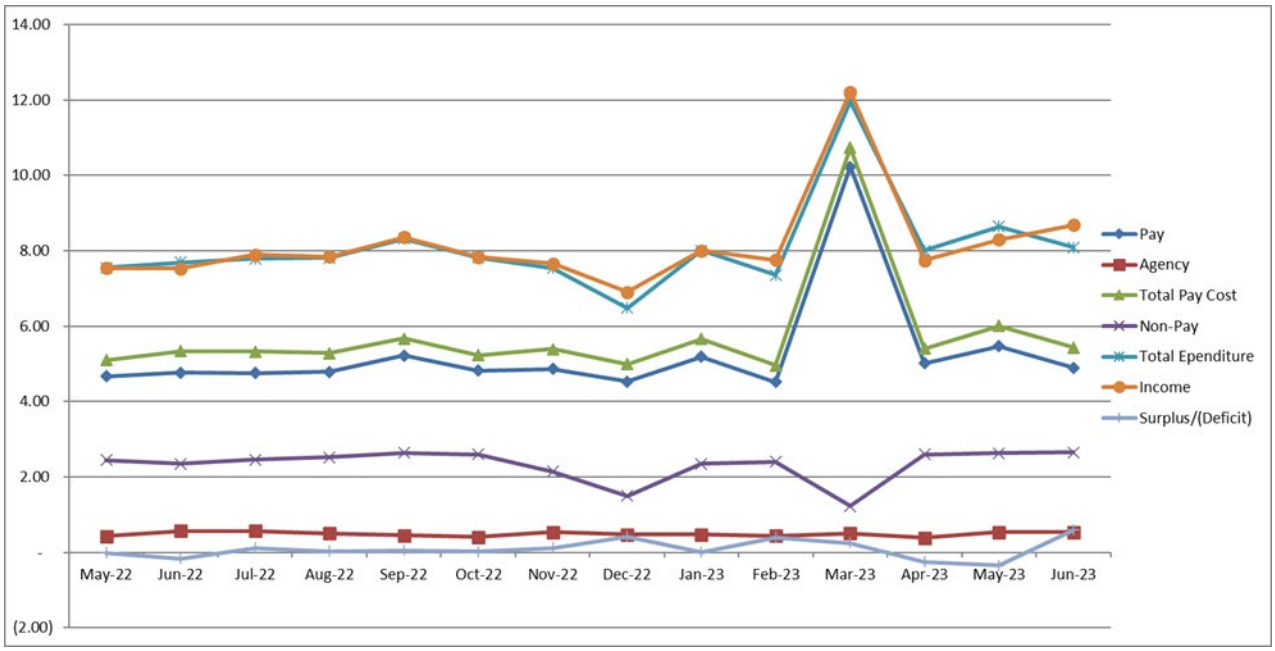
2.1 The key headlines for Month Three are shown in the table below.

Table 1 – Summary of financial performance

Summary Performance Month 03 2023-24	Month 3 Plan (£M)	Month 3 Actual (£M)	Month 3 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.00)	(8.68)	0.69	(23.84)	(24.74)	0.90	(95.83)	(95.83)
Expenditure - Pay	5.34	4.90	0.44	15.88	15.39	0.49	63.95	63.95
Expenditure - Agency	0.35	0.54	(0.18)	1.06	1.46	(0.41)	4.22	4.22
Expenditure - Non Pay	2.26	2.59	(0.33)	6.77	7.88	(1.11)	27.10	27.10
EBITDA	(0.04)	(0.66)	0.62	(0.14)	(0.01)	(0.13)	(0.55)	(0.55)
Financing	0.05	0.07	(0.02)	0.14	0.01	0.13	0.55	0.55
Normalised (Surplus)/Deficit	0.00	(0.60)	0.60	(0.00)	(0.00)	0.00	0.00	0.00
Exceptional Costs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Net (Surplus)/Deficit after Exceptional Items	0.00	(0.60)	0.60	(0.00)	(0.00)	0.00	0.00	0.00
Other Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Adjusted Net (Surplus)/Deficit	0.00	(0.60)	0.60	(0.00)	(0.00)	0.00	0.00	0.00
CIP	0.43	0.62	0.19	1.29	1.05	(0.24)	5.15	5.15
Capital	0.00	(0.05)	0.05	0.00	0.27	(0.27)	2.10	2.10
Cash	24.31	21.30	(3.02)	24.31	21.30	(3.02)	24.65	24.65
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 break even position at month three in line with plan.

Income

- Income was above plan by £0.69m in month, primarily due to recognising income anticipated to fund the 2023/24 pay award.

Pay

- Pay costs are below plan by £0.44m in month three primarily due to the release of a pay provision relating to GPOOH employment claims and vacancies. The 2023/24 pay award has been fully recognised in the actuals.

Agency

- During month three, the Trust has incurred costs of £0.54m against the plan of £0.35m. The month-on-month expenditure has remained the same.

The three services with the highest agency spend both in-month and cumulatively are:

- Dermatology – locum consultants. This is activity driven – the service now has no over 45 week waiters.
- Halton District Nursing – high cost off framework agency use.
- Intermediate Care Bed Based (Padgate House) – high cost off framework agency use.

An Executive led workplan is being produced for 2023/24. The Director of Finance is meeting with members of the Senior Leadership Team to discuss and agree the detailed approach and targets to ensure delivery of the reduction in spend required to meet the submitted plan spend.

- Agency costs incurred in month three equated to 79.52 whole time equivalent staff.

Non Pay

- During month three the Trust has spent £2.59m on non pay, £0.33m 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 are largely offset by additional 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 one off working capital adjustments and the pay award impact, all month three 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 £5.14m (5.2%) in line with ICB instruction, of which £1.50m is covered by working capital adjustments in year.

3.4 The Trust plan to month three is £1.29m, against which achievement of £1.05m is reported. The in-month increase in CIP recorded, primarily relates to working capital adjustments finalised in month 3.

3.5 The Director of Finance is meeting with the Senior Leadership Team to discuss the current planned CIP schemes and opportunities to support identification and delivery of additional savings in year.

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 June was £0.27m against a plan of £nil.

5.2 Bids for Capital prioritisation templates have been received for the majority of capital schemes and the prioritised capital programme is shown at **Appendix 1** together with the list of reserve schemes.

5.3 The proposed capital programme includes a contingency of £0.35m which consists of £0.10m general contingency and £0.25m for schemes which are either awaiting approval through the Trust's governance process or the capital prioritisation template has not yet been received. Should these schemes not progress then schemes on the reserve list will be deployed.

The prioritisation order for schemes is as follows:

1. Schemes brought forward from 2022/23.
2. Locally mandated schemes, i.e., those schemes which must be funded from capital.
3. Business critical schemes, i.e., schemes which are critical to service delivery.
4. Risk score order.

5.4 The proposed capital programme includes a contingency of £0.35m which consists of £0.10m general contingency and £0.25m for schemes which are either awaiting approval through the Trust's governance process or the capital prioritisation template has not yet been received. Should these schemes not progress then schemes on the reserve list will be deployed.

5.5 The Finance and Performance Committee have reviewed the proposed capital programme and have recommended the programme to the Board for approval. Once approval is received from Trust Board, schemes will go through Procurement and expected completion dates confirmed.

5.6 Whilst schemes will be under monthly review via Capital Council, any schemes not progressed by October 2023 will have approval rescinded and schemes from the reserve list will take their place. This to ensure that capital is spent on a timely and appropriate basis.

5.7 In June 2023 there was a net cash outflow of £0.12m with a closing cash balance of £21.30m. The outflow is due to the backdated pay award for 2023/24 and larger than usual payment runs as the Finance team continue to clear old invoices.

5.8 Total debt as at 30th June is £9.43m excluding bad debt and credit note provisions, of which £4.56m relates to invoiced debt. Overall debt has decreased by £0.98m from May, overdue debt has decreased by £0.46m.

5.9 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
May-23	95	99.3	99.4
Jun-23	95	98.9	99.8
Year to date performance	95	99.2	99.7

5.10 NHSE 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.
- Approve the capital programme for 2023/24.

Appendices

1. Proposed Capital Programme 2023/24

Appendix 1 – Proposed 23/24 Capital Programme

Project Description	Coding	A2 code	Prioritisation risk	PLAN - (23/24) £	Expected Completion date	Scheme RAG rating	YTD Actual - M3 (23/24) £
22/23 Schemes	*Various*	*Various*					*5,328.08*
Air Conditioning at Fountains Dental Clinic	000000.0041.00080		B/F 22/23	36,420.00			0.00
Europa Point Flooring phase 2	000000.0041.00080		B/F 22/23	26,683.20			0.00
Spencer House fit out	000000.0041.00080		Locally mandated	256,000.00			256,000.00
Green action plan	000000.0041.00080		Locally mandated	120,000.00			0.00
Europa Point reconfiguration	000000.0041.00080		Locally mandated	360,000.00			0.00
Replace flooring in waiting room Kingsgate	000000.0041.00080		260	20,000.00			0.00
Total Premises Schemes				**819,103.20**			**261,328.08**
22/23 Schemes	*Various*	*Various*					*(6,338.71)*
Telephony SIP gateways	000000.0111.00080		Business critical	27,588.67			0.00
IT deployment resources	000000.0111.00080		360	64,800.00			0.00
Total IT Schemes				**92,388.67**			**(6,338.71)**
22/23 Schemes	*Various*	*Various*					*(1,184.00)*
Ashton PCC - Bariatric dental chair	000000.0131.00080	S4835	B/F 22/23	17,217.60			17,217.60

Project Description	Coding	A2 code	Prioritisation risk	PLAN - (23/24) £	Expected Completion date	Scheme RAG rating	YTD Actual - M3 (23/24) £
Ashton PCC - 6x intra oral x-ray machines	000000.0131.00080	S4838	B/F 22/23	20,000.00			0.00
CES - Floor scrubber, fork lift truck, and wave machine	000000.0131.00080	S4841	B/F 22/23	8,189.40			0.00
CES - Unitech handheld system and inventory sign in and out system	000000.0131.00080		Business critical	10,756.20			0.00
Replacement Intra-oral imaging scanner CS7600 - Moorgate PCC	000000.0131.00080		450	6,048.00			0.00
CES decontamination and Brysdales storage	000000.0131.00080		440	15,948.00			0.00
Point of care testing machine for Widnes UTC	000000.0131.00080		440	22,800.00			0.00
Bariatric Adec 500B dental chair - Moorgate PCC Bury	000000.0131.00080		420	34,628.40			0.00
Fountains - replacement OPG machine	000000.0131.00080		410	34,908.00			0.00
2 Bariatric plinths and portable slings and hoists for Halton treatment rooms	000000.0131.00080		380	11,507.35			0.00
Paediatric resus trolley for Widnes UTC	000000.0131.00080		380	5,587.60			0.00
OPG Xray machine - Nye Bevan House Rochdale	000000.0131.00080		360	17,267.40			0.00
Replacement washer disinfector at Hallwood HC	000000.0131.00080		360	16,775.35			0.00
Dene Drive - replacement intra oral x-ray machine	000000.0131.00080		360	9,900.00			0.00
2 x replacement Eschmann Little Sister SES 3000B 17 Litre B type vacuum Autoclaves - Union Street Hyde	000000.0131.00080		340	9,363.60			0.00

Project Description	Coding	A2 code	Prioritisation risk	PLAN - (23/24) £	Expected Completion date	Scheme RAG rating	YTD Actual - M3 (23/24) £
Halton Paediatric Audiology equipment	000000.0131.00080		Business critical	56,130.84			0.00
Replacement Dental chair in surgery 4 Bath St HWBC Warrington	000000.0131.00080		280	27,600.00			0.00
Replacement Dental chair in surgery 1 Ashfields Sandbach	000000.0131.00080		280	27,600.00			0.00
Bladder Scanners - Halton & Warrington	000000.0131.00080		Business critical	70,394.22			0.00
Total Equipment Schemes				**422,621.96**			**16,033.60**
22/23 Schemes	*Various*	*Various*					
New staff extranet	000000.0541.00080		B/F 22/23	30,000.00			0.00
Dentally EPR system	000000.0541.00080		Business critical	387,000.00			0.00
Total Intangibles Schemes				**417,000.00**			**0.00**
Contingency	TBC	TBC		348,886.17			0.00
Total Contingency				**348,886.17**			**0.00**
TOTAL CAPITAL SPEND				**2,100,000.00**			**271,022.97**

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**58/23ii**		
Report Title	**2022-23 ADAPTIVE RESERVE UPDATE**		
Executive Lead	Nick Gallagher – Executive Director of Finance		
Report Author	Nick Gallagher – Executive 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 the utilisation of the 2022-23 Adaptive Reserve funds.

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.

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☒ **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**	**03 August 2023**
Agenda Item	**58/23ii**		
Report Title	**2022-23 ADAPTIVE RESERVE UPDATE**		
Report Author	Nick Gallagher – Executive Director of Finance		
Purpose	To brief the Board on the utilisation of the 2022-23 Adaptive Reserve funds.		

1. SCOPE

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

- Background around fund purpose,
- How the 2022-23 Adaptive Reserve funding was utilised across the system.

2. BACKGROUND

2.1 The Board considered a paper in April 2022 requesting approval to invest into a Warrington System Adaptive Reserve Fund. The Board paper describing the purpose and potential use of this fund is attached as Appendix 1.

2.2 The Board approved an investment of £250k in April 2022.

2.3 The total funds available to the system was £2,606k. See breakdown of funding sources below.

Funding Sources	£
Warrington CCG	1,056,156
Warrington and Halton NHSFT	1,000,000
Bridgewater	250,000
Warrington Borough Council	300,000
Total	**2,606,156**

3. 2022-23 FUND UTILISATION

3.1 Warrington System Sustainability Group (WSSG), with representation from Warrington Place (ICS), Warrington and Halton Hospital NHSFT, Warrington Borough Council and Bridgewater, is the group deciding collectively on the utilisation of the fund. The table below shows the breakdown of the fund utilisation.

Scheme description	Organisation/Host	£	22/23 Total Spend £	Carry Forward into 23/24 £
WHHT Supporting Discharge	WHHT	(370,000)	(14,486)	(355,515)
WBC - Intermediate Care Hours (Part Year)	WBC	(530,208)	(530,208)	0
WBC - Dom Care	WBC	(300,000)	(300,000)	0
Bridgewater - Equipment	BW	(295,000)	(147,500)	(147,500)
WBC - Hospital Discharge Programme Manager	WHHT	(56,000)	(30,300)	(25,700)
Ward B4 Additional Capacity	WHHT	(700,000)	(700,000)	0
Primary Care Support	ICB / PCN	(100,000)	(100,000)	0
Voluntary Sector Proposal	ICB / WVA	(42,000)	(42,000)	0
Extension of Falls Response Service	WHHT	(80,000)	0	(80,000)
Workforce Development Officer	WBC	(80,000)	(15,000)	(65,000)
Additional capacity over the Bank Holiday weekend	ICB / Quay Healthcare	(3,000)	(3,000)	0
Balance unallocated		(49,948)	0	(49,948)
Total		**(2,606,156)**	**(1,882,494)**	**(723,663)**

3.2 It should be noted that the Trust invested £250k into the fund and was successful in being allocated £295k to fund the extension of some services within the community equipment store.

3.3 As at the end of 2022-23, the Trust had spent £148k of the agreed allocation, with the remaining balance available to spend in 2023-24. The balance should allow the service extension to continue to operate for the first six months of 2023-24. Commissioners have recognised that the extended service is likely to be required beyond this point and have indicated that funding would be a priority from a 2023-24 Adaptive Reserve, if available.

4. 2023-24 ADAPTIVE RESERVE FUND

4.1 Warrington System discussions are ongoing regarding the creation of a 2023-24 Adaptive Reserve fund. The Trust has £250,000 ear marked for this fund, but the Trust is awaiting full details on the 2023-24 proposal for consideration.

5. RECOMMENDATIONS

5.1 The Board is asked to:

- note the contents of this report,
- and the future potential ask for investment in a 2023-24 Adaptive Reserve fund.

Appendix 1

Title	Warrington Wider System Sustainability Group – Supporting Discharge Mandate
Author	Sarah Quinn, Chief Operating Officer
Date	25th April 2022
Purpose	This paper aims to inform the Board of the opportunity to support the programmes being undertaken by the Warrington Wider System Sustainability Group.
Audience	Board

1.0 EXECUTIVE SUMMARY

1.1 This paper aims to inform the Board of the opportunity to support the programmes being undertaken by the Warrington Wider System Sustainability Group.

1.2 The group is working together to develop an Adaptive Reserve Fund to pump prime schemes that will improve patient discharge.

1.3 The Trust would like to invest £250,000 in the scheme.

1.4 The Board are asked to approve the investment of £250,000 into the reserve.

2.0 BACKGROUND / CONTEXT

2.1 Health and Care leaders in Warrington have a strong partnership and shared vision: "a philosophy of Home First and Home is best approach - supporting people to live well and independently at home" and a recognition that by working together as a system on this aim, we can:

- Keep people independent and well for longer
- Better manage demand and flow both in and out of the hospital
- Manage current and future cost effectively

2.2 Warrington has historically had a significant number of patients who experience a delayed discharge, often following a prolonged stay in hospital with a length of stay of 21 days or more.

2.3 During the COVID pandemic, problems in relation to long length of stay have been exacerbated and it has been recognised that transformational work needs to be undertaken to reshape existing services both in the hospital and the community to identify gaps in provision which potentially require additional capacity to address.

2.4 To manage this, it was suggested that system partners would each financially contribute to an adaptive reserve fund to enable transformational work to be undertaken and to potentially fund cost pressures of running existing services whilst undertaking service transformation.

2.5 In order to set out how partners would work together a mandate was developed by members of the Warrington System Sustainability group. The group consists of representatives from Health and Social Care providers in Warrington including Warrington Borough Council (WBC), Warrington and Halton Hospitals, Warrington Clinical Commissioning Group (CCG) and the Trust.

3.0 MANDATE AND CONTRIBUTION

3.1 The mandate is embedded below.

PROGRAMME MANDATE.doc

3.2 Contributions from the provider organisations have been proposed as follows:

- WHH - £1 million
- Warrington CCG - £1.05 million
- WBC - £300k
- Bridgewater £250k

Therefore totalling £2.6 million.

3.3 WHH, WBC and Warrington CCG have confirmed their contributions via their relevant governance processes and now await a decision by the Trust.

4.0 PROPOSED AREAS FOR INVESTMENT

4.1 There are several areas which have already been identified for consideration where gaps in existing services have been recognised and these are:

- ICAHT including D2A – step up and step down.
- Independent Domiciliary Care Provision
- Transitional step up and step-down bed capacity
- Enhanced Urgent Community Response Service
- Enhanced Integrated Hospital Discharge Model
- Community Equipment Store

These are only initial ideas and will need to be discussed further and developed.

4.2 All areas will be reviewed, and business cases developed to request funding from the adaptive reserve monies and the options will be discussed at the Wider System Sustainability Group meetings where all organisations are represented, and all business cases will be subject to approval by all organisations.

4.3 The focus for the adaptive reserve monies will be service transformation to enable recurrent system spending to deliver more connected and cost-effective services and to reduce the number of people requiring hospital admission or to reduce the length of stay for patients who are admitted. The monies will not be used to fund gaps in currently commissioned services.

4.4 The aspiration for this work undertaken would be that the number of people in beds at WHH could be reduced by 25 patients and therefore deliver the ability to close one hospital ward. This would act as the pilot project which could be scaled up to eventually

result in the closure of four hospital wards to 'right size' the hospital to support the bid for new hospital monies.

5.0 OPTIONS

Option	Benefits	Risks
Option 1 – Do Nothing	• No financial investment required	• Organisation viewed as not engaged which could be reputationally damaging. • Additional funding available is not received by the Trust
Option 2 – Invest the £250k	• Opportunity to seek additional monies to fund service developments. • Reputationally beneficial • Test ability to work closely with system partners	• Financial impact of investing monies which may not be reinvested into the Trust. • Mandate does not deliver additionality. • Potential additional recurrent cost pressures

6.0 Recommendations

The Board are asked to:

- Accept the contents of the paper.
- Approve option 2 to invest £250k into the Adaptive Reserve Fund

Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	**Audit Committee - Extraordinary**		**Report to:**	**Board of Directors**
Date of Meeting:	28 June 2023		Date of next meeting:	26 July 2023
Chair:	Linda Chivers, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers, Committee Chair Dame Elaine Inglesby, Non-Executive Director Gail Briers, Non-Executive Director Martyn Taylor, Non-Executive Director Tina Wilkins, Non-Executive Director	**In Attendance & Observers:** Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Louise Thornton, Senior Financial Accountant Sarah Brennan, Chief Operating Officer Jan McCartney, Trust Secretary Samantha Scholes, Head of Corporate Governance James Boyle, Director, Public Sector Audit, KPMG John Blewett, Manager, KPMG Gary Baines, MIAA Audit Engagement Manager **Observers** Bill Harrison, Governor Andrew Mortimer, Governor	**Key Members not present**:	**Apologies received from:** Abdul Siddique, Non-Executive Director Lynne Carter, Deputy Chief Executive / Chief Nurse

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

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

Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Mersey Internal Audit Agency - Final Head of Internal Audit Opinion	1,8		The Committee received the final Head of Internal Audit Opinion which had not changed since the draft report received by the Audit Committee in April. The overall for the period 1st April 2022 to 31st March 2023 provided robust Substantial Assurance; that there was a good system of internal control designed to meet the organisation's objectives; and that controls were generally being applied consistently. The Trust had taken into account recommendations on the timescales for audits and although some had delays, all extensions had been approved by the Committee and were fully justified. Thanks was passed to all teams for taking the recommendations from MIAA and implementing them at pace.	The Committee received the report and informed the Board of the HOIA Substantial Assurance opinion.
External Auditors Findings Report / ISA260 & Final Management Letter of Representation	1,4		Confirmation was received from KPMG that the auditors completed the audit of the accounts of the Trust for the year ended 31 March 2023 with an unmodified unqualified opinion and conclusion on VFM that no significant weakness had been identified. The audit had been carried out within the timescales to meet the national submission deadline. The Management Representation Letter followed the standard template, with only one additional clause. James Boyle, Director, Public Sector Audit, reflected that the audit work had been smooth and thanked the teams for their cooperation and hard work. John Blewett, Manager, took the Committee through the details of the ISA 260 report, referring to Significant risks and other audit risks and outlined the assurance received or recommendations provided.	The Committee received the documents and approved the opinions for information and the Management Representation Letter for recommendation to the Board.

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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

			The Annual Report had been reviewed and compliance checked against the requirements and relevant parts of the Remuneration Report had been audited with no issues identified. The Value for Money report had been audited with no significant risk and no significant weaknesses identified. All recommendations were detailed in Appendix 2 of the ISA 260 report. There were no priority one recommendations and management responses had been included along with a summary of the recommendations from the previous years. Appendix 3 – Audit Differences. The audit did not identify any misstatements greater than £100k that management had adjusted. A number of presentational adjustments were identified, which had been adjusted. The Committee Chair noted the additional fee of £5k for the External Audit and reminded the Committee that the Trust was selected for additional sample component procedures this year for which KPMG charged an additional £5k. James Boyle advised that the Auditor's Annual Report 2022-23, provided a summary of the findings and key issues arising from the 2022-23 audit of the Trust and was required to be published by the Trust alongside the annual report and accounts. James Boyle further referred to the Financial Statements Opinion and Management Representation Letter, these were standard templates for sign off respectively from External Audit and the Trust, with an addition of one clause regarding leases in the Management Representation Letter. The Committee Chair reiterated that she was delighted with the unqualified opinion on the Trust's financial statements.	

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			She observed that it had been a complicated audit process requiring very intense effort from both the auditors and finance team and thanked all involved for all their hard work.	
Review of audited annual accounts and financial statements to include the Annual Governance Report	1,4		**(i) 2022-23 Annual Accounts** The draft Annual Accounts document had been reviewed multiple times, and changes were listed in a detailed log, however there were no changes to the significant major targets and numbers of the financial statements. Attention was brought to Note 28, Adjusted financial performance (control total basis), which contained explanation regarding adjusted surplus figures. There had been minor changes to the Financial Statements originally provided as a result of work with KPMG, namely addition of a paragraph on page 3 to accounting officer responsibilities statement, Note 28 – reference to Monitor changed to NHSE and a couple of changes to figures and narrative in Note 16 – Inventories. The Director of Finance and Committee Chair asked the Chief Operating Officer, who was present at the meeting, to pass on the Committee's thanks to all teams for their contribution to achieving compliance with the audit process. **(ii) 2022-23 Annual Report and Annual Governance Statement** All changes to the document, made since the Committee's last review, were listed in a detailed log of changes. Most of the updates resulted from KPMG review and there were also some updates to Board Profiles. The Trust Secretary informed that since the issue of the agenda to the Audit Committee, an additional paragraph was proposed to be added to the Opening Statement from the Chair and Chief Executive Officer, paying tribute to the two Governors who recently passed away. The	The Committee received the Annual Accounts. Including the minor changes, the document was signed off and approved for recommendation to the Board. With the addition of the tribute paragraph, the Annual Report was signed off and recommended to the Trust Board for final approval

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Committee Chair's Report

			suggestion was strongly supported by the Chair and the Chief Executive Officer and suitable wording has been agreed. The addition was this paragraph had been observed by the KPMG, who were satisfied that this was the only addition to the Annual Report post KPMG review. The Committee Chair was pleased to note that this tribute to the late Governors was prominently placed in the Opening Statement of the Annual Report, rather than in any other section of the report. She thanked the KPMG for checking the report and allowing this addition at this late stage.	
Review of the meeting	1		There was general agreement the meeting had been effective.	
Risks Escalated: None from the meeting				

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	Audit Committee		Report to:	Board of Directors
Date of Meeting:	6 July 2023		Date of next meeting:	12 October 2023
Chair:	Linda Chivers, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers, Committee Chair 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 Lynne Carter, Chief Nurse / Deputy Chief Executive Nick Gallagher, Director of Finance Rachel Hurst, Deputy Director of Finance Jan McCartney, Trust Secretary Louise Thornton, Senior Financial Accountant 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 Adam Lyon, KPMG **Observers** Bill Harrison, Governor Andrew Mortimer, Governor	**Key Members not present**:	**Apologies received from:** Gail Briers, Non-Executive Director Debbie Weir, Financial Controller John Blewett, Audit Manager, KPMG

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
e- Governance Freedom To Speak Up (FTSU) Policy	1		Confirmation was received that the revised FTSU Policy had been approved by e-Governance.	Assurance received.
Audit Committee Terms of Reference	1		The Committee considered 3 minor changes to the Terms of Reference, which were approved and they is recommended to the Board for approval	The Terms of Reference are provided to the Trust Board for approval.
Review of Committee Business Cycle	1		The Committee considered a number of proposed changes to the Business Cycle. The changes were approved.	Assurance received.
Well Led Action Plan monitoring	1		The Committee received a report outlining the process to be implemented in delivering against the 9 accepted recommendations from the Facere Melius review. Recommendations have been assigned to an Executive Sponsor and Board Committee. Executive Sponsors are identifying appropriate deliverables and success criteria and a further report outlining these will be provided to the October Audit Committee. Committee Chairs agreed to take oversight of their Committee specific actions in addition to ensuring each action had an appropriate time scale for delivery set.	Assurance received.
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.	Assurance received

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			It was noted that a refreshed BAF would be available to the October Board following the acceptance of revised Strategic Objectives and the work undertaken on Risk Appetite. As the October meeting will be prior to the next Audit Committee, The Cahir of the Audit Committee and Martyn Taylor agreed to review the new BAF against the existing BAF to ensure there were no gaps or elements lost in the transition In relation to BAF1 it was agreed to add the Head of Internal Audit and External Audit Opinions to the controls and assurances and to update the rationale for the current score to reflect the position with the Facere Melius Well Led review. 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 provided good assurance.	
Registers of Interests	1, 4		The Committee received updates on the declarations of interest from Directors, Governors and decision-making staff and agreed the registers could be published. It was noted that for the first time the Trust has achieved 100% compliance from staff required to submit a declaration.	Assurance received.
Review of Losses, Special Payments and Waivers	1,4		Proposed bad debt write offs totalling £680.71 were noted and assurance received that all possible recovery options had been exhausted. It was noted there had been 1 Special Payment of £350 in the quarter. The Committee were assured that due process had been followed for all 8 waivers, which were documented.	Assurance received.

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Committee Chair's Report

Mersey Internal Audit Agency Progress Report	1,8		The Committee received assurance that the Internal Audit Programme was progressing to plan, albeit it was early in the financial year. The Committee noted the completion of the Data Security and Protection Toolkit (DSPT) review since its last meetings and were delighted to note the Substantial level of Assurance provided. Tribute was paid to the leadership of this work by the Trust Secretary, and it was noted there were a number of areas of good practice identified.	Assurance received. The Assurance level for the DSPT audit will be added to the BAF 8
MIAA Anti-Fraud Progress report	1,4		The Committee received the regular progress report. It was noted that the Trust's Annual Counter Fraud Functional Standards return had been submitted by the set deadline. A Green rating had been achieved across the 12 components. It was noted that as always this was a comprehensive report on the work undertaken. The work undertaken by Rachel Hurst, Deputy Director of Finance, and Fraud Champion, and Debbie Weir, Financial Controller was highlighted and acknowledged.	Assurance received
External Audit progress report	1,4		Confirmation was received from KPMG that all submissions relating to the Year End accounts had been made in advance of the national deadline.	Assurance received
Review of the meeting	1		There was general agreement the meeting had been effective.	
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:	26 July 2023		Date of next meeting:	12 October 2023
Chair:	Linda Chivers		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers – Non-Executive Director Gail Briers – Non-Executive Director Dame Elaine Inglesby – Non-Executive Director Martyn Taylor – Non-Executive Director Tina Wilkins – Non-Executive Director	**In Attendance & Observers:** Nick Gallagher – Director of Finance Rachel Hurst - Deputy Director of Finance Sarah Davies - Procurement Lead Bill Harrison – Public Governor Andrew Mortimer – Public Governor	**Key Members not present**:	**Apologies received from:** No apologies received. Not present Abdul Siddique – Non-Executive Director

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
Procurement Process for External Audit 23/24 onwards	1,4		The Committee met to consider the process to be applied in going out to procure external audit provision for 2023/2024 and onwards as delegated by the Council of Governors. This was as a result of the decision by KPMG, the incumbent External Auditors to only accept a one year extension of their contract for the financial year 2022/2023. A small working group consisting of the Audit Chair, Finance and Performance Chair and Senior Independent Governor along with the Director of Finance, Deputy Director of Finance and Procurement Lead had met previously to consider the various framework options. From these discussions a recommendation was made by the Director of Finance to go to a procurement using the CCS (Crown Commercial) Framework. Although the route to procurement for this Framework is a Mini Comp only it was confirmed that should only one supplier express	The Committee agreed that to go through a procurement exercise would demonstrate good governance had been applied and although there is a risk that there may be little or no interest the timeframe would still allow the Trust to consider alternative provision.

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			interest a direct award could be made if the Trust was happy with the offer. After discussing the rationale for the recommendation and the alternative of KPMG for a further one year at the current fee level plus inflation the Committee agreed to go through a procurement process as recommended. The Board should note KPMG are included on the CCS Framework so would be eligible to express and interest in the contract should they wish. The draft specification and timeframe were also shared and accepted. It is anticipated that if the timetable pans out that an appointment may be made in early November which would allow any new external auditor to start working with the Trust well in advance of the year end. The Committee will monitor the procurement process and convene at a further additional meeting to evaluate bids in order to make a recommendation to the Council of Governors.	
Risks Escalated: There is a risk that Trust may not receive any Expressions of Interest but this should be mitigated by both the timeframe established and the strong financial position the Trust is currently in.				

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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	Finance and Performance Committee		**Report to:**	Board of Directors
Date of Meeting:	20 July 2023		Date of next meeting:	21 September 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 Linda Chivers, Non-Executive Director Martyn Taylor, Non-Executive Director Sarah Brennan, Chief Operating Officer Nick Gallagher, Director of Finance	**In Attendance & Observers:** Lynne Carter, Chief Nurse John Morris, Deputy Director of Transformation/Estates Mark Charman, Assistant Director of Transformation Dave Smith, Assistant Director of IT Gareth Pugh, Assistant Director of Finance Debbie Weir, Financial Controller Barry Hutton, Associate Director (Dental Network) Jan McCartney, Trust Secretary Samantha Scholes, Head of Corporate Governance Andrew Mortimer, Governor Observer Anna Millican, Operations Business Manager – Graduate	**Key Members not present**:	**Apologies received from:** Rachel Hurst, Deputy Director of Finance Eugene Lavan, Deputy Chief Operating Officer Anita Buckley, Information Team Peter Hollett, Governor Observer

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
Finance	4		Month 3 finance report received and provided assurance. The Committee noted that: • Month 3 23/24 is breakeven and on plan • CIP remains behind plan	The Committee noted the financial position is back on plan. The Committee noted that the identified CIP remains behind plan, although performance to date has improved. The Committee were

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			• BPPC remains above target • Healthy cash position, reduction in month but expected to increase again in coming months as income received back from ICS • Capital programme over subscribed, plan for 23/24 included in paper for Committee approval and recommendation to Board.	informed that the Director of Finance was meeting with the Senior Leadership Team to offer a range of additional support and advice to help improve the CIP identified to date. The Committee noted agency spend. The top three spend areas remain the same. The Committee acknowledged the actions taken to date and planned. The Committee requested more detail to be provided prior to the next Committee meeting that clearly sets out that, existing processes are being followed, all options are being considered prior to engaging agency staff, and the plans to reduce spend. Future finance reports will contain extended information on agency spend reduction performance. The Committee noted the capital position, the 23/24 plan and agreed to recommend the plan to the Board for formal approval. The Committee recommended the financial report to the Board.
Finance	4		Chair's report from CIP Council was received.	The Committee noted the report and performance to end of month 2. The CIP identified has been split into schemes, recognising recurrent and non-recurrent savings. The total savings plan for 23/24 are behind target, although there have been more savings identified in month 4 that need to be fully assessed and confirmed.

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				The Committee requested that the Council focus on finalising and ensuring schemes identified are delivering or are going to deliver in 23/24, and schemes for future years are progressed once this has been completed. The Committee agreed that it would have a deep dive into CIP at the September meeting.
Performance	4,8		Dental Deep Dive paper presented to Committee	A paper was presented that detailed an analysis of capacity and demand across all the dentistry areas. The paper articulated the current pressures, the key drivers and the range of activities that were being deployed to manage these issues, eg designing a career framework that is aligned to the dental strategy. However, the paper clearly set out that the impact of the issues surrounding high street dentistry are beyond our immediate control and will require that we work closer with, and take a leadership role, with commissioners to identify and implement solutions / mitigations. The Committee acknowledged the quality and content of the paper, and were concerned that the timing of system wide discussions was critical in addressing current pressures and needed to be actioned as soon as possible. The Committee noted that the Quality and Safety Committee were having a deep dive review for dental services.

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Committee Chair's Report

Performance	4,8		IQPR for month 2 was received by the Committee.	The Committee noted the report. Operations – 13 green indicators and 6 red indicators. 4 of the 6 red indicators have shown an improvement in performance. There is 1 red indicator related to cancer performance which was due to 4 breaches, 2 patient choice, 1 service breach and 1 that required additional histology testing. There has been a significant improvement in the RTT performance and the patients waiting under 18 weeks which has increased from 58.57% to 67.55% largely due to an improved performance in the dermatology service. There are still a number of breaches in the audiology service, but the team are being supported and this is already showing an improvement in performance. From a quality perspective there are 5 red indicators, 2 new in month. 1 relating to duty of candour and 1 relating to an increase in the % of high risks which is due to an increased number of risks in children's services. Compliance with safeguarding level 3 adults training has increased. From a people perspective, rolling turnover has increased from 12.66% to 14.67% but there are improvements in sickness both rolling and actual and PPDR compliance.

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Committee Chair's Report

Performance	4,8		IQPR – new proposed format	The new indicators were presented to the Committee. It was recognised that this was a journey that we were on and the new indicators may need to be further amended in the future. The Committee is recommending that the Trust incorporate the changes to the indicators, to the Board and also requests that each committee reviews the section relating to their area of responsibility.
Performance	4,8		The Chair's report from Performance Council for month 02 was received.	The Committee noted the report. The Committee commented that the report format was really helpful and informative. The Committee noted that there was a deep dive into Nursing presented to the Quality and Safety Committee in month 3
Performance	4,8		Drive Ability North West	The Committee received an update report detailing the process and progress to date in developing a financial sustainable model. The Committee was informed that EMT were awaiting additional information in order to make a formal decision on the future provision of this service. The Committee will receive the outcome

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				and detail of this decision as soon as it is completed.
Digital	8		Chair's report from DIGIT	The Committee received the report. The Committee reminded the DIGIT Chair to ensure that the Patient Safety Information Reporting Framework software provision was included on DIGIT's agenda.
Digital	8		Annual SIRO Report	The Committee received the 22/23 SIRO report on the activities performed and reported at DIGIT. The Committee requested that the DSPT assurance level be reflected in the report.
Estates	4		Estates Update	The Committee received the estates update report. It was noted that the Trust had been successful in its legal case with the landlord at Irwin Road. This has resulted in the Trust being reimbursed for all associated legal costs and a formal public apology from the landlord.
Estates	4		Green Plan update	The Committee received an update on progress against the green plan.
Audit	4		MIAA and KPMG Audit recommendations	The Committee noted the report.

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				The Committee agreed to recommend to Audit Committee to accept the requested extension to the completion dates to the end of December 2023 for IT Cyber security (recommendation 2 and 4) The Committee requested a short paper on the use of credit note and/or bad debt write off processes for debtors cleared in 2022/23.
Risks	4		Risk paper	The Committee noted the report.
BAF	4,7,8		BAF 4 BAF 7 BAF 8	The Committee requested that the narrative in the GAP section of BAF 4 be reviewed and updated. Risk rating unchanged No changes identified. Risk rating unchanged DSPT assurance level to be added. Risk rating unchanged
Governance	4,7,8		Terms of Reference	Minor amendments to Terms of Reference agreed. The Committee noted that the Quality and Safety Committee will be considering where the Transformation Council will report in to. This may require a change to the Terms of Reference.

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Committee Chair's Report

			Review of meeting	All Committee Terms of Reference may need to be amended to include Health Equity considerations. It was recognised that 'the meeting was focussed and detailed and the level of scrutiny and discussion was impressive'
Risks Escalated: None from the meeting **Actions delegated to other Committees: IQPR – new proposed format – each committee review the proposed indicators that they are responsible for.** **Nothing delegated**				

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BOARD OF DIRECTORS

Bridgewater Community Healthcare NHS Foundation Trust

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**59/23**		
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	03 August 2023
Agenda Item	59/23		
Report Title	INTEGRATION & 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

1.1.1 The recruitment to the independent chair of the Warrington Together Partnership Board has been delayed as the scheduled interviews had to be cancelled. This will be progressed once the interviews can be rearranged.

1.1.2 Warrington Together is currently reviewing the roles which support the Partnership and considering what these will look like moving forward, now that the Partnership Board is established.

1.1.3 Interdigitate who have been commissioned to develop the Workforce Strategy for Warrington Place presented to the Partnership Board in June some of their initial findings and they will now consider the actions which they will take forward in conjunction with the

1.1.4 The Trust has continued to support the work of all of the 'Wells' and the Chief Operating Officer and the Associate Director for Integration (WHTH and Warrington Borough Council) jointly presented the work being undertaken around Ageing Well at the June Partnership Board.

1.1.5 Meetings of the System Sustainability Group have continued, and a modelling exercise has been presented to the group to consider how we could support flow from Warrington and Halton Teaching Hospitals (WHTH).

1.1.6 The Director of Collaboration and Integration will present the Trust Strategy 'Communities Matter' to the Partnership Board in August.

1.2 One Halton update

1.2.1 Following on from previously reported revisions to the One Halton governance structures, the partnership has continued to focus on developing and driving forward the priority workstreams.

1.2.2 These priority workstreams align to the Starting Well, Living Well and Ageing Well programmes. Underpinning projects include the development and launch of Family Hubs (with Halton one of 75 national accelerator areas), the Integrated Neighbourhood Model, a focus on loneliness, as well as a wider, cross-cutting approach to population engagement (project list not exhaustive).

1.2.3 Projects are at varying levels of development, but with the revised governance established and SRO leads identified, the partnership aims to build momentum into the delivery and impact of the schemes. A critical component of this is securing a Programme Management Office to support all projects.

1.2.4 Halton undertook its regular quarterly review meeting with the Cheshire & Merseyside ICS team on 27th June. The key lines of enquiry focused on place-based Finance & Planning (financial position and financial frameworks), Children's services (key challenges and plans to address), Inspection processes (system readiness), Population Health (ambitions and progress of locality working) and place Leadership and maturity (approach and permissions).

1.2.5 The focus for the next review meeting will include primary care networks and care communities.

1.2.6 Finally, as part of the recent C&M Transformation Fund bidding round, Bridgewater were a named partner on a submitted bid, led by the two Primary Care Networks (PCNs) in Halton. The focus of the bid was on same day urgent care and an ambition for a more joined up primary care approach. If successful, this project will further support our integrated working approach with local general practice and primary care.

2. Provider Collaborative

2.1 As reported previously to the Board, the Mental Health, Learning Disabilities and Community Provider Collaborative (MHLDC PC) presented its work programme and value proposition to the Cheshire & Merseyside ICB Board in June. This was done following the CMAST Provider Collaborative work programme presentation to May's ICB Board Both work programmes are now supported and approved.

2.2 The MHLDC PC Board will continue to embed the governance to drive forward delivery of the work programme.

2.3 As an important component of the new governance approach, a meeting is being organised to bring together chair and NED representatives from the member organisations, for a discussion about the collaborative and future NED input into the Board, prior to the changes to the governance structure being made. This will take place in the next 4-6 weeks

2.4 Finally, the MHLDC PC has been successful in recruiting to all posts in its new leadership/team structure. The posts are:

- Provider Collaborative Director
- Head of Programme Management
- Programme Lead
- Project Support Officer

2.5 All staff have commenced in post.

2.6 Bridgewater are the host employer to these roles. A workforce risk sharing agreement is agreed by all partners and in place, ensuring that Bridgewater, as the host, are not solely liable for all of any potential future employment costs or redundancy.

3. RECOMMENDATIONS

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

Committee Chair's Report

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	12 July 2023	Date of next meeting:	13 September 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 Paula Woods, Director of People & Organisational Development Dr Ted Adams, Medical Director Lynne Carter, Chief Nurse In attendance Jo Waldron, Deputy Director of People and Organisational Development Tania Strong, Head of Human Resources Kathryn Sharkey, Head of Workforce Adie Richards, Education and Professional Development Lead Helen Hollett, Head of Leadership and Organisational Development Ruth Besford, Equality and Inclusion Manager Denise Bradley, Unison Bridgewater Branch Secretary and Staff Side Chair Jeanette Hogan, Deputy Chief Nurse Helen Young, Freedom to Speak Up Guardian Eugene Lavan, Deputy Chief Operating Officer attending on behalf of Sarah Brennan Kate Oakes, Senior Communications and Engagement Manager, attending in behalf of Mike Baker. Jan McCartney, Trust Secretary Observers Sarah Power, Staff Governor Carl Dixon, Transformation Manager	Quorate (Yes/No):	Yes
		Key Members not present:	Member: Dame Elaine Inglesby, Non-Executive Director Member: Sarah Brennan, COO Committee Attendee: Mike Baker, Deputy Director of Communications and Engagement

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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
UPDATED PEOPLE COMMITTEE BUSINESS CYCLE	BAF 5 and 6		The People Committee Business Cycle was presented by Jan McCartney, Trust Secretary for assurance and approval purposes. Minor amendments made which will be taken forward by Jan McCartney. Amended Business Cycle will be sent to the Chair for final approval.	The Committee approved the changes to the business cycle proposed. Final version to be sent to Abdul Siddique by Jan McCartney for final approval.
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 on the HR Risk Register in the reporting period, one of which was scored at a level of 12 as at 3rd of June 2023. Risk No: 3059 - Ongoing Industrial/Strike Action linked to National Pay award. Risk level remains at 12 due to the pending industrial action by Consultant BMA members from 8am on Thursday 20/07/23 to 8am Saturday 22/07/23. We'll operate at Christmas Day levels of service. We have consultants across Paediatrics, Audiology and Palliative care. The Industrial Action Planning group has been	The Committee noted the content of the reports and were assured that the risks were being managed appropriately.

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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
			reestablished to evaluate the impact on the Trust and plans are in place. There are no intentions to submit derogations. **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. 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. **Communications Risk Report** During the reporting period there is 1 risk detailed on the Communications Risk Register: • Bridgewater staff intranet – continuity of service The scoring of this risk has changed and has now lowered in severity. What was a score of 9 (high risk), is now a score of 6 (moderate risk). This reduction follows further assurance to the Communications and Engagement Team as the forthcoming extranet project develops. It is anticipated the risk score of 9 will fall further as completion nears for the project (late summer/early autumn 2023).	

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Committee Chair's Report

NHS
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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
IQPR – PEOPLE INDICATORS	BAF 5 and 6 WLR 9 PP 1-7		The 5 IQPR people indicators were presented to the Committee for month 8. Four of the five People Indicators were reporting as red – the exception being Induction which is reporting green – however all indicators had improved month on month. Detailed reports in relation to Sickness and Statutory and Mandatory Training and PPDR rates were presented later in the agenda. Turnover has decreased since January 2023. Turnover presented in the IQPR since March 2023 now excludes turnover as a result of a large TUPE transfer in March 22 and has continued to decrease month on month to 12.66% in April 2023 from 13.25% in March 2023. The Recruitment and Retention Pod actions are focusing on retention, recruitment, and workforce planning strategies including identifying areas of the new national retention toolkit that can support existing strategies, best practice, and resources to help NHS Trusts recruit and retain staff. Turnover data is provided to Borough leads each month to ensure that local plans can be put into place to address and improve retention. The report highlights the themes from Onboarding Surveys and Exit Interviews. The POD report presented later in the agenda provides an overview of the workstreams being progressed in order to address the identified themes.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings. Piece of work around workload management to come to the next Committee, including a Case Study - to be included in the Staffing System Implementation Update Report in relation to the CNSST.

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			The Committee Chair opened up a discussion in relation to triangulation of the data, and that there appears to be an issue with workload. Lynne Carter, Chief Nurse/Deputy CEO and Jo Waldron, Deputy Director of People and Organisational Development noted the national challenges with Recruitment and Retention and the impact this is having on staff workload nationally. It is recognised that this is an issue for us as a Trust and the work across the PODs is aiming to address that in addition to the work being progressed in the Quality Team such as the Quality Summit's. The Chair asked for a piece of work to come to the next Committee in relation to workload, including a Case Study. Jeanette Hogan, Deputy Chief Nurse agreed to include this in her report in relation to the introduction of the Community Nursing Safer Staffing Tool (CNSST). That said, it was noted by the Committee members that all indicators had seen an improvement and recognition of the significant work taking place across the People Agenda.	
DIRECTOR'S UPDATE REPORT	BAF 5 and 6 WLR 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 following areas were highlighted to the Committee by Paula Woods, paying attention to any developments since the writing of the report by way of verbal updates: The Director's update report additionally tabled the following:	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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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
	PP as highlighted in the report		• Industrial Action Update • NHS Long Term Workforce Plan (LTWP) • NHS EDI Improvement Plan • Continuous Professional Development Funds (CPD) – Our allocation of £258k • North West Anti-racist Framework • North West Wellbeing Pledge Update • Mental Health, Learning Disabilities and Community Provider Collaborative (MHLDC) • Workforce Session held on 31st March – Update on Workforce Programmes • NHS Cheshire and Merseyside and Carers UK • HCA Collaborative Bank – Cheshire and Merseyside • Warrington Together Workforce & OD Enabling Group Update (WEG) • Agenda for Change Pay Deal Implementation • Occupational Health and Payroll Services – extension of contracts • POD amalgamation update • IQPR People Indicators – Rates and Trust Target Review • Staff Awards 2023 • Trust Headquarters – moves to Spencer House • Well-led Review – Trust Action Plan (People elements) A discussion took place in relation to the pending Industrial Action and the impact on the Trust as a knock on from local Acute Trusts. Ted Adams, Medical Director assured that he	

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			was linked into regional meetings with peers from across the system and confirmed that there is no specific ask from the Trust as such but there is a recognition that it may impact on the Urgent Treatment Centre. The Industrial Action Group are tied into assessing this and plans are in place.	
PEOPLE STRATEGY AND PEOPLE PLAN – PEOPLE OPERATIONAL DELIVERY GROUP REPORT, PODs PROGRESS UPDATE AND FUTURE PLANS	BAF 5 and 6 PP 1-7		The Review of the People Strategy: People Operational Delivery Plan Report was presented by Jo Waldron, Deputy Director of People and Organisational Development for information and assurance purposes. Four People Operational Delivery groups, more commonly known as PODs, were established to deliver on the NHS People Plan and People Promises, the Trust's People Strategy and other strategic People agendas. The four PODs were: • Recruitment and Retention • Health and Wellbeing • Education and Professional Development and; • Culture and Leadership Over the previous two years, the work of the PODs has progressed significantly, and POD members are fully emersed into what they are aiming to achieve. Task and Finish Groups are well established, many having been concluded and work across all of the PODs has become collaborative and supportive across key members of the People, Nursing, Quality, Operational and Corporate Teams.	The Committee noted the content of the report and were assured on the progress of the work being undertaken.

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Committee Chair's Report

NHS
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			Discussions and workstreams across the POD's are fluid and workstreams are ultimately achieving outcomes which impact on all of the PODs. As a result, during the summer of 2023, there are plans to amalgamate the four PODs into one POD which is testament to the work that has been progressed over the previous years, and the collaborative approach taken across the Trust in relation to the delivery of the People Plan. The Deputy Director of People and Organisational Development updated on the progress of the current four POD's, with a specific focus on those workstreams that are aimed at addressing the data presented at the PODs in addition to the discussions which had taken place during Committee discussions. Health and Wellbeing • Stress Risk Assessment uptake is progressing well • Early Adopter of the North-West Wellbeing Policy and involvement in the regional development work Recruitment and Retention • Entry level Apprenticeships progressing well with 17 new starts following Apprenticeship week • Focus on support for Newly Qualified Nurses and AHP's • Flexible Working Campaign	

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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
			Culture and Leadership • Civility and Respect Toolkit • Staff Survey Action Plans in place and being reviewed Education and Professional Development • Trust wide Competency Framework Task and Finish Group established • Scope for Growth plans in place	
REVIEW OF PEOPLE INDICATOR TARGETS: SICKNESS AND TURNOVER			The Deputy Director of People and Organisational Development presented the report for information and approval purposes. Given the challenges nationally, regionally and locally from a Trust perspective, it is recognised that the Trust's targets in relation to actual and rolling sickness and turnover are potentially not in keeping with those challenges, and therefore have not been achieved and are unlikely to be achievable in the near future, as they currently stand. Additionally, there is a recognition of the significant work achieved and underway in terms of the people agendas and the fact that the many programmes of work and initiatives do not translate in the IQPR People Indicators which are ragged red month on month, except for attendance at induction. As a result, work has been undertaken to understand the current picture in terms of the Trust's sickness and turnover rates over the previous two years, in addition to	The Committee noted the content of the report and approved the escalation to Board for the proposed review of targets as follows: Sickness: 5.5% (from 4.8%) Turnover: 12% (from 8%)

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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
			understanding how other Cheshire and Merseyside Trusts are performing against their targets. The information gathered has been presented to the Executive Management Team at its meeting held on the 4th of July. The outputs of that discussion informed further options for the People Committee to consider, discuss and approve. These include a review of two years of data, the mean and median of data gathered, along with the consideration of the Trust having no targets for sickness absence and turnover. In that respect, there would need to be key metrics included in our reporting, which could include, but not be limited to: the number of individual and team stress risk assessments completed, attendance/nonattendance at occupational health appointments, the utilisation of our Employee Assistance Programme, incident reporting in relation to the taking of breaks and a having lunch, the uptake of wellbeing training etc. The People Indicators are put into context by various reports presented to the People Committee, including the POD Group Action Plans. The Chair initiated a discussion to illicit the views of the Committee; however in advance of doing so he expressed that he did not feel that having no targets at all was the appropriate way forward. There was support for this, and overall, the Committee were in agreement and as such had a discussion about what the targets should be, taking into consideration the information presented.	

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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
			It was agreed that a target of 5.5% for sickness and 12% for turnover would be positioned with the Trust Board with a view to reviewing the position in 3 months' time. Current targets were 4.8% and 8% respectively.	
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET OF 4.8%	BAF 5 and 6 WLR 8 PP 4		The Review of Sickness Absence against Trust Target report was presented by Jo Waldron, Deputy Director of People and Organisational Development for information and assurance purposes. 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 from 6.95% to 6.19%. Rolling Sickness increased in February 2023 (6.41%) and decreased month on month to May 2023 to 5.90%. Actual sickness absence % rate has fluctuated month on month over the 12 month period. Support and programmes of work to support improvements were presented to the Committee. The Committee asked for some additional disaggregated data to be included in the report in relation to headcount and reasons for absence by Borough.	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied. Next report to include details of headcount and reasons for absence by Borough.
EMPLOYEE RELATIONS 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 and they welcomed the additional information included in relation to lessons learned.

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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
			The report details numbers of ER 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. Over the rolling 12-month period there have been 15 employee relations cases opened, and at present there are 8 cases currently open. Breakdown of cases by ethnicity of employee are provided in order to monitor for any potential bias within our processes, as per the request at the last Committee meeting. As per the request at the last Committee meeting a breakdown of cases by area is provided so that any 'hot spots' or themes can be identified and put forward for triangulation across other workstreams – for example wellbeing, civility and respect and freedom to speak up. The report this time identified some lessons learned in relation to a number of employee relations cases which the Committee welcomed.	
FREEDOM TO SPEAK UP REPORT			The Freedom to Speak Up Report was presented by Tania Strong, Interim Head of HR for information and assurance purposes.	

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Committee Chair's Report

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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
			Speaking Up activity has increased since May 2023, however overall numbers remain low. A FTSU media plan is in place to further grow the FTSU agenda. The National Guardians Office (NGO) have produced a report analysing the 2022 staff survey called 'Fear and futility: what does the staff survey tell us about speaking up in the NHS?' The results show a fall in NHS workers' confidence to speak up. Of particular concern is the marked fall in how safe people feel to raise a clinical concern. The report provided a summary of the FTSU activity during the first quarter of 2023/24. The report also provided: • An overview of developments including current mechanisms for 'Speaking Up' • Details of recent promotion activity undertaken • Provides the number and type of cases raised via 'Speaking Up' processes. • Provides details of the NGO national staff survey results relevant to 'Speaking Up'. Concerns being raised remain relatively low and during 2022/23 a total of 13 concerns were raised with the FTSU Guardian, compared to 3 in 2021/22.	

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			For the year 2023/24 to date a further 3 concerns have been raised, taking the rolling total to 16. A breakdown of FTSU concerns raised by Directorate/Network was presented. The higher number of concerns in Halton and St Helens should be considered with some context – of the 10 concerns raised since 2022/23, 5 relate to a common issue raised by a team– our reporting guidance from the NGO requires the Trust to log these as individual contacts rather than collectively as one.	
SYSTEM STAFFING IMPLEMENTATION UPDATE	BAF 5 and 6		The System Staffing Implementation Update report was presented by Jeanette Hogan, Deputy Chief Nurse for information and assurance purposes. The National Quality Board (NQB 2016) and National Workforce Standards (NHSI 2018) expectations and recommendations are that Trusts use evidence-based workforce planning tools to deliver the right staff, with the right skills, in the right place at the right time for nursing and midwifery staffing to help NHS provider boards reduce unwarranted variations in the deployment of nursing and healthcare support workers. Trusts compliance with the 'triangulated approach' combines the use of evidence based tools, professional judgement and outcomes in make local decisions that will deliver safe, high quality care for patients within the available staffing resource.	The Committee noted the reports and were assured on the progress and plans. Information in relation to workload management including a case study to be included in the next report.

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			Whilst evidence-based guidance such as that produced by NICE to inform workforce planning has been available for hospitals for some time, such guidance has been lacking for community nursing. Subsequently in 2019, the Chief Nursing Officer NHS England commissioned the development of the Community Nursing Safer Staffing Tool (CNSST). The evidence-based establishment setting tool for use in adult community physical health services was approved for use in March 2021 and issued under licence to community organisations from 2022. Within Bridgewater, a CNSST implementation group was set up in May 2023, led by the quality team with membership of clinical teams, operational managers and corporate teams i.e., performance and workforce. Current progress: • Training of staff has commenced – (all staff in teams need to be trained in care categorisation and must undergo inter rater reliability assessment). • Developing data collection and validation methodology. Testing in the use of the tool will commence in July 2023 with implementation in District Nursing and Community Matron services in September 2023.	

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
HR POLICIES AND PROCEDURES	BAF 5 PP 1-7		The progress with the review and approval of HR Policies and Procedures was presented by Tania Strong, Interim Head of HR for information and assurance purposes. There were four policies presented to HRPG since the last Committee as follows: • **Grievance Policy (refreshed) -** There was broad support for the policy however further discussion and negotiation is required with staff side on a small range of aspects of the new policy. Progression to JNCC will be deferred until further discussions have been held and a way forward/agreement reached. • **Freedom to Speak Up in the NHS Policy** - the JNCC were asked to note and approve the further minor amendments made by Audit Committee in their June meeting. The policy was replaced on the intranet immediately after. The policy will be next reviewed in June 2026. • **Staff Carer Support Policy** - The Director of People & OD (PW) is to present the policy to Executive Management Team in late June/early July 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** - The policy was presented to JNCC in April but was not approved due to concerns regarding processes relating to	The Committee noted the content of the report.

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			recouping overpayments due to manager error, and advances in salary linked to underpayments to staff. Members agreed that the Director of People & OD (PW), the Deputy Director of People (JW) and representation from Trade Unions (DB) would, in partnership, discuss and agree the process to use going forwards. This discussion has now taken place with an agreement reached. The revised process will be reflected into the policy by the Policy Author as soon as possible and to avoid further delay in the ratification of the policy, it has been agreed that the final version will be signed off via e-governance rather than wait until nest JNCC meeting in August.	
EQUALITY, DIVERSITY & INCLUSON: - **Gender Pay Gap** - **Workforce Disability Equality Standard (WDES) Report and Action Plan** - **Workforce Race Equality Standard (WRES) Report and Action Plan** - **Bank Workforce Race Equality Standard (BWRES) Report and Action Plan**			The Equality and Diversity Reports were presented by Ruth Besford, Equality and Diversity Lead for information and approval purposes. Each report provides some detail on 2023 results plus results for the previous years of reporting, where applicable, to allow better understanding of patterns of improvement. Further narrative has also been added to identify areas of work that align to indicator/metric improvement plans. Action plans for the Workforce Disability and Race Equality Standards have been provided, these have been produced following engagement with the relevant staff networks. Following publication of the NHS England Equality, Diversity, and Inclusion Improvement Plan in June 2023 Trust action	The Committee noted the contents of the reports and approved escalation to Board for final sign off. Reports attached: - Gender Pay Gap Report 31st March 2023 - WDES 2023 - WDES Action Plan 2023 - WRES (including Bank and Medical Workforce) - WRES Action Plan

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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
- **Medical Workforce Race Equality Standard (MWRES) Report and Action Plan**			plans have also been mapped against the six priority areas for improvement mandated within this updated requirement for all providers. The Committee approved these reports to allow progression to Board for the mandated sign off before publishing, and in the case of Gender Pay Gap submission of data to Government Equalities Office. Deadline dates are as follows, but all reports are scheduled for August Board: • Gender Pay Gap 31st March 2023 – submission and publication by 30th March 2024 • Workforce Disability Equality Standard Report and Action Plan 2023 – 31st October 2023 • Workforce Race Equality Standard (including Bank and Medical) Report and Action Plan – 31st October 2023	
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 will be asked to prioritise safeguarding training and maintain overall compliance.
PDR AND STATUTORY & MANDATORY TRAINING COMPLIANCE	BAF 5 and 6 WLR7 and 8		The PDR and Statutory and Mandatory Training Compliance Report was presented by Adie Richards, Education and Professional Development Lead for information and assurance purposes.	The Committee noted the reports and were assured on the progress and plans, as above. Positive compliance trends were noted.

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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
	PP 1, 4 and 5		Month 2 (latest available data when this paper was written) compliance with Mandatory Training shows 18 requirements at green, 4 at amber and 1 at red. PPDR compliance at Month 2 stands at 72.85%. In the interests of providing the most up to date information to the Committee, since the paper was written new reports for Month 3 show an improvement in all required modules. In the June and July Team Briefs, the Trust's Chief Executive, Colin Scales communicated the requirement for full compliance by 31st July 2023. The focus of communications is ensuring that staff are provided with the right environment and conditions to be able to complete their mandatory training and PPDR, to minimise the risks associated with non-compliance, particularly for clinical staff seeing patients. Communications were supportive and stressed the commitment from the Executive Management team to support those staff and managers who have been unable to achieve full compliance by offering appropriate support in order to do so. Colin Scales, the Trust's CEO and Paula Woods, Director of People & OD committed to meeting with managers during July 2023 who may be experiencing challenges in achieving compliance, to offer their support to remedy that situation. At Risk Management Council (RMC) in February, it was recognised by the Council that areas of low compliance within individual services should be recognised and managed locally, and service specific risks should be raised and assessed to	

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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
			address these areas as required. The overall risk identifying the corporate responsibility for ensuring that all required training is available and accessible for all staff remains in place, and is reviewed regularly by the council and EPD Leads. A set of compliance principles were developed in partnerships with our Staff-side Colleagues. These have been endorsed by the Board and will be applicable after the July compliance date.	
TALENT MANAGEMENT AND SUCCESSION PLANNING	BAF 5 and 6 PP 1, 4 and 5		The Talent Management and Succession Planning Report was presented by Helen Hollett, Head of Leadership and Organisational Development for information and assurance purposes. The 22-23 Mary Seacole Programme completed in February 2023. Participants excelled with results ranging between 72% and 100% (pass awarded at 50 %). Impact audits are planned to be implemented during quarter 2. The 23-24 cohort commenced on the 22nd of May 2023. The Transactional aspects of the Operational Managers Programme commenced in February 2023 and has a cohort of 47 Operational and aspiring Operational Managers. The First Line Managers programme is now established with 35 participants on a rolling programme. Following the successful appointment of an OD Practitioner with the lead for Talent and Performance Management. An implementation plan for Scope for Growth has now been	The Committee noted the reports and were assured on the progress and plans.

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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
			developed. A pilot group has been identified and conversations are planned to take place in August 2023. Following a Mersey Internal Audit Agency's audit of Performance and Personal Development Reviews in December 2022. Quality audits commenced in June 2023. The results of which will help us to identify and target training in this area for managers and staff. Findings will be brought to the next People Committee. The Trust's Leadership and Organisational Development Team are working with procurement to secure future external coaching provision. With a key objective for 23/24 to investigate potential to provide an internal course for staff to access a coaching qualification to increase internal coaching capacity. Health and Wellbeing training for managers and staff has been reviewed and re-established within Bridgewater. The Leadership and Organisational Development Team are currently working with Workforce colleagues, reviewing the stress audit data to target training at managers and teams, while also being able to offer further health and wellbeing interventions if required.	
STAFF ENGAGEMENT AND RECOGNITION UPDATE	BAF 5 PP 1-7		The Staff Engagement and Recognition Report was presented by Kate Oakes, Senior Communications and Engagement Manager for information and assurance purposes.	The Committee noted the reports and were assured on the progress and plans.

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Committee Chair's Report

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			Following the internal promotion of the previous lead for staff engagement in spring 2023, the Communications and Engagement Team has had a reduced offering of staff engagement activity due to the gap it left within the service. A reimaging of the wider Communications and Engagement Team was quickly developed with a key purpose to help deliver a service with greater resource and need. It was reported that a new (full-time) Staff Engagement Coordinator and a new (part-time) Senior Communications and Engagement Manager are now in post and are already building on a new and flourishing staff engagement function for the organisation. The report was broken down as follows: • The importance of linking staff engagement to the NHS People Promises • The NHS Staff Survey • The National Quarterly Pulse Survey • Staff Engagement Champions • Time to Talk • Leader in Me events • Bridgewater 'Thank You' Awards • Additional recognition	

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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
			The above is not an exhaustive list outlining staff engagement and recognition. As flagged, this has been a time of recent change for the Communications and Engagement Team. This change and restructure however has in fact been a creative opportunity to repurpose and realign how staff engagement is delivered within Bridgewater. With a fully resourced team, greater focus can now be secured on staff engagement and its delivery. What is key though; all staff engagement must add value, is data driven and must link to the seven NHS People Promises.	
MIAA INTERNAL AUDIT UPDATE - **MANDATORY TRAINING AND APPRAISALS REVIEW** - **PAYROLL FEEDER SYSTEM REVIEW**	BAF 5 and 6		The Mandatory Training and Appraisals Review report was presented by Adie Richards, EPD Lead for information and assurance purposes. All recommendations are progressing to plan and it was noted by the Committee that despite the moderate assurance and the significant challenges in relation to Statutory and Mandatory training which the Committee are well cited on, lots of good work had taken place. The Payroll Feeder System Review was presented by Kathryn Sharkey, Head of Workforce for information and assurance purposes.	The Committee noted the reports and were assured on the progress and plans.

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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
			All recommendations progressing to plan and it was noted by Tina Wilkins as Chair of Finance and Performance Committee that there had been a noted decrease in late payment and overpayments reported through to Finance and Performance Committee.	
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	BAF 5 and 6		A review of BAF 5 and 6 was undertaken. With regards to BAF 5, the 'assurances' were to be updated to reflect: • Temporary increase in mileage payments over 3,500 miles • National increase in mileage rates from 1st of April It was noted that pay deals had been agreed as per the 'gaps in control and assurance' section of BAF 5. The publication of the NHS Long Term Workforce Plan was noted for BAF 6.	The Committee were assured on the progress and governance around the monitoring of the BAF. The risk rating of 4 x 4 = 16, was reviewed by the Committee who after some discussion recommend a risk rating of 4 x 3 = 12
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 5 and 6		The Equality Reports, as presented, were approved for escalation to Board in August for overall final approval. It was agreed that BAF 6 changes should be escalated to Quality and Safety Committee.	Equality Reports to be escalated to Board.
REVIEW OF MEETNG ANY ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK			Sarah Power, Staff Governor (Observer) reviewed the meeting as informative and welcomed the open and supportive discussions.	

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Committee Chair's Report

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
Risks Escalated			None.	

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Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3 August 2023**
Agenda Item	**60/23 (ii)**		
Report Title	**ANTI-RACIST FRAMEWORK UPDATE**		
Executive Lead	Paula Woods - Director of People and Organisational Development		
Report Authors	Ruth Besford - Equality & Inclusion Manager Paula Woods – Director of People and Organisational Development		
Presented by	Paula Woods - Director of People and Organisational Development		
Action Required	☐ **To Approve**	☒ **To Assure**	☒ **To Note**

Executive Summary

The Trust Board endorsed the implementation of the NHS North West Black, Asian, and Minority Ethnic Assembly (the BAME Assembly) Anti-Racism Framework back in April 2022, following its publication in 2021.

A gap analysis of the Framework identified areas of compliance, where actions were already underway or planned, and also some gaps to address. The Framework in this first iteration was an 'all or nothing' approach, and with the very high standard required to meet all twenty drivers set out in the Framework the Trust continued work to submit an application when all deliverables were met.

Reports have progressed to Trust Board with regards to this agenda. An overall anti-discrimination report was presented the to the Trust Board at its meeting held on the 8th of December 2022. The report outlined the systems, processes and programmes of work we have at the Trust, along with policies procedures and frameworks. Furthermore, our 'measures' were included in the overview as mapped out in detail to associated legal frameworks and statutory duties.

In April this year, the Board's attention was dawn to a statement from the Assembly that was issued on the 28th of March 2023, highlighting a recent employment tribunal claim outcome. The details of that claim were shared, along with the need to consider the lessons learned from this case of racism and discrimination that was successfully pursued by a Black Nurse. There was a call for action and commitments on NHS Leaders across the North West that we recognised and endorsed.

In 2023 the Assembly refreshed their Framework. This was issued to Chairs and Chief Executives with a letter dated 26th of June 2023. The essence remains the same, but with some additional clarity on the deliverables, by way of a bronze, silver and gold framework accreditation. With the Framework comes increased access to resources and support via the Assembly to enable a self-assessment and overall application for recognition. A copy of the letter and Framework are at appendices 1 and 2 to this report.

Following the refreshed Framework being tabled at the Executive Management Team (EMT) meeting held on the 27th of June, this paper provides brief detail of the new Framework, information on progress to date, and detail of actions and alignment to national mandated equality drivers. A draft Action Plan is at appendix 3. This will be discussed with the POD Council and Race Inclusion

Network. The former will consider the key leads initially assigned, along with timeframes and the actions proposed. These may therefore be subject to change.

Progress will be reported from the POD Council to the People Committee as part of the People Operational Delivery Group Action Plans. Reference to the Framework was included in the Director Update Report presented to the People Committee at its meeting on the 12th of July. The letter and Framework were included with the report for completeness.

The Board are asked to note the content of this report and the plans to further assess and review the initial draft Action Plan at appendix 3.

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**	**3 August 2023**
Agenda Item	**60/23 (ii)**		
Report Title	**ANTI-RACIST FRAMEWORK UPDATE**		
Report Author	Ruth Besford - Equality & Inclusion Manager		
Purpose	To provide information to the Trust Board on the refreshed North West Black, Asian, and Minority Ethnic Assembly's (BAME) Anti-racist Framework, and the Trust work undertaken to date and as planned.		

1. SCOPE

1.1 All staff, including agency, bank, volunteer, and learners in practice are within scope of the Framework.

1.2 A positive anti-racism culture within the Trust should impact positively on employment and service delivery for our staff and the communities we serve.

1.3 The Framework supports the following legal and mandated requirements:

- Equality Act 2010: Public Sector Equality Duty - General Equality Duty
- NHS Long Term Workforce Plan (LTWP)
- NHS Equality, Diversity, and Inclusion Improvement Plan (EDI)
- Workforce Race Equality Standards (WRES), including Medical and Bank Standards
- A Model Employer: Workforce Race Equality Standard Disparity Ratio Plan
- Equality Delivery System (EDS)

2. INTRODUCTION

2.1 The founding principle of the NHS is one of equity, a service that is free to all at the point of access regardless of age, disability, ethnicity, or other aspects of personal identity or means. Evidence has shown that racial inequalities still exist, impacting on the health and life expectancy of ethnically diverse communities. In the NHS workforce disparity of experience, including experiences of racism, still exists for ethnically diverse staff.

2.2 In April 2022 the Board endorsed the implementation of the NHS North West Black, Asian, and Minority Ethnic Assembly (the Assembly) Anti-Racism Framework that was published

in 2021. There were twenty drivers against five principles: to prioritise anti-racism, to understand lived experience, to grow inclusive leaders, to act to address inequalities, and to continually review progress and performance.

2.3 Since the publication and Trust commitment to the Framework, there have been several developments in the NHS. We have recently seen the publication of the NHS Long Term Workforce Plan and accompanying Equality, Diversity, and Inclusion Improvement Plan. Furthermore, awareness has been raised to the employment tribunal case of Ms Cox v NHS Commissioning Board. Ms Cox pursued claims of racism and discrimination which were successful.

2.4 The Assembly, having listened to feedback from committed Trusts have undertaken a refresh of the original Framework, creating a tiered approach to accreditation, embedding further the available support and resources, and ensuring alignment to the above national drivers.

2.5 Following discussion at our Executive Management Team (EMT) meeting in June, this paper provides information and a high-level update on the refreshed Framework. We as a Trust have a continuing commitment to this updated Framework, and this paper outlines the progress to date, and planned actions required to allow for an application of recognition for accreditation to the Assembly.

2.6 Appendices 1 and 2 of this report were featured in the Director of People's Update Report to the People Committee held on the 12th of July. The Committee were advised that a draft action plan was under development.

2.7 The initial draft action plan in appendix 3 will be routed through the POD Council and Race Inclusion Network for further input in relation to the key leads, timeframes and the proposed actions. The POD Council reports to the People Committee.

3. FRAMEWORK APPROACH

3.1 As stated earlier, back in April 2022 the Trust Board endorsed the implementation of the Anti-racism Framework.

3.2 The original Framework required Trusts to submit an application to be assessed against all twenty drivers, with accreditation being awarded to those that met **all** of the criteria.

3.3 At the time of Board endorsement, a gap analysis was undertaken against the deliverables. Areas of achievement were identified alongside existing alignment to Trust actions in progress or planned, and of course any identified gaps were highlighted.

3.4 During the past year work has been undertaken to deliver planned actions that would support an application for accreditation. As per an 'all or nothing' approach, this has taken time and has now been subject to a further review.

3.5 In February 2023, an employment tribunal found against the NHS Commissioning Board in the North West in the case Ms Cox v NHS Commissioning Board (operating as NHS England/NHS Improvement). This tribunal case was discussed at our Trust Board in April.

The case findings, the details of which were shared with the Board, against the NHS organisation were of:

a. Direct race discrimination

b. Harassment because of race

c. Victimisation following a protected disclosure under the Equality Act 2010

d. Whistleblowing detriment

3.6 The remedy for the above case has not yet been published, but previous race discrimination cases in the NHS have run to millions of pounds, dependant on factors such as loss of future earnings to the claimants.

3.7 In June and July this year, the NHS Long Term Workforce Plan and NHS Equality, Diversity, and Inclusion Improvement Plan were published, the former placing a great deal of emphasis on ethnic and racial equity in the workplace. Alongside the existing drivers detailed in 1.3 there is a pressing need to prioritise anti-discrimination work generally, and anti-racism work in particular.

3.8 The Assembly have undertaken a review of the Anti-Racism Framework, and in light of the above employment tribunal case have contacted all Trusts to highlight the Framework as an important tool to support anti-racism work and the delivery of the above mentioned mandated and legal requirements. This is now called the Anti-racist Framework.

3.9 The Assembly letter can be viewed at appendix 1 to this paper, and the refreshed Framework at appendix 2. Our initial self-assessment and draft action plan is at appendix 3. This will be shared with the People Council and Race Inclusion Network. The former will consider the actions and the proposed timeframes. The latter may be subject to change following the wider communication and engagement required.

3.10 Importantly the refreshed Framework now has greater clarity on the deliverables that support the twenty drivers. It features an accreditation scale from bronze to silver and to gold. It has the commitment of support from the Assembly and signposting to a lot of resources to support Trusts in developing and delivering their anti-racist plans.

3.11 The Trust's 2023 – 2024 Equality Action Plan was submitted to the Culture & Leadership People Operational Delivery group (POD) in June alongside this year's Workforce Race Equality Standard (WRES) report and action plan. The group signed off all documents with the official reports to continue through governance infrastructures to Board, and the action plan for anti-racism and the wider equality work being undertaken to be overseen by the POD Council.

3.12 The action plan has been aligned to all the previously stated mandatory requirements and aligns to the deliverables within the Anti-racist Framework. For ease the initial draft Anti-racist Framework Action Plan is provided at Appendix 3, with the actions against each level described. They key leads assigned, timeframes and proposed actions require wider discussion and engagement with the People Council and Race Inclusion Network, so may be subject to change.

4. RECOMMENDATION

4.1 That the Board

- note the further iteration of the NW BAME Assembly's Anti-racist Framework.
- note the information provided with regards to the Trust's ongoing commitment to the Anti-racist Framework, and;
- be assured with regards to the governance of oversight on delivery of the required actions to support an application for accreditation over time.

5. APPENDICES

Appendix 1	North West Black, Asian, and Minority Ethnic Assembly Letter dated 26 June 2023
Appendix 2	North West Anti-racist Framework
Appendix 3	Bridgewater's draft Anti-racist Framework Action Plan

NORTH WEST
Black, Asian and Minority
Ethnic Assembly

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

Anti-racist Framework

NHS
England
North West

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Foreword

As partners in championing this ambition, the North West Black, Asian and Minority Ethnic Assembly (the Assembly) and NHS England (NHSE) North West believe that the NHS in our region should be unapologetically anti-racist. We also believe that the NHS should take positive action to eliminate racism in our organisations, stand with our colleagues when they experience racism, and eradicate the inequalities in access, outcomes and experience of health care that some of our communities face.

This document provides a framework for all NHS organisations across the North West to work towards the ambition of becoming actively anti-racist organisations. It aims to embrace both the spirit of our commitments and provide NHS organisations with guidance to put into action quickly, the steps needed to reduce the inequalities we still see every day across our workforce and to become intentionally anti-racist.

We all recognise the history and impact of institutional racism across our organisations and the harm caused to both our colleagues and communities through the continued inequalities that we still see across our society. From higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting, all of these issues and many more needed to be tackled intentionally and as a priority by all our organisations.

We are asking our NHS partners across the North West to make a commitment to embrace the intentionally inclusive language and the approach of becoming actively anti-racist organisations. As intentionally inclusive leaders it is vital that we all look at each of the areas set out in this anti-racist framework and seek to embed the change needed to transform our own departments and teams into places where this activity is not seen as just a nice to do, but is seen as mission critical to all that we stand for; and that messaging is backed up by senior colleagues across the region, being clear that actions to tackle inequalities are a priority in all that we do.

Leaders should use the practical steps and suggested actions to support existing change activity, to add focus to future equality action plans and to build on any long-term inclusion strategies you may have. While there is not a one size fits all solution to advancing equity within any one organisation, we hope that the guidance and structure provided will help with the task of co-creating the solutions that will work for your organisation easier.

This document has been produced by The Assembly, the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West.

Richard Barker
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Why does an intentionally anti-racist approach matter?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas even get worse.

- The NHS is built on a founding principle of equality and social justice. That the service is free at the point of need anchors the NHS in social egalitarianism and makes equal rights part of our core business.
- We have seen a growth of hate incidents and racism across our communities in the UK despite existing equality and human rights legislation. It is more important than ever that as public sector organisations, we contribute to ensuring racism has no place in our society and is addressed across the communities we serve.
- Racism and discrimination are major drivers behind the health inequalities we still see today. It is our role as a health care system to be intentional in tackling those inequalities we see across our communities, but we should also be ensuring discrimination experienced by our staff is not further contributing to the problems.

Our anti-racism journey

Becoming an intentionally anti-racist organisation is a continuous journey that involves leaders and organisations continually reviewing their progress and being intentional about their actions for change.

The Fear, Learning, Growth Zone tool can help you both as an individual and as an organisation to consider honestly where you are on the path to become more anti-racist.

Approaches to move through the zones

FEAR ····· LEARNING ····· GROWTH

Provide clear factual information that challenges and supports the overcoming of any fears that individuals and teams may have with talking about racism and what is needed to address this issue.

Consider more development building on any existing learning; steps and opportunities that increase confidence with existing learning.

Empower inclusive leaders through allyship programmes and activities.

1. Prioritise anti-racism

As the NHS we have always been instinctively supportive of equality as social justice is the bedrock and foundation of our creation as an institution back in 1948. However, prioritising anti-racism work is more than simply caring about equality or stating support for inclusion; it is about ensuring we are giving it the same attention and response as other mission critical work we manage across the NHS.

The two main commodities we give to a task or area of work when we prioritise it are both time and resources. When equality activity is seen as an add-on or a nice to do, other mission critical work is seen as more important; time and resources are directed elsewhere and progress around tackling inequalities slows and stops.

Organisations need to commit to the principle that anti-racism work matters and their leaders need to see it as a priority for them as well. There will always be competing time and resource pressures when it comes to managing any large organisation, but anti-racist organisations understand that investing the time and resources needed to tackle the inequalities that exist across their workforce and services is more effective in the long term and will support them in meeting their other long-term goals.

What does this look like?

Leading from the front

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Dedicated EDI Resource

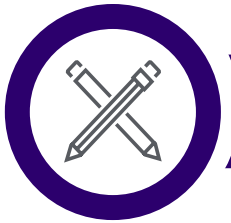
The amount of dedicated resource we have allocated to focus on an area of work is a key indicator of how much it has been prioritised. Equality, diversity and inclusion (EDI) professionals are experienced experts who can support leaders with this work. They must, however, be considered an important part of the organisation's leadership for their activity to be impactful and transformational over the longer term.

Mission Critical

Anti-racism activity needs to be at the heart of all work across an organisation, not simply a central equality action plan. Organisations that have got this right can clearly demonstrate how anti-racist practice is considered mission critical in plans around service delivery and the development of their workforce.

Actions Not Words

Organisations that are committed to anti-racism do more than the minimum ask; their work is driven by a desire to transform and have a big impact on the inequalities they see. This should be clearly visible in the activity and actions of any anti-racist organisation.



2. Understand lived experience

It is everyone's responsibility to tackle racism not just Black, Asian and Minority Ethnic colleagues, but meaningful involvement of people who experience racism and inequalities across your organisation will ensure decisions on how to tackle it are informed by real insights that reflect the different challenges people may face.

Meaningful involvement of people you would like to share their lived experiences involves committing to acting on what you hear and embedding their voices into change focused activity and decision making. Leaders need to be intentional in seeking out lived experience perspectives and considering what may be preventing some people feeling able to be involved.

When reaching out to seek the lived experiences of Black, Asian and Minority Ethnic communities it is important that leaders acknowledge and value intersectionality and understand the need to get more than a single person's perspective. When engaging others to hear their lived experiences, we should be intentional in ensuring we are hearing from a diverse range of voices rather than simply identifying a single individual to invite into a space.

Sharing lived experiences can have a weathering effect on people's wellbeing. Any activity that looks to involve and encourage others to share their lived experiences to support leaders and an organisation make better decisions should also include a clear and intentional focus around the wellbeing of those involved.

What does this look like?

Listen and Learn

Leadership matters and while being a leader often involves the management of multiple priorities, the amount of dedicated time we give to an issue is a key indicator of how much we have prioritised that area of work.

Empowering Your Talent

As well as hearing the lived experiences of staff, it is important that the underutilised potential of talented leaders from ethnic minorities is considered and empowered to support decision making. A key consideration is where you can diversify the decision makers in a space and how you can ensure the full talent potential of your diverse workforce is used.

Growing Cultural Competency

Connecting a diverse range of lived experiences with leaders is vital to improving the cultural competency of an organisation over a longer period of time. Leaders who understand their colleagues, service users and local communities are better placed to make decisions that are fair for all.

Data Plus

Organisations need to be intentional about understanding the experiences of Black, Asian and Minority Ethnic staff and service users.

3. Grow inclusive leaders

Inclusive leadership is vital if an organisation aims to be anti-racist in all that it does and aims to tackle the inequalities it sees across its workforce and services.

Where an organisation has a mature, inclusive leadership culture you will see diversity clearly represented at all levels across the workforce and colleagues will feel they belong and are included at work. On that journey to growing an inclusive leadership culture it is vital that there is an approach and strategy for reducing inequalities, not just at the top of the hierarchy, but also a commitment to increase diversity and reduce inequalities across middle leadership.

Too often the focus around developing Black, Asian and Minority ethnic leaders has been on providing them with more skills and academic development to help them move up to the next level in the leadership ladder; this reinforces a deficit stereotype rather than tackling the institutional racism that has been holding them back. Positive action measures should be targeted on the bias and prejudice that has led to ethnic minority colleagues not being given the opportunities to demonstrate the skills they have.

Inclusive leadership is not a destination. It is a continuous journey to look at how you can do more to reflect and own your own privilege, understand others more, act to tackle bias in the decisions you make, and ensure that change is seen as a positive step to tackle inequalities and injustice rather than simply a threat to the status quo.

What does this look like?

Visibility matters

Our most senior public sector leaders should come from a wider diverse range of backgrounds and should broadly represent the communities they serve. This diversity and visibility help to build communities' trust in our institutions and also lead to better decision-making overall.

Where is your talent?

Understanding your talent trajectory in respect to Black, Asian and Minority Ethnic colleagues helps an organisation know where actions need to be to increase diversity and tackle departmental or structural inequalities. Diversity should be visible across all levels of an organisation.

Levelling up middle leadership and inclusion

If we only focus development on our most senior leaders, commitment to change is often not followed through by those leaders tasked with implementing decisions across the organisation.

Real opportunities

For some time we have seen sending colleagues on dedicated learning programmes as the solution to under representation in leadership roles. However, it is often the case that development does not lead to an opportunity for promotion and reinforces the idea that Black, Asian and Minority Ethnic colleagues need to work harder and earn more to achieve the same as their white peers.

4. Act to tackle inequalities

"Let my actions speak for themselves" is a famous saying that represents the mantra by which an organisation truly committed to anti-racism needs to run.. Words alone can often become a shield through which organisations are able to justify, consciously or unconsciously, their inaction over time, and determine whether they have followed through with meaningful actions to tackle an inequality.

Initiatives like the Workforce Race Equality Standards (WRES), Model Employer plans and others are not a solution in themselves, but can be a positive tool to measure existing inequalities and target actions to have the biggest impact. These tools need to be used actively to support equality activity across an organisation rather than simply as an assurance framework completed once a year and not looked at again.

The inequalities we see across our communities today will only be addressed when organisations use their resources collectively in partnership to tackle their main causes. Building a critical mass of activity around neighbourhoods, localities and our region as a whole is key to the numerous health inequalities and social injustices that harm so many being relegated to history, instead of being a painful reality of today that many are forced to live with.

The amount of action needed to tackle inequalities is large. It reflects the generations of institutional racism and injustice developed over decades in this country. However, when viewed as mission critical and delivered through embedded priorities across all areas of an organisation's structure, the task is not insurmountable and the outcomes will be transformational for our communities as a whole.

What does this look like?

More than a tick box

While assurance frameworks have at times been labelled as just a tick box for an organisation to deliver against, this does not have to be the case. Tools like the WRES and others can be used to prioritise, leverage and monitor real change. Anti-racist organisations use all the resources and tools available to them to achieve their goals of reducing inequalities and tackling discrimination.

Zero tolerance matters

Being anti-racist is an active stance and means more than simply not acting to do harm, but actively tackling the harm we see. Organisations that are on the journey to getting this right are clear in the zero tolerance they have for racism from anyone, including colleagues and service users. It is vital that organisations consider how they handle these types of incidents and constantly learn to do more to tackle racist abuse.

We do this together

Many inequalities are too big to tackle on your own as a single organisation. It is vital that organisations work in partnership to tackle the racial inequalities we see across our communities. When looking at health inequalities, NHS organisations should work with their local community and other statutory sector bodies to tackle these collectively rather than them staying in the too hard to do pile.

Fair and just

The processes that exist across an organisation to look at grievances and disciplinaries for staff should feel fair and equitable for all. Where this is not the case, the outcomes experienced by colleagues lead to mistrust and a clear weathering effect on the wellbeing of Black, Asian and Minority Ethnic staff.

5. Review progress regularly

The NHS is no stranger to performance measures and the need to be intentional about tracking progress with a clear and detailed approach.

However, when it comes to anti-racism and wider equality, diversity and inclusion activity, this often lacks the same rigour in monitoring performance as other areas of our organisations.

Research from the USA has shown us that one of the most important aspects to diversity and equality activity is grounding this work in social accountability and taking time to measure and be clear about whether progress is being made.

While an organisation may have implemented actions elsewhere to tackle and reduce the impact on bias within decision processes and decision making, it is vital that the same consideration is taken when reviewing an organisation's overall performance around anti-racism and equality as a whole. What this means in practice is ensuring progress is reviewed by not just the people who have led or commissioned any activity, and that there is intentional consideration to the diversity of those involved in the reviewing and monitoring progress.

The NHS is the biggest employer in the country. However, as we are split up into hundreds of separate organisations we often look inward for ideas and feedback around change. Through the work of the BAME Assembly, we in the North West have an opportunity to collaborate and ensure reviewing organisational progress is a task that we are able to support each other with; this can be done through ideas and the sharing in equal measure of success and failure to support our anti-racism journey.

What does this look like?

How are we performing?

It is vital that organisations consider the management of performance around inclusion as seriously as they monitor performance of other areas of work. Leaders at all levels should understand how their area is doing in relation to key targets.

What is our approach?

Becoming an anti-racist organisation takes a clear intention to deliver a range of actions and measures consistently over a prolonged period of time. Understanding where the organisation is on its journey to become anti-racist is vital.

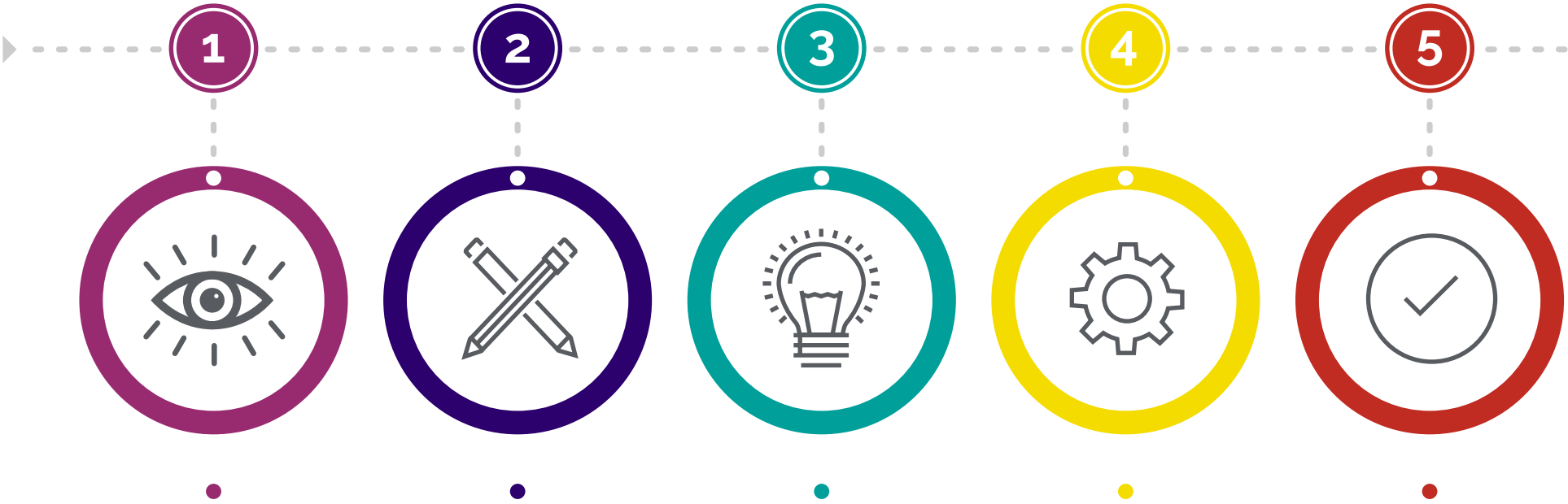
Our voices matter

The voices of Black, Asian and Minority Ethnic people should be at the heart of an organisation considering where they are on their journey to become anti-racist. This helps ensure actions that have been meaningful and impactful are prioritised, and where progress has not been made, this is not hidden.

Open and transparent

To have credibility around a statement that an organisation is anti-racist, it is vital the label is not just coming from the organisation itself but that the statement is supported by the community it serves.

The 5 anti-racist principles - Reflection questions



PRIORITISE ANTI-RACISM

How much of my time have I actually spent on anti-racism work in the last month?

UNDERSTAND LIVED EXPERIENCE

Whose voice and experience is not present, what have I done to address this, and how have I supported others to share their lived experience?

GROW INCLUSIVE LEADERS

What does the diversity of my organisation look like and how have I created opportunities for colleagues from ethnic minority backgrounds to grow and be included?

ACT TO TACKLE INEQUALITIES

What actions have I taken towards addressing racial inequalities and what impact has been made?

REVIEW PROGRESS REGULARLY

How has my organisation built anti-racism into their EDI targets and how is progress being measured?

Framework overview

This framework aims to support organisations on the journey to becoming intentionally and unapologetically anti-racist. The framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, organisations will create meaningful and measurable change within their workforce and service delivery.

The framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Bronze status

Bronze status signifies that an organisation has taken initial steps towards becoming an intentionally anti-racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Key Drivers	Direct Deliverables	Supporting Actions
Leading from the front	The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism. • Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures.

Silver status

The silver status shows that organisations have embedded structures to ensure commitment and accountability towards achieving anti-racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change, and improve data collection, quality and reporting.

Key Drivers	Direct Deliverables	Supporting Actions
Empowering Your Talent	Set up a local Black, Asian and Minority Ethnic leadership council within your organisation.	• Ensure Black, Asian and Minority Ethnic talent is intentionally included across organisational talent programmes. Numbers should reflect the need for positive action to increase diversity within leadership roles. • Must have set targets and a published talent trajectory for Black, Asian and Minority Ethnic representation across every level of the organisation. • An organisation should have a dedicated positive action secondment or stretch projects programme in place to give Black, Asian and Minority Ethnic colleagues the chance to gain experience to support with career progression.
Levelling Up Middle Leadership & Inclusion	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion, and a process to report annually the percentage of these goals that have been met.	• Leaders / managers to identify actions and create plans within their work to advance anti-racism.
Growing Cultural Competency	Evidence of inclusive leadership education for all executive directors.	• Further education for leaders, including inclusive recruitment, cultural awareness / competency, inclusive leadership, equality strategy and direction. • 75% of executive and non-executive directors and their direct reports have been part of a racial equality reverse mentoring programme over the past three years.
Listen and Learn	An executive director must attend Black, Asian and Minority Ethnic staff network meetings at least four times a year.	• A reciprocal arrangement with Black, Asian and Minority Ethnic staff network chair to attend and contribute to committee / board meetings.
Data Plus	WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.	• A detailed breakdown by ethnicity of the staff survey report should be presented to the board annually, including the involvement of Black, Asian and Minority Ethnic staff network members to ensure more than just data is presented. • Quarterly monitoring and review of WRES data, workforce data and action plans by executive EDI lead and presented to board and staff networks.

Gold status

To obtain Gold status, the organisation must demonstrate that anti-racism has been embedded throughout all levels of the organisation, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring anti-racism is seen as everyone's business through performance and engagement.

Key Drivers	Direct Deliverables	Supporting Actions
Visibility Matters	An organisation's board of directors diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (which ever figure is higher).	• Creation and implementation of talent development and pipeline plan for Black, Asian or Minority Ethnic directors or associate non-executive director programme. • Partner with the North West Black Asian and Minority Ethnic Assembly to create a mentorship programme for Black, Asian or Minority Ethnic talent within the organisation.
How are we performing	An organisation must use an EDI performance dashboard that is presented quarterly to board and include performance against the race disparity ratio, WRES, and other race specific targets as appropriate.	• Organisation should record and publish their ethnicity pay gap annually • Intersectional data collection and analysis (by ethnicity, sex, gender, disability and sexual orientation) to be published and presented annually. • Chairs and non-executive directors to be updated annually on the progress on anti-racism plans.
More than a tick box	The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.	• Creation of a cross-departmental WRES actions working group to support and challenge progress on WRES data.
Fair and Just	The organisation can evidence diverse representation within their disciplinary and grievance processes.	• Freedom to Speak Up Champions within the organisation to support in incidents involving racial discrimination.
Our Voices Matter	The organisation should bring together annually Black, Asian and Minority Ethnic staff to review EDI progress and any learning be built into the following year's plans.	• WRES and anti-racism action plans to be co-produced with staff networks.

Regular review

Key Drivers	Deliverables	Supporting Actions
What's our approach	Organisations should review progress against each of the key drivers and direct deliverables within the NHS North-West Anti-Racism Framework at least annually.	Draft an annual action plan to attain initial or next accreditation that is reported on at board to ensure delivery and commitment.
Open and Transparent	The organisation should apply to the North West Black, Asian and Minority Ethnic Assembly to receive feedback against their anti-racism framework at least every two years.	Organisations should liaise with the Assembly / their Assembly member regarding progress and support in attaining recognition.

Support

The North-West BAME Assembly is here to support you in the implementation of this framework in your organisations.

We have a dedicated resource who can assist with strategy, queries, and troubleshooting any issues you may come across on your journey.

Please contact **england.nwbame_assembly@nhs.net** to discuss further.

Recognition

1. Assess your organisation's current progress using the self-assessment tool.
2. Draft action plan towards achieving either Bronze, Silver or Gold status, and implement necessary strategies to achieve the deliverables.
3. Apply to the North West Assembly for recognition. A small panel of Assembly members will review applications, make assessments and recognise successful organisations.

Self-assessment tool

The self-assessment tool has been designed as an assurance checklist. The checklist should be used by organisations as they begin to implement the Anti-Racist Framework to identify which of the key deliverables from the framework are already in place and which are the development areas for the organisation.

When an organisation has identified their gaps using the checklist, actions can then be developed to support the implementation of the framework fully prior to moving towards requesting recognition.

Anti-racist framework checklist

Summary of direct deliverables

Bronze

- [ ] The appointment of a senior director level EDI lead with a commitment to advancing anti-racism within the organisation.
- [ ] Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.
- [ ] An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.
- [ ] The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.
- [ ] The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.

Silver

- [ ] Set up a local BAME leadership council within your organisation.
- [ ] Evidence of inclusive leadership education for all executive directors.
- [ ] All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met.
- [ ] An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.
- [ ] WRES data and workforce data disaggregated by ethnic groups to be presented at board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual.

Gold

- [ ] An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher).
- [ ] An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio, WRES and other race specific targets.
- [ ] The organisation must be able to demonstrate two years of consecutive improvements against at least five WRES measures.
- [ ] The organisation can evidence diverse representation within their disciplinary and grievance processes.
- [ ] The organisation should bring together annually Black, Asian and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans.

Sample action plan

Once the self-assessment is complete, an action plan to address the gaps should be developed. The action plan should identify a responsible person or team, a target completion date, and progress updates.

Level	Action	Person/ Team	Timescale	Target completion date	Progress	Comments
Bronze	The appointment of an executive / director level EDI sponsor.	HR	6 months		Ongoing	Proposal taken to board; nominated sponsor to be appointed at next meeting.
	Senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	HR	12 months		Ongoing	HR to explore the addition on an anti-racism PDP goal to role descriptions; meeting to discuss progress and next steps scheduled for 07/08.
	Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	HR	6 months		Ongoing	Once senior sponsor appointed, meetings with Exec directors and chief executive to be scheduled on a six monthly basis to provide updates.

Resources

To support your journey towards becoming an unapologetically anti-racist organisation, we have compiled a list of resources to assist in the development of your strategies, plans and actions.

NHS North West Black, Asian and Minority Ethnic Strategic Advisory Group

National Education Union Anti Racism Framework

NHS Leadership Academy Allyship Toolkit

NHS Leadership Academy Resources on Racism

NHS Employers Resources to Tackle Racism

NHS England WRES 2022 Data Analysis Report

NHS England Patient Carer Race Equality Framework

NHS Race and Health Observatory

NHS Confederation BME Leadership Network

Change the Race Ratio Guidance - KPMG

Board Diversity More Action Less Talk

Why companies Need a Chief Diversity Officer

Competency Framework for Equality and Diversity Leadership

Diversity Management That Works - CIPD

Embed Anti-Racism in the NHS

Guide to Establishing Staff Networks - CIPD

WRES Board Briefing BAME Leadership Council Case Study - NHS England

Building Narrative Power for Racial Justice and Health Equity

Lived Experiences of Ethnic Minority Staff in the NHS - The Kings Fund

A Case for Diverse Boards - NHS England

Taskforce on Increasing Non-Executive Director Diversity in the NHS - NHS Confederation

Develop a Strong Talent Pipeline from Entry Level to Executive Roles - CBI

Practical Guide Bridging the Gap - CBI

Six Traits of Inclusive Leadership - Deloitte

Northern Care Alliance NHS Foundation Trust Intentional Inclusion Model

Black Jobs Matter - Personnel Today

Health Inequalities Hub Case Studies - NHS England

BMA Charter for Medical Schools to Prevent and Address Racial Harassment

Hospital CEO on Zero Tolerance - BBC News

Addressing Race Inequalities Needs Engagement - The Kings Fund

A fair experience for all: Closing the ethnicity gap in rates of disciplinary action across the NHS workforce - NHS England and NHS Improvement

Health Education England Diversity Performance Dashboard

Civil Service Diversity and Inclusion Dashboard
The Value of Lived Experience - HPMA Newsletter

Diversity and the Case for Transparency - PWC

Shattered hopes: Black and minority ethnic leaders' experiences of breaking the glass ceiling in the NHS - BME Leadership Network NHS Confederation

No more tick boxes: a review on the evidence on how to make recruitment and career progression fairer - NHS England

If your face fits: exploring common mistakes to addressing equality and equity in recruitment- NHS England

Bridgewater Community Healthcare
NHS Foundation Trust

The North West Black, Asian, and Minority ethnic Assembly Anti-racist Framework

Trust Action Plan (Draft)

Date: July 2023

Introduction

The Northwest BAME Assembly has called upon NHS Leaders across the North West to adopt their Anti-racist Framework. The first iteration of the Framework was issued in 2021, with the latest edition being released in June 2023.

Key messages:

- The Framework is not a stand-alone document, it very much supports broader work related to the Public Sector Equality Duty, Equality Objectives, workforce Race Equality Standard (WRES), EDI Improvement plan and the Equality Delivery System
- On the 26th of June 2023 the Co-Chairs of the NHS BAME (Black Asian Minority Ethnic) Assembly wrote to all North West NHS Trusts, and Integrated Care Boards inviting them to adopt the Anti-Racist Framework that has been developed by the Assembly, in conjunction with the Northern Care Alliance's Inclusion Centre of Excellence, and NHSE North West
- The Framework provides a mechanism for NHS organisations to work towards the ambition of becoming actively anti-racist organisations. It aims to enable organisations to put into action quickly, the steps needed to reduce inequalities and eliminate racism, which can be evidenced by the higher rates of bullying and harassment, disproportionate referrals into disciplinary processes, recruitment and selection where ethnicity still impacts your chance of appointment after shortlisting. We also know that racism causes harm to communities through the continued inequalities that we still see across our society
- The Framework seeks to embed the change needed to transform our own departments and teams
- This is not seen as just a nice to do, but is seen as mission critical to all that we do and stand for
- The Framework encourages the tackling of structural racism and discrimination through collaboration, reflective practice, accountability and action. Through the embedding of the themes, deliverables and actions outlined into structures, processes, policies and culture, will help create meaningful and measurable change within the workforce and service delivery
- The Framework is organised into three levels of achievement: Bronze, Silver and Gold. Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination
- Through a commitment to ongoing learning, development and action, the Trust Board can play a pivotal role in effecting positive change within the organisation

The Five Anti-racist Principles: Prioritise anti-racism, understand lived experience, grow inclusive leaders, act to tackle inequalities and review progress regularly

Executive Sponsor: Director of People & Organisational Development

Governance: POD Council, People Committee and Trust Board

Anti-Racist Framework Action Plan 2023 - 2024

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
Bronze Status	**Leading from the front** **The appointment of an executive or director level EDI sponsor with a commitment to advancing anti-racism within the organisation:** • Named Executive Lead • A Race Inclusion Network for staff, chaired by an Executive Lead	Board Director of People & Organisational Development (DoP&OD)		• Equality, Diversity and Inclusion sits in the portfolio of the Trust's Director of People & Organisational Development (DoP&OD) • It has been agreed that the DoP&OD, will be the Race Inclusion Network Chair with effect from July 2023. The Network has always had Executive level support • Executive/NED sponsors are the Trust's CEO and Chair • The Executive Lead reports to the Chief Executive • The Exec Lead channels reporting via the Trust's People Operational Delivery Groups, more commonly referred to as PODs. The 4 PODs are transitioning to an overall POD Council that will report to the Trust's People Committee that meets bi-monthly. The NED Chair produces a report to the Trust Board following each Committee • As referred to above, the Trust has 4 People Operational Delivery Groups (PODs) with EDI running through them all, but reportable to the Culture & Leadership POD • The People Committee were advised at its July meeting that the 4 PODs were now mature enough to form one overall POD Council, reporting to the People Committee and ultimately the Board • EDI reporting is a feature of the Trust Board's Business Cycle • The DoP&OD has had oversight on Board Development days, and has also supported the delivery of Leader in Me (LiM) events - September and December 2022 • The DoP&OD delivered an anti-discrimination in workforce/employment practice paper to the Trust Board at its meeting on the 8th of December 2022 • The DoP&OD and Trust Chair tabled the employment tribunal case of Ms Cox v NHS Commissioning Board Assembly paper to Board in April 2023. The discussion was followed up with a briefing on the details of the employment tribunal case by the DoP&OD

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	• Trust Strategic Objectives • Executive Objectives 2023/24 (Team and Individual)	Executive Management Team		• The Trust has 6 Strategic Objectives, with objective 5 dedicated to Equity, Diversity and Inclusion • There are Executive Team objectives, one of which is "we will create the conditions that promote and allow health equity, equality, inclusivity, diversity and anti-racism to thrive" • There are individual Executive objectives, one of which is "to actively promote equality, diversity, inclusion and anti-racism by creating the conditions that enable compassion and inclusivity to thrive • Appraisals have been conducted, objectives reviewed and signed off for the Trust Board and each Executive has regular 121 meetings with the Chief Executive and objectives and key priorities are discussed at the Executive Management Team (EMT) meetings that are held weekly • The Trust has a Senior Leadership Team (SLT) that meets regularly and the Trust's Equality & Inclusion Manager is a member
	Anti-racism as Mission Critical **Evidence of how the organisation has acted to make anti-racism work mission critical in the past year:** • Overall review of anti-racist actions, work programmes and initiatives that have taken place	Board guided by the DoP&OD and various Leads		• Anti-racism statement published 2020: https://bridgewater.nhs.uk/aboutus/ • Gypsy, Roma, Traveller History Month lunch and learn hosted by Bridgewater and partnering with Irish Community Care and Wirral Community NHS June 2022 • EDI included in the Trust's Corporate Induction Programme - updated to include Anti-racist Framework and statement June 2023 • Board development day held in September 2022 focussed on our anti-racism framework, words to actions • Leader in Me held in December 2022 focussed on anti-racism/discrimination facilitated by external subject matter experts • BAME Assembly letter and information regarding Ms Cox v NHS Commissioning Board shared at Trust Board and with HR colleagues – April 2023 • Just Culture Programme launched August 2021, resulting in a reduction in employee relations cases and ongoing positive trends • Civility and Respect Programme due to be launched summer 2023 • Communications – Ramadhan and South Asian Heritage Month (fostering good relations). April and July/August 2023

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
				• Hate crime information hosted on our Staff Networks Hub page, and shared regularly in awareness events in partnership with our Heath & Wellbeing and Safeguarding teams
	• Review anti-racism statement	Board		•
	• Publish anti-racism objectives annually	Board		•
	• Anti-racism communications and events plan development for 2024	DoP&OD, Comms, EDI and HR Leads		•
	• Update EqIA policy and templates to include being anti-racist as specific	EDI Lead		•
	Actions Not Words **An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance:** • Make contact with the BAME Assembly as per exploring their offer of support	Board guided by EDI Lead		• WRES A Model Employer: Disparity Ratio action plan progression • Identified areas of potential disparity in workforce – experience of discrimination, experience of violence, bullying and harassment, belief that employer provides equity of opportunity in career progression (all NHS Staff Survey 2022). Disparity in experience between UK born and overseas born ethnically diverse staff (Race Inclusion Network)

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	We do this together **The Organisation can demonstrate progress over the last 12 months of reducing an identified health inequality:**	Board		•
	Zero Tolerance **The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members:**			• The Trust has a zero tolerance approach and has a Violence and Aggression Policy (both physical and non-physical) • The Trust has an Equal Opportunities Policy • The Trust has a Dignity & Respect at Work Policy • The Trust has Disciplinary and Grievances Policies and Procedures • The Trust has an Incident Reporting Policy with associated reviewing mechanisms
	• Implementation of the Trust's Civility and Respect Programme	POD Council guided by HR and EDI Leads		• Civility and respect Programme (C&R) • C&R Training • C&R Toolkit development • Dignity at Work Policy refresh is underway • Disciplinary and Grievance policy and toolkit refresh underway. A revised Disciplinary programme is being rolled out and has been attended by Trust Executives • Our Just & Learning Culture Journey is now embedded with clear positive trends on employee relations activity • Zero Tolerance Policy and Procedures • The Trust as a Health & Safety Group, where zero tolerance is discussed • Zero tolerance is referred to at Corporate Induction which takes place each month and is mandated for all new starters, included those retiring and returning • Staff are encouraged to speak up and raise concerns via various means. The Trust's Freedom to Speak Up Guardian has a slot on Induction and is also actively engaging with services to promote 'we

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
				each have a voice that counts' – one of seven of the NHS People Promises
	• Review of procedure and processes requirements, including wellbeing offers/support	POD Council guided by HR and EDI Leads		• As above – we have a 4 step procedure for our Just Culture approach to incidents that we have agreed in partnership with our Staff-side Colleagues • An Employee Relations report is tabled at every People Committee, as is a Freedom to Speak Up Report • HR Policies are reviewed via a formal HR Policy Review Group. A policy review and compliance report is presented to the People Committee at each meeting • The Trust has a Wellbeing Offer, supported by two staff within the Trust's Organisational Development Department • National and regional support for ethnically diverse staff is shared on a regular basis • Our Wellbeing Offer(s) feature in the weekly Bridgewater Bulletin
	• Review the above for cultural appropriateness	POD Council guided by HR and EDI Leads		•
Silver Status	**Empowering Your Talent** **Set up a local BAME leadership council within your organisation:** • EDI governance through the POD Council • Race Inclusion Network to link to the above • Leadership, Education, Learning & Development	HR OD/L&D and EDI Leads		• The Trust has a POD Council where all EDI matters are routed. This reports to the People Committee with Chair's Reports to Trust Board • WRES A Model Employer: Disparity Ratio action plan • Opportunities shared with Race Inclusion Network, including Mary Seacole and other programmes • Reciprocal Mentoring for Inclusion Programme - launched with John Moores University - June 2023 (6 pairs sharing lived experiences) • Engagement with Race Inclusion Network members supporting development of IMG/IEN retention and development project

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	Team to explore targeted talent management, coaching conversations, succession planning, and stretch opportunities			
	All leaders at Band 8A and above must have a personal development plan goal agreed around equality, diversity and inclusion and a process to report annually the percentage of these goals that have been met: • Trust Strategy – strategic objectives, mission, vision and values • Review of PPDR and Appraisal Paperwork • Leaders/Managers to identify actions and create plans within their work to advance anti-racism	HR OD/L&D and EDI Leads		• A review of the Trust's PPDR and Appraisal processes are underway to dovetail with the NHS People Plan, Promise and Long Term Workforce Plan • Adoption and implementation of "Scope for Growth" is underway (a North West initiative/programme of work)
	Growing Cultural Competency **Evidence of inclusive leadership education for all executive directors:**			• Board development day September 2022 – anti-racism framework, words to actions • Leader in Me December 2022 – anti-racism/discrimination • Reciprocal mentoring programme launch in June 2023 • HR Skills training

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
				• Civility and respect training • Operational, and first line managers training
	• Black History Month – conversations about race and racism proposals	EDI Lead		•
	• Equality Act/Public Sector Equality Duty (PSED) training	EDI Lead		• Operational managers and first line managers training programme
	• Cultural awareness training	EDI Lead		• Board Development Programme • Specific CAT proposal pursued via Enable 2
	• Reciprocal Mentoring for Inclusion Programme	Board, EDI Lead and Mentors		• Partnered with John Moore's University • Programme launched 12th of June – 6 Mentoring Pairs • Programme of work / shared experiences over the coming months • Consideration of outcomes
	• Inclusive Recruitment Programme	POD Council guided by Head of Workforce		• A review of the Trust's recruitment and selection practices are underway • A Recruitment Pack and branding is under development
	Listen and Learn **An executive director must attend Black, Asian and Minority Ethnic staff network meeting at least four times a year.**	Director of People & Organisational Development (DoP&OD)		• Executive Lead is in place with Chair and CEO sponsors aligned to the Trust's Race Inclusion Network. • DoP&OD is Chair of Race Inclusion Network • Network updates are provided through People governance cycle – POD Council and People Committee • The Trust's Corporate Partnership Forum and Local Negotiating Council (Trade Unions and Management) receive updates

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	• Executive attendance at the Race Inclusion Network	DoP&OD		• The Trust's Director of People & OD chairs the Network
	• Propose recruitment of co-Chair from membership of Race Inclusion Network	DoP&OD		• An ask for a Deputy Network Chair is to be tabled at the Race Inclusion Network's meeting in July
	• Consider ethnically diverse staff voice at Board level	Board		•
	Data Plus **WRES data and workforce data disaggregated by ethnic groups to be presented at Board meetings to ensure that racial disparities are monitored and addressed as a part of the business as usual:**			• NHS Staff Survey data included within 2023 WRES report • Race Inclusion Network engagement supported development of WRES action plan 2023 • Discussions held at People Committee on IQPR report re representation in workforce data • Model Hospital EDI dashboard launched with WRES and NHS Staff Survey data available for all Trusts • Regional EDI dashboard in development – content as yet unseen
	• Include full NHS Staff Survey breakdown in annual WRES report	HR, Workforce and EDI Leads		•
	• Discuss with HR proposal for disaggregation of appropriate workforce data	EDI and HR Leads		•

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	• Submit paper to POD Council and People Committee to reflect the above	EDI and HR Leads		•
	• Develop review cycle for the Race Inclusion Network	EDI Lead Chair of the RIN (DoP&OD)		•
Gold Status	**Visibility Matters** **An organisation's board of directors' diversity by ethnicity must match closely the diversity of the local population or at the minimum include one Black, Asian or Minority Ethnic member (whichever figure is higher):**			
	• Review to be undertaken following recent changes in April 2023	EDI Lead		• WRES data shows over-representation of ethnically diverse Board when compared to overall workforce
	How are we performing **An organisation must use an EDI performance dashboard that is presented quarterly to at least a sub-group of the board and include performance against the race disparity ratio,**			

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	WRES and other race specific targets:			
	• Review options for EDI dashboard within governance structures	EDI and Workforce Leads		• Model Hospital EDI dashboard launched with WRES and NHS Staff Survey data available for all Trusts •
	• Publish ethnicity pay gap report	EDI Lead		• Ethnicity pay gap report 2022 completed but requiring review and sign off
	• Review PSED/WRES/WDES/GPG for intersectionality of data provided	EDI Lead		• PSED annual report published 2010 to 2023 – some data provided with additional analysis regarding some intersectionality - to be reviewed
	• Staff self-reporting project	EDI and Workforce Leads	30.09.23	• Draft guide produced
	• Anti-racist update in governance requires agreement	EDI Lead		•
	More than a tick box **The organisation must be able to demonstrate two years of consecutive improvement against at least five WRES measures:**			
	• Identification and review of an initial 5 WRES	EDI Lead		• WRES reports and data will support this, including information from the annual NHS Staff Survey

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	measures, subject to extending the number of measures over time			
	• Evidence of 2 year's consecutive improvements in the 5 WRES measures, subject to extending the number of measures over time	EDI Lead		• As above - WRES reports and data will support this, including information from the annual NHS Staff Survey
	Fair and Just **The organisation can evidence diverse representation within their disciplinary and grievance processes:**			• Our Just & Learning Culture Programme • Disciplinary & Grievance Policies and Procedures • Employee Relations Report to the Trust's People Committee as a standing agenda item
	• FTSU Guardian and Champions • Alignment to Staff Networks	EDI, FTSU and HR Leads		• FTSU Guardian aligned to Staff Networks • FTSU Champion recruited from Race Inclusion Network • Civility and Respect Programme ready to launch in summer 2023
	• Draft proposal for diversity in panels for employee journeys	EDI, HR and Workforce Leads		• Engagement with the Race Inclusion Network to understand barriers and experiences began 2023
	• Review un/subconscious bias training options	EDI, EPD and OD Leads		•

LEVEL	KEY DRIVERS, DELIVERABLES AND SUPPORTING ACTIONS	KEY LEADS	TARGET COMPLETION DATE	COMMENTS / PROGRESS
	Our Voices Matter **The organisation should bring together annually Black, Asian, and Minority ethnic staff to review EDI progress and any learning be built into the following year's plans:**			
	• Include action plan updates on the Race Inclusion Network agenda every three months	EDI Lead		• Race Inclusion Network members engaged in review of data and creation of WRES action plans before reports submitted for sign off through governance

Version 1: 22nd July 2023

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**3 August 2023**
Agenda Item	**60/23iii**		
Report Title	**NHS LONG TERM WORKFORCE PLAN (LTWP)**		
Executive Lead	Paula Woods – Director of People and Organisational Development		
Report Author	Paula Woods – Director of People and Organisational Development Joanne Waldron – Deputy Director of People and Organisational Development Kathryn Sharkey – Head of Workforce		
Presented by	Paula Woods – Director of People and Organisational Development		
Action Required	☐ **To Approve**	☒ **To Assure**	☒ **To Note**

Executive Summary

On Friday the 30th of June 2023, NHS England published the long-awaited NHS Long Term Workforce Plan (LTWP). The plan supports the efforts to shape the future of the healthcare workforce following the acceptance of the current workforce shortages and challenges.

The plan sets out the expansion in training, changes to ways of working and improvements to culture that will increase the NHS permanent workforce over the next 15 years.

The plan was supported by timed and explicit communications from NHS England. Trust communications were dispatched at 10am that day which included links to the plan. The following Monday, the 3rd of July saw a feature on the plan delivered at Team Brief and there was also a feature in the Bridgewater Bulletin.

The actions of the plan fall into three clear priority areas – **Train, Retain and Reform**:

- **Train** - Substantially growing the number of doctors, nurses, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.
- **Retain** - A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.
- **Reform** - Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

NHS Employers produced a key action report to aid Trusts in reviewing their position against the LTWP. Appendix 1 contains a readiness exercise that we have completed to examine our current position, practices, and approaches. Furthermore, we have identified the next steps that we can consider taking to achieve outcomes to support the delivery of the LTWP. It should be noted that this is very much an 'initial' assessment, and it requires wider engagement within the Trust which we are on with.

As the Board are aware, we currently have had 4 People Operational Delivery Groups, more commonly referred to as PODs. We established these to deliver on the NHS People Plan and Promises. These are now embedded enough to enable us to progress to having one overall POD Council.

The POD Action Plans and progress are reported to the Trust's People Committee. These governance and reporting infrastructures will be the route for updating on the progress we are making with the NHS Long Term Workforce Plan.

Reference, and a link to the Workforce Plan, featured in the Director of People and Organisational Development's Update Report to the People Committee that met on the 12th of July.

A number of webinars have been attended by Trust personnel, with one specific to the North West region. Further detail is expected on the funding regimes, education infrastructures and plans. The LTWP is a total of 151 pages and is accessible via NHS Long Term Workforce Plan (england.nhs.uk)

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 DIRECTOR

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 AUGUST 2023**
Agenda Item	**00/23**		
Report Title	**NHS LONG TERM WORKFORCE PLAN (LTWP)**		
Report Author	Paula Woods – Director of People & Organisational Development Joanne Waldron – Deputy Director of People & Organisational Development Kathryn Sharkey – Head of Workforce		
Purpose	To inform the Board of the key points for consideration of the newly launched NHS Long Term Workforce Plan.		

1. SCOPE

1.1 This report summarises, at a high level, the details of the long-awaited publication of the NHS Long Term Workforce Plan (LTWP) which was published / launched on the 30th of June 2023 NHS Long Term Workforce Plan (england.nhs.uk)

1.2 The report is supported by an initial Trust readiness assessment against the plan as per Appendix 1. This has been carried out using documentation provided to Trusts by NHS Employers, by Members of the People Directorate in the first instance. Plans are now in place to facilitate wider Trust engagement.

2. INTRODUCTION

2.1 On Friday the 30th of June 2023, NHS England published the NHS LTWP. This plan supports the efforts to shape the future of the healthcare workforce following the acceptance of the current workforce shortages and challenges. The plan sets out the expansion in training, changes to ways of working and improvements to culture that will increase the NHS permanent workforce over the next 15 years.

2.2 As at March 2023 there were 112,000 vacancies nationally - an 8.0% vacancy rate. Levels of staffing in the NHS are proportionally lower than other comparable health systems internationally.

2.3 The LTWP was supported by timed and explicit communications from NHS England. Trust communications were dispatched at 10 am on Friday 30th June, which included links to the plan itself – all 151 pages. The following Monday, the 3rd of July saw a feature on the plan delivered at Team Brief and also featured in the Bridgewater Bulletin. Staff will be kept updated on our progress.

3. KEY THEMES FROM THE NHS LONG TERM WORKFORCE PLAN

3.1 The actions of the LTWP fall into three clear priority areas:

- **Train** - Substantially growing the number of doctors, nurses, allied health professionals and support staff. This is underpinned by a £2.4 billion funding commitment.
- **Retain** - A renewed focus and major drive on retention, with better opportunities for career development and improved flexible working options. This comes alongside reforms to the pension scheme, with an aim to retain 130,000 staff working in the NHS for longer.
- **Reform** - Working differently and delivering training in new ways. Advances in technology and treatments will be explored and implemented to help the NHS modernise and meet future requirements.

3.2 The plan commits to supporting and developing the workforce with an immediate boost in training numbers. There will be an investment of more than £2.4 billion to fund the 27% expansion places by 2028/29. The roles important to us as a Trust are identified below. This will increase:

- Adult nursing training places by 92%. Over the next 6 years at least 8,000 more adult nurses will start training compared to the current levels.
- Training places for nursing associates to 10,500 by 2031/2032. This will increase training places by 7,000 by 2028/2029. Over the next 2 years, this equates to 5,000 by 2024/2025.
- AHP training places to 17,000 by 2028/29.
- Expand places for Pharmacists by 29% to around 4,300 by 2028/2029.
- Increase training places for dental therapists and hygiene professionals to 500 by 2031/2032 and increase training places for dentists by 40% to more than 1,100 by the same year.

3.3 Apprenticeship expansion is a key focus within the plan and supports recruitment within local communities. To implement this plan, NHS England will develop an apprenticeship funding approach that better supports employers. As a Trust that is heavily wedded to the support for apprenticeships, this is most welcomed.

3.4 Retaining staff is also a key element of the plan, along with embedding the right culture to improve retention. The impact of the plan's proposals is to reduce overall leaver rates to between 7.4% and 8.2%. Again, this is something that we are focused on and we are reporting our turnover as per the IQPR and by way of more detailed reports to the People Committee.

3.5 As we continue to embed the NHS People Plan and Promise, the NHS national retention programmes and leadership recommendations of the Kark Report and Messenger Review will support the delivery of sustained gains across the workforce and support retention.

3.6 The NHS Our People Promise is covered in the plan, with the 7 Promises contributing to retention and embedding the right culture to improving retention. As the Trust Board are aware, we have 4 PODs that are delivering on the Promises that we are able to measure via the annual NHS Staff Survey. The maturity of the PODs has lent itself to us having one overall POD Council, reporting to the Trust's People Committee.

3.7 Training and working differently will support reform to grow the workforce to meet the changing needs and complexity of patients within our communities. Innovation including digital innovation is key to shifting skills and capacity into the community. The plan supports the delivery of out-of-hospital care and identifies that the total number of NHS staff working in non-acute settings is projected to increase from the current 30% to 37% and the total community workforce will nearly double in size by 2031/2032.

3.8 NHS England will continue to provide guidance in working with education institutes, registered bodies and the Education Reform Programmes.

3.9 The 'devil is in the detail' which we await, whilst moving forward with our next steps as outlined in Appendix 1.

4. NEXT STEPS

4.1 NHS England will refresh the LTWP every two years and set out education and training expenditures in regular financial reports.

4.2 Following the publication of the LTWP, it was tabled at the Cheshire & Merseyside Social Partnership Forum (SPF) in July. The SPF comprises of HR Directors and Regional Trade Union Representatives. Following on from that there was North West Regional Roadshow that took place on Monday the 10th of July. Amanda Pritchard, NHS Chief Executive was unable to attend the meeting, which was opened up by Graham Urwin, CEO of NHS Cheshire and Merseyside. Also present were Steve Powis, National Medical Director; Ruth May, Chief Nursing Officer; Navina Evans, Chief Workforce Officer; along with other NHS England Executive Group colleagues. The North West Regional invite was extended to ICB and Trust CEOs, Medical Directors, Chief Nurses, Chief Operating Officers and HR Directors. The session was attended by the Trust's CEO, Deputy CEO/Chief Nurse and Director of People & Organisational Development.

4.3 The ICS will play a critical role in bringing the plan together with Local Authorities and wider system partners. The ICBs and partner Trusts will set out their priorities for workforce action in their five-year joint forward plans (JFPs).

4.4 As referred to earlier, NHS Employers have produced a key actions report. In Appendix 1 there is a readiness exercise that has been completed to examine our current practices and approaches, including our next steps that can be taken to achieve outcomes to support the workforce plan.

5. RECOMMENDATIONS

5.1 The Board is asked to:

- note the content of the report and be assured of the programmes of work and initiatives to support the implementation of LTWP.

6. APPENDICES

Appendix 1 Trust Readiness Exercise

NHS LONG TERM WORKFORCE PLAN 2023

ACTION FOR EMPLOYERS – TRUST POSITION AND NEXT STEPS

Theme	Action for Employers	Bridgewater's Position (including next steps)
Train	**By significantly expanding domestic education, training and recruitment, we will have more healthcare professionals working in the NHS.**	
Apprenticeships	Upscale apprenticeship offer for all training of clinical staff. Share voice through networks to feed into NHS England's development of an apprenticeship funding approach to facilitate the increase in apprenticeship places. Widen access of opportunities to people from all backgrounds and in underserved areas to join the NHS through apprenticeships. Transfer apprenticeship levy funds between employers to ensure committed funding is used.	• We have significantly increased our internal and external Apprenticeship Offer in 2022/2023. This is continuing into 2023/2024 • We had 40 Apprenticeship starts during 2023/2024 • As at 19th of July 2023, we have 105 Apprentices within the Trust • We have an Apprenticeship Lead engaged with National and Regional Networks • We are member of the North West Apprenticeship Strategy Network, actively participating in its agenda and work programmes (Executive input is via the Deputy CEO/Chief Nurse and Director of People & OD) • Healthcare Support (Nursing and Therapies) and Business Administration Level 2 and Level 3 Apprenticeships are in place. We are recruiting and have recruited externally to roles • We have Degree Nurse, Physiotherapy, Occupational Therapy and Podiatry Apprenticeships within the Trust • We are using the Apprenticeship Levy to support local Hospice Apprenticeships • The total Apprenticeship Levy expiry for 2022/23 was £43,672.56 which is 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

Theme	Action for Employers	Bridgewater's Position (including next steps)
		moving forward due to significantly increased spend and utilisation of funds • We are working with Schools, Colleges and the Department of Work & Pensions (DWP) to promote our vacancies • We have Service Workforce Plans and there are continuing discussions as to how to change our skills mix, develop new roles, new ways of working etc • Our Director of People & OD is the Chair of the Warrington Together Workforce & OD Enabling Group (WEG). One of its key priorities is a place-based approach to Apprenticeships and an aspiration to have a centralised approach to recruitment, at place. The WEG meets monthly and an Integrated Place-based Workforce Strategy is under development and nearing completion. Apprenticeships and the levy has been agreed as a top priority – 19th July 2023 • We are committed to the national Care Leaver Covenant (CLC) that offers those aged 16-25, leaving the care system employment, training and education opportunities. We, as a Trust have signed up to the CLC Employment Charter. There is also a local, place-based and ICB commitment to this and it is an integral part of workforce plans (and strategies) at both levels. The Trust's Director of People & OD is co-ordinating a Warrington place-based approach in conjunction with Cheshire & Merseyside ICB Leads. There is scope to link the CLC to Apprenticeships. We have a Care Leaver at the Trust who attended Westminster Abbey to celebrate the NHS' 75 Birthday • We have won awards and received both national and regional recognition for our Apprenticeship Programmes and our approaches to the recruitment and development of the same • We have an Apprentice of the Year Award from a local College for one of our Health Care Support Workers

Theme	Action for Employers	Bridgewater's Position (including next steps)
		Next Steps • To map out and plan set recruitment drives to continue to increase Apprenticeship placements • To increase the centralised budget for Apprenticeships to allow for planned recruitment drives and development • To progress a place-based approach to Apprenticeships which, as referenced above, is a key priority
Placements	Increase placement capacity and experience to support increased training places in the NHS. Support legislation suggestions to reduce placement hours from 2,300 to 1,800 over the course of a Nursing and Midwifery Council (NMC) degree. Engage with higher education institutions to support students, placement capacity and maximise accreditation of recognition of prior learning (RPL). Develop multi-professional, system-based rotational clinical placement models to increase capacity. Ensure clinical placements are designed into health and care services through co-design of a nationwide approach to clinical placement management.	• The Trust's Practice Education Facilitators (PEFs) support student placements and work with higher education providers to support students • Current placement capacity is mapped out with Trust teams. The PEF Team work with services to identify issues with placement capacity to ensure that placements are available • We have increased engagement events for students • We have recruited 2nd & 3rd year students into our vacancies • We have extremely positive feedback from students – very high satisfaction levels which we are proud of, year on year • Our PEF Team are working with regional organisations to identify different ways of hosting placements **Next Steps** • Increased placements will require, without doubt, increased support and mentorship to ensure the safety of service and students. Induction and onboarding programmes are more crucial than ever noting that we have a workforce that is under pressure, locally, regionally and nationally • We will identify and produce a process for a system-based approach to clinical rotational placements

Theme	Action for Employers	Bridgewater's Position (including next steps)
Students	Understand and address the reasons students leave training and the variation in their experiences to increase support. Implement a single consistent policy for funding excess travel and accommodation costs incurred by students undertaking placements. Implement the new educator workforce strategy which sets out actions that will lead to sufficient capacity and quality of educators.	• The PEF Team work with students and local higher education providers to understand any issues that can increase support **<u>Next Steps</u>** • Further information is required from NHS England and how this impacts the regional direction of the Education Reforms and Policy
Nursing and Midwifery	Increase nursing and midwifery training capacity to support a higher number of training places available through traditional routes and apprenticeships. Focus on mental health and learning disability nursing training and recruitment. Recruit newly qualified nurses to join the NMC register on qualification at end of third academic year, permitting new registrants to be in employment up to four months earlier.	• Our first cohort of employed Degree Nurse Apprentices completed year one in July 2023 • We have new recruitment drives to recruit 2nd & 3rd year students. Recruitment days/events have been very successful • We have and continue to attend University recruitment and career events • We have a Muti-Professional Preceptorship Policy and with the support of NHSE Preceptorship Leads, we are working towards the Preceptorship Quality Mark • We have Preceptorship Programmes in place for newly qualified staff and pre-preceptorship for 3rd year students • We are in the final stages of recruitment to a Legacy Mentor in both Halton and Warrington, which will increase the wrap around support already in place for Newly Qualified Nurses and AHPs (Preceptors, Professional Nurse Advocates, Clinical Practice Educators, Practice Education Facilitators) • We have increased Trainee Nurse Associate roles for 2023/2024. Development pathways are available for top-up to Degree Nurse Apprenticeships

Theme	Action for Employers	Bridgewater's Position (including next steps)
		Next Steps • Increase recruitment / career fair events • Identify funding for the cohort of the next Registered Nursing Degree Apprentices • Identify areas where we can increase capacity where safe and quality placements can take place – induction and onboarding are key • Identify where increased support will be required for placements and preceptorships i.e. Practice Education Facilitators and Clinical Practice Educators
Domestic Recruitment	Add value to your local communities through access to employment programmes and the provision of education and training. Recruit more people from local communities, focusing on those who may experience health inequalities. Boost recruitment to support worker roles and in-role development. Supported by a national recruitment programme and recruitment exercises for entry-level NHS jobs. Continue work at the system and local level to build on talent attraction strategies, taking advantage of the strong reputation and unique employee value proposition the NHS offers. Facilitate skills development including digital skills, career progression and social mobility	• Working with local Schools, Colleges and the Department of Work and Pensions (DWP) to offer Readiness for Work Programmes and promote vacancies. This has been extremely successful for Healthcare Support Workers and Business Administration Apprenticeships • We have increased Healthcare Support Worker Nursing and Therapies Apprenticeship roles. This has supported career development with 4 out of 5 Registered Degree Nurse Apprentices starting on the Healthcare Support Worker Nursing pathway • A Recruitment Task and Finish Group was established and is now embedded, working on improving Trust recruitment processes including job descriptions, digital enhancements, recruitment fairs, recruitment communications and veteran recruitment • We have signed up to the Care Leaver Covenant, that commits to offering employment, education and training opportunities to 16-25 year olds **Next Steps** • To continue to improve our recruitment processes

Theme	Action for Employers	Bridgewater's Position (including next steps)
	programmes. Adopt new recruitment practices and systems in line with the outcomes of the national programme to overhaul NHS recruitment.	• To continue to work within our local communities to support recruitment drives
Allied Health Professions (AHPs)	Increase AHP training capacity to support higher number of training places available through traditional routes and apprenticeships. Support paramedic students to enter the workforce as a registered clinical within two years rather than the traditional three years.	• The Trust has a dedicated AHP Workforce Strategy Lead • The Trust has a AHP Workforce Strategy • We have staff undertaking Physio and Occupational Therapy Apprenticeships to become registered AHP staff (career pathways and development) **<u>Next Steps</u>** • Identify funding for the cohort of the next Registered AHP Degree Apprentices
Healthcare Scientists	Increase healthcare science training capacity to support higher number of training places available through traditional routes and apprenticeships.	• The Trust employs a small number of Healthcare Scientists within its Audiology Services **<u>Next Steps</u>** • To identify career development and Apprentice opportunities within these services
International Recruitment (IR)	Scale back dependence on international recruitment. The speed and scale of action in each area of the plan will determine how quickly this can happen. In 15 years' time, it is expected around 9-10.5 per cent of the workforce to be recruited from overseas, compared to almost a quarter now.	• As a Community Trust, it was agreed that we would not commit to the 'International Recruitment Drives' due to the infrastructure required not lending itself to us in terms of pastoral support, shadowing, the ability to travel across our patch, accommodation etc • Our position on IR was discussed with the ICB and it was recognised that as a Community Trust we were very restricted, as

Theme	Action for Employers	Bridgewater's Position (including next steps)
	Maintain current levels of ethical international recruitment of adult nurses in the short and medium term to meet workforce demand.	outlined above, in our ability to provide the required accommodation, shadowing and pastoral support
Pre-employment	Support pre-employment initiatives to equip young people and adults into a career of their choice in the NHS through next steps of higher education or apprenticeships. Work with system partners to maximise how the NHS works as an anchor institution to expand access routes into training in the NHS.	• Working with local Schools, Colleges, Career Hubs and the Department of Work and Pensions (DWP) to offer Readiness for Work programmes and promote vacancies. This has been successful for the Healthcare Support Workers and Business Administration Apprenticeships • Recruitment of support roles - the number of local applicants from both Warrington and Halton is high. Additionally encouraging is the number of candidates who are either seeking first steps into employment, applying in the hope of ending a period of unemployment or seeking to join us from a different employment sector **<u>Next Steps</u>** • Continue to work with local partners to support pre-employment initiatives • To develop processes working with systems partners to offer a system approach for pre-employment placements and career opportunities
Doctors	Increase training capacity to support higher number of training places available and increased use of the apprenticeship route. Support changes in approach to training to provide a better balance of generalist and specialist skills.	• Work is being undertaken to identify future placements and training capacity for Doctors **<u>Next Steps</u>** • Awaiting further information from National and Regional teams to support the changes in approaches to training

Theme	Action for Employers	Bridgewater's Position (including next steps)
		• Identify areas/roles/education to access the apprenticeship levy/route
Retain	**By improving culture, leadership and wellbeing, we will ensure up to 130,000 fewer staff leave the NHS over the next 15 years. The plan aims for a reduction in leaver rates from 9 to 7.4 per cent over time.**	
Retention - embedding the right culture and improving retention	Implement local level plans to deliver improvements. Make the NHS People Promise a reality for our NHS staff, recognising the differing needs of the workforce in terms of generational differences and career stage. Work differently to create a consistently compassionate, inclusive and values-driven culture that delivers better staff experience now and in the future. Offer every staff member the opportunity for regular conversations to discuss what will keep them in work. System partners should work together to determine how these actions are best implemented to provide a consistent staff experience across organisational boundaries.	The Trust has implemented the below to deliver improvements to embedding the right culture local to our organisation: • A new POD Council – combing the 4 existing well embedded People Operational Delivery Groups more commonly referred to as PODs: Culture & Leadership, Recruitment & Retention, Education and Health & Wellbeing, now that they are fully embedded and engrained • We have implemented the Just & Learning Culture Programme – a significant transformation programme with regards to how we manage and handle incidents and employee relations matters. This has resulted in a reduction in employee relations cases. We have two Executive Directors sponsoring this programme • We have a Trust 'Behavioural Framework' • We have developed a Civility & Respect Toolkit (Bullying & Harassment) • We have Staff Survey Action Plans at Corporate and Borough levels which are actively monitored and reported to the Performance Council, Committees and ultimately Trust Board • We have quarterly 'Leader in Me' events with guest speakers on various topic such as compassionate leadership, race equality, health and wellbeing etc • Board Development Days – aligned to the Trust's objectives • We have a People Strategy that is delivered via the Trust's PODs and is measured via the NHS Staff Survey and regular NHS Pulse

Theme	Action for Employers	Bridgewater's Position (including next steps)
		Surveys. Our Staff Survey results are positive with high response rates • The NHS People Plan has been aligned to the People Directorate outcomes and monitored via the PODs and People Committee • Career Development pathways are being produced for all staffing groups • We are implementing 'Scope for Growth' – This includes robust 'Career Conversations' (a North West initiative/programme of work) • Health & Wellbeing Conversations are prevalent, supported by training and now included as an integral part of the PDR and Appraisal processes • We have 'Retention Toolkits' and are an active member of the North West Retention Network • We are analysing and are reporting on leaver data to identify areas of improvement • We are using exit Interview data to support retention initiatives • We are progressing the implementation of 'Stay Conversations' • We are an Early Adopter Site for the North West Holistic Attendance and Wellbeing Policy that will see the removal of absence triggers and a wellbeing plan developed for all staff – this is a significant culture change programme. We are taking the lead on developing the associated training programme and toolkit **Next Steps** • To continue to drive forward improvements to support organisational culture and retention via the established task and finish groups and the POD Council • Improved data triangulation via the POD Council • Working with System Partners to implement Workforce Strategies

Theme	Action for Employers	Bridgewater's Position (including next steps)
Flexible Retirement	Implement plans to improve flexible opportunities for prospective retirees and deliver the actions needed to modernise the NHS Pension Scheme, building on changes announced by the government in the Spring Budget 2023 to pension tax arrangements, which came into effect in April 2023. Offer every staff member the opportunity for regular conversations to discuss pension flexibilities.	• Flexible Retirement options are readily available to staff and are actively promoted. We have lots of retire and return staff • We promote flexible working arrangements and this includes flexible working for those who retire and return • NHS Pension webinars and Pension support are available via our payroll provider • We have systems that monitor retire and returns to the Trust • Retire and return staff attend the Trust's Corporate Induction Programme **<u>Next Steps</u>** • Increase NHS Pension conversations and sessions with qualified Pensions Teams to provide discussions with staff on pension options
Flexible Working- boosting the flexibilities we offer our staff to work in ways that suit them and work for patients	Offer every staff member the opportunity for regular conversations to discuss flexible working options. From day one of employment, offer people flexible working and the best possible start to an NHS career. Support individuals, managers and teams to work together to explore flexible working options. Engage with opportunities to work closely with system partners to consider flexible working options for every job and clearly communicate these to staff.	• We have a Flexible Working Policy and Procedure • We have established a Flexible Working Task and Finish Group. We are in the planning stage of launching a Flexible Working Campaign • We have a Pilot about to commence to encourage flexible working arrangements with the Trust's District Nursing services with the aim of supporting those services where traditional ways of roster planning are reviewed, to allow more flexibility across the workforce • Flexible Working discussions are promoted at interview and are detailed in job adverts • We have a new recruitment pack that contains a section on flexible working – it's currently at design stage • We are set to complete an audit on current flexible working arrangements to understand our current position

Theme	Action for Employers	Bridgewater's Position (including next steps)
	Ensure e-rostering and e-rostering metrics are regularly reviewed at board level. Adopt the NHS Digital Staff Passport at pace once available at ICS level. Develop collaborative banks to offer more flexibility opportunities for staff and help reduce agency spend. Restrict staff offering services via agency.	• As referred to earlier, flexible working requests are monitored via the ESR System so that monitoring can take place, particular refused applications which are further explored • Health & Wellbeing Conversations are taking place and there are training programmes to support this. These conversations are integral to the Trust's PPDR process • Flexible working reporting is via to the PODs and soon to be the POD Council. This routes through the People Committee • Our Deputy Director of People & Organisational Development and Deputy Director of Nursing are actively working with regional groups to implement and share best practice. The same applies for HR Director and Chief Nurse Networks • We have a focus on the NHS Nursing Retention Toolkit which includes the population of returns, action plans etc **<u>Next Steps</u>** • To adopt the NHS Digital Staff Passport when available at ICS level • To produce E-Roster reports to detail flexible working options as part of a People Scorecard which is under development already
Reward and Recognition	Everyone working in the NHS should be recognised and rewarded fairly to help ensure we attract and retain the staff we need to provide the best possible care for patients. From 2023/24, NHS organisations should work with system partners to develop a clear employee value proposition (EVP) and promote this across the workforce.	• Reward and recognition are included in the work of the Trust's PODs. It's a People Promise that we are committed to, as measured by the annual NHS Staff Survey • We pay in line with national Terms and Conditions of Service/Employment • There is a commitment in Cheshire & Merseyside to have a level playing field on incentives and to operate in line with national terms and conditions of service

Theme	Action for Employers	Bridgewater's Position (including next steps)
	ICSs to agree plans across their system for implementing flexibilities – where permissible – within national terms and conditions (such as local incentives for new recruits and bank rates), to facilitate a more strategic and aligned approach to improving reward and recognition for staff. ICSs are encouraged to work with partners to support the recommendations of the Fuller stocktake for innovative employment models and adoption of NHS terms and conditions in primary care.	• We have career pathway and development opportunities available via Apprenticeship routes and routes such as our Dental Nursing Programme • We have Band 5 to 6 career progression protocols in place in line with Agenda for Change terms and conditions of service/employment • We have a Staff Engagement Framework that recognises awards, accreditations and achievements. Our successes are featured in the Trust's Bridgewater Bulletin and Team Brief. We also have an annual Staff Awards event • We have Long Service Awards and these are recognised at our Staff Awards ceremony each year • We have received a number of national workforce awards and have also been recognised regionally for our achievements • At a system and place-based level there is work to have level playing fields with regards to incentives, agency rates, etc • At a system level there is an Efficiency at Scale Working Group – the Trust's Director of People & Organisational Development is a member • The Trust's Director of People & Organisational Development chairs the Warrington Together Workforce & OD Enabling Group (WEG) who are looking at key workforce priorities as a Warrington place. Work is underway to finalise a Warrington Place-based Workforce Strategy by the summer/autumn of 2023. Key priorities were proposed at the WEG's July meeting: Apprenticeships, Staff Health & Wellbeing, Career Incubators, and a Workforce Dashboard • It is the ICB's intention to sign Trusts up to the Care Leaver Covenant – target date of October 2023. We are engaged with this and have signed up as a Trust in July. The NHS as a whole is to be committed to the Charter

Theme	Action for Employers	Bridgewater's Position (including next steps)
		Next Steps • We await further guidance from ICS and system partners to support agreed plans
Medical Associate Professions (MAPS)	As part of the continuing drive to provide safe, accessible and high-quality care for patients, the NHS has seen the emergence of new medical associate professions (MAPs) working across multi-professional teams.	• Currently the Trust does not employ any Medical Associate Professionals (MAPSs). • Four roles have been established within both hospital and community settings which include Physician associates, Advanced critical care practitioners, Surgical care practitioners and Anaesthesia associates. **Next Steps** • Identify if the Physician Associates role could be introduced into teams to support multi professional and/or disciplinary teams
Healthy Working Conditions	Develop and implement plans to invest in occupational health and wellbeing services at ICS level. Occupational health services and interventions to improve health and wellbeing should be overseen by the wellbeing guardian (or equivalent leadership role) and reviewed continually by local boards, drawing on evidence to assess impact and priorities for further improvement. Review the NHS Health and Wellbeing Framework and the National Standards for Healthcare Food and Drink to ensure that all staff	• Occupational Health and Staff Health and Wellbeing is on the North West and Cheshire & Merseyside HR Director Network's agendas • The Trust has a Health & Wellbeing POD that is well established with a significant wellbeing offer – this will be incorporated into the newly established POD Council • We have Health & Wellbeing Function/Team • Individual and Team Stress Risk Assessments • We have various Health & Wellbeing Training programmes • We are working in partnership with Rugby League Cares – a mental and physical wellbeing programme, the results of which are having a positive impact on our staff • We have targeted Team Health & Wellbeing support from a Trust Health & Wellbeing Lead, who is responsible for overseeing the implementation of the Health and Wellbeing Framework

Theme	Action for Employers	Bridgewater's Position (including next steps)
	are working within an environment that supports their health and wellbeing. Appoint domestic abuse and sexual violence (DASV) leads. Offer every staff member the opportunity for regular wellbeing conversations.	• Health & Wellbeing Conversations are now embedded and supported by training • We have signed up to the North West Wellbeing Pledge: We are an Early Adopter of the Wellbeing & Sickness Absence Policy that has been approved with Trade Unions. The four organisations involved in the 'early adopter' programme met in May and will meet again in July. The key Lead is in the process of developing the education and training package which is very much a work in progress, offered up by a HR Business Partner at the Trust • Health & Wellbeing Packages are available for all staff to access including Rugby League Cares sessions referred to earlier which are really well received by staff • Our Occupational Health Services provide support to staff. We have monthly meetings in place to review the offer and uptake. We also have an Employee Assistance Programme (EAP) which provides advice, guidance and support to staff 24/7, 365 days a year which includes face to face interventions • We have a fast-track Physiotherapy service available to all staff **<u>Next Steps</u>** • Further guidance from ICS on developing and implementing plans to invest in occupational health and wellbeing services at ICS level
Culture and Staff Engagement	Employers should ensure staff and learners are treated fairly within a compassionate and inclusive culture and deliver outcomes against the six high-impact actions set out in the equality, diversity and inclusion improvement plan for the NHS.	The Trust has implemented the below to deliver improvements to embedding the right culture and Staff Engagement local to our organisation: • We are establishing a new POD Council – This involves combining the existing Culture & Leadership, Recruitment & Retention, Education and Health & Wellbeing PODs

Theme	Action for Employers	Bridgewater's Position (including next steps)
	Employers should embed a compassionate culture built on civility, respect and equal opportunity. Employers should undertake a regular culture review to understand how to improve staff experience. Organisations should consider how best to support team development. Organisations should have a clear and regularly communicated freedom to speak up approach. Organisations are encouraged to review their existing approach to listening to staff to ensure it engages and staff feedback is acted on. Organisations should make better use of national tools and to more regularly use employee engagement metrics to inform improvement plans.	• We have Implemented a Just & Learning Culture Programme – a significant culture change and transformation programme that is yielding benefits and seeing a reduction in employee relations cases • We have a Trust Behavioural Framework, closely linked to the Trust PEOPLE Values • We have Civility & Respect Toolkit • We have Staff Survey Action Plans • We conduct a Quarterly NHS Pulse Survey • We have Staff Engagement roles and Champions within the Trust – approx. 70 Champs that also promote staff health and wellbeing as part of their role • We have Staff Network Groups – Menopause, Race Inclusion, Carers, LGBTQ+, Disability etc. The Networks have Executive Sponsors • Leader in Me Events are open and accessible to all staff • We have Freedom to Speak up Leads and Champions across the organisation with Executive Sponsors • We have a People Strategy that we are delivering on as reported to the Trust's People Committee • The NHS People Plan has been aligned to the People Directorate outcomes and is monitored via the PODs and People Committee • Career Development pathways are being produced for all staffing groups and we have a programme under development for Dental Nurses • Scope for Growth – Career Conversations are being implemented with links to North West Networks • Career Development sessions for support staff, AHP and Nursing have taken place. There have been several Quality Summits take place also

Theme	Action for Employers	Bridgewater's Position (including next steps)
		• The Trust's Organisational Development Team deliver bespoke sessions on Team Development with a focus on data, staff views and team dynamics **<u>Next Steps</u>** • Identify how to implement national and local employee engagement tools and Trust metrics and include them within Trust scorecards
Development	Develop healthcare support workers, giving them opportunities to build knowledge and skills to develop their careers in the NHS. Commit to continuing professional development for nurses, midwives and AHPs. Line managers should hold regular conversations with individuals about learning and development opportunities and career progression.	• We have our Healthcare Support Worker Apprentice programme in nursing and therapies • We have Nursing Healthcare Assistants and Therapy Assistants accessing Nursing, Physio and Occupational Therapy Apprenticeships to become registered professionals • We have increased Trainee Nursing Associate recruitment for 2023 • Career conversations are now becoming embedded • Scope for Growth – Career Conversations are being implemented during a cycle of conversations with links to North West Networks • Career development/ road maps are being produced for staff to access to see clearly the career options and development available to them • A Task and finish Group has been set up to develop a Trust wide Competency Framework with input from Clinical and Corporate teams **<u>Next Steps</u>** • To map out the future cohorts for Nursing and Therapy Degrees • To map out the future cohorts for Healthcare Support Worker Apprenticeships

Theme	Action for Employers	Bridgewater's Position (including next steps)
Preceptorship	Support newly qualified healthcare professionals through offering a robust preceptorship programme by adopting the national preceptorship frameworks.	• We have a Multi Professional Preceptorship Policy in place and are working towards the Preceptorship Quality Mark • Our Practice Clinical Facilitators (PEFs) are supporting newly qualified Nurses in the organisation • We have a number of roles across the organisation who provide wrap around support for newly qualified Nurses and AHPs, more recently the introduction of the Legacy Mentor role **Next Steps** • Increased newly qualified staff will require increased support for preceptorship. We need to identify support requirements to retain and support services • Induction and onboarding programmes
Re-engaging retired Doctors	Use NHS Emeritus Doctor Scheme to secure recently retired consultant doctors to support delivery of outpatient care.	We need to identify the process to support this action
Promoting alternative medical career paths	Continue to support doctors who wish to choose alternative career paths in medicine rather than core and specialty training routes. Explore better support postgraduate career progression for locally employed doctors.	We need to identify the process to support this action
Reform	**Working differently means enabling innovative ways of working with new roles as part of multidisciplinary teams so that staff can spend more time with patients. Training will be reformed to support education expansion.**	
Advanced Practice	Expand enhanced and advanced roles through increasing pathways.	• We have increased applications for Advance Practice apprenticeships for 2023 **Next Steps**

Theme	Action for Employers	Bridgewater's Position (including next steps)
	Support career progression by offering advanced practice opportunities. Use national funding available to introduce more enhanced practice-level roles. Implement formal pathways established to facilitate the transition from advanced to consultant practice roles.	• Via Service specific Workforce Plans, identify roles that require advanced practice and increase pathways • Identify and implement formal pathways to facilitate the transition from advanced to consultant practice especially in areas with hard-to-fill roles such as Dermatology and Urgent Care Centres
Nursing Associates	Increase training opportunities for nursing associates to modernise careers through apprenticeships.	• We increased Trainee Nurse Associate roles in 2022/2023 via Apprenticeship routes. Roles will become permanent Nurse Associate roles upon completion of the apprenticeship (offering career development) • We have identified within Service Workforce Plans that are now introducing Nurse Associate roles and are currently out to advert/recruitment **<u>Next Steps</u>** • To map out and plan set recruitment drives to continue to increase apprenticeship placements for Trainee Nurse Associates • Support career development and top-up for Nurse Associates to support career development to become qualified Nurses
Technological Innovation	Use technological innovation to help nursing and medical students gain the skills, knowledge and experience they need to practise safely and competently in the NHS in less time (within parameters set by the relevant regulator).	We need further guidance and understanding from National, Professional Bodies and Education Providers to support the implementation of this.

Theme	Action for Employers	Bridgewater's Position (including next steps)
	Fully embed digital technology in training pathways, to support more efficient and effective ways of learning and improved learner experience. Offer blended learning programmes to which integrates technology and digital media with traditional classroom-based learning. Work with higher education institutes to adopt the NMC's new standard allowing up to 600 hours of practice learning to be undertaken via simulation. Make the best use of emerging technology applications such as AI and robotics in diagnostics, robot process automation, genomics and personalised healthcare.	
Temporary Staffing	Reduce reliance on temporary staffing in line with the expansion of domestic education and training.	• Services are working to reduce to the reliance on agency staffing as per the NHS England request by March 2024 • The Trust's Director of Finance and Director of People & OD are working together on strategies to reduce agency spend and usage • NHS Professionals are now engaged at the Trust
Reducing clinicians' admin burden	Better deployment of the administrative workforce to free up clinicians' time and support patient flow, alongside using technology to reduce administrative burden.	• Business Administrative Apprenticeships have been made available to increase support for services, thus reducing administrative burdens and freeing up clinical time • An Admin Review has been undertaken at the Trust – organisational change principles are being considered in line with consultation business cases (July 23) • Service Workforce Plans have identified administrative vacancies to support clinical services

Theme	Action for Employers	Bridgewater's Position (including next steps)
		Next steps • To further identify vacancies to convert to support administrative duties • To recruit to current administrative vacancies to offer Apprentice support roles and promote within local Colleges and the Department of Work and Pensions (DWP)

Version 1: 21st July 2023

Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**61/23i**		
Report Title	**STRATEGY AND BOARD ASSURANCE FRAMEWORK UPDATE**		
Executive Lead	Colin Scales – Chief Executive Officer		
Report Author	Rob Foster, Programme Director – Collaboration & Integration Jan McCartney – Trust Secretary/DPO		
Presented by	Rob Foster, Programme Director – Collaboration & Integration Jan McCartney – Trust Secretary/DPO		
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.

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

systems of corporate governance							

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**61/23i**		
Report Title	**STRATEGY AND BOARD ASSURANCE FRAMEWORK UPDATE**		
Report Author	Rob Foster, Programme Director – Collaboration & Integration Jan McCartney – Trust Secretary/DPO		
Purpose	1. To provide a regular update and assurance to the Trust Board on progress with the delivery of the new Communities Matter Trust Strategy 2. To provide an update on progress with the BAF		

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 and revision to the Board Assurance Framework (BAF).

2. 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, setting out work programmes for the year, alongside SMART targets. The workstreams are underpinned by a series of milestones.

2.2 As discussed in previous reports, all workstreams (and associated milestones) have been mapped and aligned to the appropriate, existing, governing meeting, council and/or committee.

2.3 A fifth Corporate Delivery Plan has also been developed to capture cross-cutting workstreams. The same governance mapping and alignment process is being finalised in July.

2.4 Discussions are taking place amongst the Senior Leadership Team (SLT) to continue to develop an approach to share and learn from each other. A number of the workstreams are common across the Directorates but the approaches may differ. The SLT recognise the value of shared learning.

3. MEASURING AND MONITORING

3.1 A first draft of the new strategy Performance Dashboard has been developed, which has been designed to align with the current and emerging Performance Assurance

Framework and Integrated Quality & Performance Report (IQPR). The plan is for the Dashboard to start to be used by Directorates and councils in August.

3.2 The new Dashboards reports on progress against our mission statement, objectives, workstreams and milestones, with five views – Trust total, and then a summary view for the four service Directorates.

3.3 The capturing of data to feed the dashboard has been, and continues to be fully aligned with existing governance processes and the IQPR production. As such, no additional input or time is required by any of teams to populate the new dashboard.

3.4 Monitoring and assuring on progress against our "We will…" deliverables that underpin our six Objectives will form an evidence-based process via the Quarterly Directorate Review meetings, with Directorates asked to incorporate developments, delivery progress and/or impact evidence against individual or multiple deliverables.

3.5 Dovetailing our measuring approach with our engagement approach, our plan is to develop a blend of quantitative and qualitative measures. This includes insight and feedback from our stakeholders to help us assess and assure ourselves on our approach and impact. This approach was discussed further in both a Board Development session and SLT meeting in July. Based on the discussions, a plan is now being developed, considering the optimum approach for each stakeholder group.

3.6 The table below presents a summary of the approach, reporting methods and proposed initial governance.

Targets	Measurement approach	Reporting method	Ops/delivery focus	Scrutiny	Oversight
Mission	Marmot indicators (place alignment)	New dashboard	SLT	EMT	Board
Objectives	IQPR alignment/ Insights	New dashboard	SLT	EMT	Board
Deliverables	Collective evaluation	Evidence based assessment	SLT	Quarterly Directorate Review meetings	EMT
Workstreams	SMART targets	BAU / Summary in new dashboard	DLTs/QI/Boost/ PODs/Councils	Transformation Council	Quality & Safety Committee
Milestones	Achievement (Y/N)	BAU / Summary in new dashboard	DLTs	Relevant council(s)/PODs	Transformation Council

4. ENGAGEMENT

4.1 Section 8 of our new Communities Matter strategy sets out our engagement ambitions. Our ambitions are shared across all engagement activities, with a key focus is on enhancing our public and community engagement.

4.2 To oversee and deliver this important component of our strategy, we have set up a Communities Matter patient engagement group. This includes representation from our public governors, Non-Executive Directors and internal teams.

4.3 The group met for the first time in July and reviewed a draft Terms of Reference and draft public engagement plan. The group plans to meet monthly and will report progress into the Bridgewater Engagement Group (BEG), who report into Quality Council.

4.4 It is planned to report progress to BEG, the Board (via this regular paper) and to our Council of Governors. Engagement metrics and progress will also be incorporated into the new Dashboard.

5. BOARD ASSURANCE FRAMEWORK (BAF)

5.1 The Board Assurance Framework (BAF) is the mechanism by which the Board uses to hold itself to account. It provides an overview of the risks to the strategic objectives, the risk appetite of these objectives and the current risk ratings of the risks to the objectives.

5.2 The current BAF is a document well used within the organisation. It is received by all the Committees of the Board and then to the Public Board where updates and amendments are accepted. The internal auditors have assessed the assurance framework within the Trust with significant assurance.

5.3 The strategic objectives were updated with the strategy and this change necessitated a complete re-write of the BAF. This process to date, led by the Trust Secretary, has been as follows:

a) The Board held a risk session led by the internal auditors to agree and set a risk appetite for each objective, this was undertaken in May 2023

b) The Trust Secretary met with each executive director and their deputies to craft the draft risk statements

c) The new BAF template was designed incorporating the recommendation from the well led review that ‘emerging risks’ should be included in the BAF

d) The newly designed BAF was presented to the non-executive directors who had the opportunity to feedback on the process. The non-executive directors were supportive of the process and offered assistance on the progress, it was also agreed at this meeting that the BAF would include a corporate governance section along with the six new objectives.

5.4 The new BAF will be presented to the October Public Board meeting for final sign off. To ensure the document will be ready, these are the next steps to be taken:

a) The new BAF will be taken to each of the Committees so members and attendees can review and contribute to the new document.

b) The Audit Committee will not sit again before the Board meeting in October, so the Audit Chair will be asked to review the draft before submitting to the Board.

c) The Audit Chair and the Senior Independent Director have offered to conduct a final review before the October Board meeting to ensure any items have not been missed off the new document.

5.5 The document, which will be signed off by Board in October, is likely to undergo many other updates during the first few months of it being in use, these will come by way of the usual Board report. The Trust Secretary would like to place on record her thanks for all the support she's received from the Board during this process.

6. RECOMMENDATIONS

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

Bridgewater Community Healthcare
NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**61/23ii**		
Report Title	**TERMS OF REFERENCE FOR COMMITTEES OF THE BOARD**		
Executive Lead	Karen Bliss, Chair		
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 Board is requested to approve the revised Terms of Reference for the Board and its Committees which have been reviewed by the relevant Committee.

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

The Committee business cycles are included for information.

Previously considered by:

☒ **Audit Committee**	☒ **Quality & Safety Committee**
☒ **Finance & Performance Committee**	☒ **Nominations & Remuneration 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**	**00 Month 2023**
Agenda Item	**61/23ii**		
Report Title	**TERMS OF REFERENCE FOR COMMITTEES OF THE BOARD**		
Report Author	Samantha Scholes, Head of Corporate Governance		
Purpose	To apprise the Board on the revised Terms of Reference for the Board and its Committees		

1. SCOPE

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

2. SUMMARY

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

3. RECOMMENDATION

3.1 The Board is asked to approve the revised Terms of Reference

Appendix 1: Audit Committee Terms of Reference
Appendix 2: Finance & Performance Committee Terms of Reference
Appendix 3: People Committee Terms of Reference
Appendix 4: Nominations & Remuneration Committee Terms of Reference
Appendix 5: Quality & Safety Committee Terms of Reference
Appendix 6: Audit Committee Business Cycle
Appendix 7: Finance & Performance Committee Business Cycle
Appendix 8: Nominations & Remuneration Committee Business Cycle
Appendix 9: People Committee Business Cycle
Appendix 10: Quality & Safety Committee Business Cycle

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Audit Committee
Terms of Reference

Name	Audit Committee
Purpose	The Board of Directors has established an Audit Committee for the purpose of providing the Board of Directors with a means of independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities both generally and in support of the Annual Governance Statement. The Board of Directors is responsible for ensuring effective internal control including: a) Management of the Trust's activities in accordance with statute and regulations. b) The establishment and maintenance of a system of internal control to give reasonable assurance that assets are safeguarded, waste or inefficiency avoided and reliable financial information produced, and that value for money is continuously sought. In addition, the Audit Committee shall: c) Provide assurance of independence for external and internal audit; d) Ensure that appropriate standards are set and compliance with them is monitored, in non-financial, non-clinical areas that fall within the remit of the Audit Committee; and e) Monitor corporate governance (e.g., compliance with codes of conduct, standing orders, standing financial instructions, maintenance of registers of interests).
Basis of Authority	The Board of Directors has provided delegated authority to the Audit Committee to seek assurance in accordance with these terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.
Reports to	Trust Board
Membership	**Members**

	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director
	Members	All other Non-Executive Directors
	Management Lead (but not a member of the Committee)	Director of Finance
	The Audit Committee members shall be afforded the opportunity to meet at least once per year with no others present**.** **Attendees** Only the members of the Committee have the right to attend meetings however, the following shall generally be invited to attend routine meetings: • Deputy Chief Executive Officer / Chief Nurse • Chief Operating Officer • Deputy Director of Finance • Trust Secretary • Financial Controller • Head of Internal Audit • Anti-Fraud Manager • External Audit representative **Observers** Council of Governors' Representatives. Any other person with prior permission of the Chair. **Invited as required** The Trust Chair may be invited to attend the Committee. Medical Director (depending on agenda items) Other staff will be invited as required by the Chair of the Committee, in particular to agenda items in relation to operations, contractual matters, estates or information technology. The Chief Executive will attend at least once a year to provide assurance on the annual governance statement, or as required. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.	
Connectivity	The Audit Committee connects with: • Board of Directors • Finance & Performance Committee • Nominations & Remuneration Committee • People Committee • Quality & Safety Committee The Chief Operating Officer or their Deputy attends all Committees of the Board and provides operational connectivity.	

Frequency of Meetings and Location	Meetings will take place quarterly. No less than four meetings are to be held within a calendar year. An additional meeting may be held to consider the draft Financial Statements, Annual Governance Statement and Annual report if required. Each member is to attend at least 75% of the diarised meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	The Audit Committee will be quorate when at least three Non-Executive Directors, including the Chair or Vice-Chair are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Committee are: **Internal Control and Risk Management** a) To maintain an oversight of the Trust's general risk management structures, processes and responsibilities, including the production and issue of any risk and control-related disclosure statements, ensuring the provision and maintenance of an effective system of financial and corporate risk identification and associated controls, reporting and governance. b) To review the adequacy of the Trust's arrangements by which Trust staff may, in confidence, raise concerns about possible improprieties in matters of financial reporting and control and related matters or any other matters of concern. c) To review the adequacy by way of the Board Assurance Framework of underlying assurance processes that indicate the degree of achievement of corporate objectives and the effectiveness of the management of principal risks. d) To review the adequacy of policies and procedures for ensuring compliance with relevant regulatory, legal and conduct requirements. e) To maintain oversight of the compliance report received from Q&S Committee on the delivery of the Clinical Audit programme. **Internal Audit** f) To review and approve the internal audit strategy and programme, ensuring that it is consistent with the needs of the organisation. g) To oversee on an ongoing basis the effective operation of internal audit in respect of adequate resourcing, its co-ordination with external audit, meeting mandatory NHS Internal Audit Standards, providing adequate independence assurances, having appropriate standing within the Trust; and meeting the internal audit needs of the Trust. h) To consider the major findings of internal audit investigations and management's response and their implications and monitor progress on the implementation of recommendations.

i) To consider the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal.

j) To conduct an annual review of the internal audit function.

k) To oversee the conduct of a market testing exercise for the appointment of an internal auditor at least once every five years.

Anti-Fraud

l) To review and approve the anti-fraud annual workplan, ensuring that it is consistent with the needs of the organisation.

m) To oversee on an ongoing basis the effective operation of the Trust's anti-fraud service in respect of adequate resourcing, its co-ordination with internal and external audit, meeting NHS Counter Fraud Authority Standards, having appropriate standing within the Trust; and meeting the anti-fraud needs of the Trust; and recommend the annual Anti-Fraud Report to the Board.

n) To consider the major findings of anti-fraud investigations and detection work, management's response and their implications and monitor progress on the implementation of any such recommendations.

o) To consider the provision of the anti-fraud service, the cost of the service and any questions of resignation and dismissal.

p) To conduct an annual review of the Anti-Fraud Service.

q) To oversee the conduct of a market testing exercise for the appointment of an anti-fraud service at least once every five years.

External Audit

r) To ensure that the Governors' Auditors Appointment Group are fully involved in the selection process for the appointment, reappointment or removal of the External Auditors.

s) To provide the Governor's Auditors Appointment Committee with the necessary information and to enable them to make a recommendation to the Council of Governors in respect of the appointment, re-appointment and removal of an external auditor. To the extent that that recommendation is not adopted by the Council of Governors, this shall be included in the Annual Report, along with the reasons that the recommendation was not adopted.

t) To discuss with the external auditor, before the audit commences, the nature and scope of the audit, and ensure co-ordination, as appropriate, with other external auditors in the local health economy. This should include discussion regarding the local evaluation of audit risks and assessment of the Trust associated impact on the audit fee.

u) To assess the external auditor's work and fees on an annual basis and based on this assessment, make a recommendation to the Council of Governors with respect to the re-appointment or removal of the auditor. This assessment should include the review and monitoring of the external auditor's independence and objectivity and effectiveness of the audit process in light of relevant professional and regulatory standards.

v) To review external audit reports, including the annual audit letter and the Value for Money (VFM) Risk Assessment, together with the management response, and to monitor progress on the implementation of recommendations.

w) To develop and implement a policy on the engagement of the external auditor to supply non-audit services.

x) To consider the provision of the external audit service, the cost of the audit and any questions of resignation and dismissal.

Annual Reporting

y) To review and approve the annual statutory accounts for recommendation to the Board to determine their completeness, objectivity, integrity and accuracy. This review will cover but is not limited to:

- the meaning and significance of the figures, notes and significant changes;
- areas where judgment has been exercised;
- adherence to accounting policies and practices;
- explanation of estimates or provisions having material effect;
- the schedule of losses and special payments;
- any unadjusted statements; and
- any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.

z) To review and approve the annual report and Annual Governance Statement for recommendation to the Board, to determine completeness, objectivity, integrity and accuracy.

aa) To review all accounting and reporting systems for reporting to the Board of Directors, including in respect of budgetary control.

Standing Orders, Standing Financial Instructions and Standards of Business Conduct

bb) To review on behalf of the Board of Directors the operation of, and proposed changes to, the standing orders and standing financial instructions, the constitution, codes of conduct and standards of Business conduct, including maintenance of registers.

cc) To examine the circumstances of any significant departure from the requirements of any of the foregoing, whether those departures relate to a failing, an overruling or a suspension.

dd) To review the scheme of delegation.

Other

ee) To review the Annual Self-Assessment relevant to the remit of the Audit Committee.

ff) To examine any other matter referred to the Audit Committee by the Board of Directors and to initiate investigation as determined by the Audit Committee.

gg) To develop and use an effective assurance framework to guide the Audit Committee's work. This will include utilising and reviewing the work of the internal audit, external audit and other assurance functions as well as reports and assurances sought from directors and managers and other investigatory outcomes so as fulfil its functions in connection with these terms of reference.

hh) To review the work of all other Trust committees in connection with the Audit Committee's assurance function. In particular the respective roles and performance of the Audit Committee and the Quality and Safety Committee will be regularly reviewed to ensure that the Audit Committee primarily focuses in on

	the robustness of sources of assurance whereas the Quality and Safety Committee focuses in on the adequacy of the resulting assurances offered. ii) Review the process for any significant transaction.
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting. • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item. • Reports and plans as per agreed Committees work plan • Key policies and documents relevant to clinical quality, safety, effectiveness and patient experience • Exception reports • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and/or Board level Committees.
Outputs	• Minutes • Action log • Committee Chair's Assurance report to the Board • Annual report to the Board on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors
Closed Session	On specific occasions it may be necessary for the Audit Committee to meet in closed sessions. Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.
Other Matters	• Attendees are authorised to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit. • Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation) • Review of each meeting by Members and Governor Observers.
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)

Issue Date	August 2022
Review Date	August 2023

Appendix A

Monitoring Compliance with the Terms of Reference for Audit Committee

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

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

ISSUE DATE	August 2022
REVIEW DATE	August 2023

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Audit Committee	Full review of format **Membership** Medical Director moved from Attendees to Invited as Required **Connectivity** The addition of the Chief Operating Officer or their deputy as an operational link between Committees **Frequency of Meetings and Location** Members required to attend 75% of diarised meetings per year **Quoracy** Chairman replaced with Chair **Inputs** Provision of agenda and supporting papers **Outputs** Committee Chair's Assurance report to the Board, replaces Exception reports to the Board. **Other Matters** Review of each meeting by Members and Governor Observers
2.1	August 2022	Board of Directors	**Connectivity** Connection with all other Board Committees **Duties and Responsibilities** **Anti-Fraud**

			Committee to recommend the annual Anti-Fraud report to the Board
2.2	June 2023	Audit Committee	**Duties and Responsibilities** Added: e) To maintain oversight of the compliance report received from Q&S Committee on the delivery of the Clinical Audit programme v) Value for Money (VFM) assessment to the review of external audit reports p) Title-cased anti-fraud ee) Replaced performance indicators with Annual Self-Assessment relevant to the remit of the Audit Committee gg) Title-cased audit committee **Connectivity** Added the Board of Directors **Other Matters** Removed 'Deputies have no voting rights'

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Finance and Performance Committee
Terms of Reference

Name	Finance and Performance Committee	
Purpose	The Board of Directors has established a Finance and Performance Committee for the purpose of: a) Providing detailed scrutiny of financial, performance, estates and Digital matters, in order to provide assurance and raise concerns (if appropriate) to the Board of Directors b) Making recommendations as appropriate on financial, performance, estates and digital matters to the Board of Directors c) Assessing and identifying risks within the portfolio and escalating this as appropriate. The Committee's objectives are to: d) Advise the Board of Directors on all aspects of finance, performance, estates and Digital matters. e) Seek assurance in respect of financial business planning f) Ensure corrective action has been initiated and managed where gaps are identified in relation to risks within the portfolio of the Committee g) Scrutinise the Trust's financial and relevant plans, investment policy and proposed Digital business decisions and those relating to the Trust's estate which the policy defines and requires Board approval	
Basis of Authority	The Board of Directors has provided delegated authority to the Finance and Performance Committee to seek assurance in accordance with this terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.	
Reports to	Trust Board	
Membership	**Members:**	
	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director

	Management Lead	Director of Finance*
	In addition: • Two other Non-Executive Directors • Deputy Chief Executive Officer / Chief Nurse* • Chief Operating Officer* **Attendees:** Operational Leads as requested: • Deputy Director of Finance • Trust Secretary • Financial Controller *Individuals flagged with * are required to send a deputy in the event of non-attendance.* **Observers** The Committee is open to all Non-Executive Directors to attend as observers Council of Governors' Representatives Any other person with prior permission of the Chair **Invited as required** The Trust Chair may be invited to attend the Committee. Other staff will be invited as required by the Chair of the Committee, in particular for agenda items in relation to transformation, contractual matters estates or digital. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.	
Connectivity	Sub-committees reporting to this Committee: • Capital Council • CIP Council • DIGIT • Estates Sub Committee • Health & Safety Sub Committee • Performance Council There is an operational and governance link between this Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures. The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.	
Frequency of Meetings and Location	Meetings will take place bi-monthly, with additional meetings at year end and as required. No fewer than six meetings are to be held within a calendar year. Each member is to attend at least 75% of the diarised meetings within a calendar year.	

	Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The Finance and Performance Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Finance and Performance Committee are: a) to undertake detailed scrutiny of monthly, quarterly and year to date financial and performance information against the cost improvement programme; and the capital Performance programme and cashflow b) to undertake detailed scrutiny of the financial forward projections; c) to consider proposals for financial plans and estimates; d) to consider the annual budget for the organisation in order to make a recommendation for approval at the Trust Board; e) to undertake capital planning and financial strategy formulation/review **Performance Management** f) to receive assurance from the Trust Directors in respect of performance, in relation to the Performance Management framework, against: • annual budgets, capital plans and the cost improvement programme, • innovation and productivity plans, • clinical activity by service • commissioning for quality and innovation plans (CQUIN) **Annual Planning Process** g) consider the draft Annual financial and activity plans which will be aligned to NHS England's strategic planning requirements and make recommendations on appropriate KPIs as part of the annual planning process. h) recommend the Trust's Business Plan to the Trust Board. **Contract Negotiation and Performance** i) to oversee the negotiation of contracts with the organisation's commissioners; j) to receive assurance from the Trust Directors' and Executive Leads in respect of the organisation: • meeting the contractual requirements and expectations of commissioners; • meeting the legislative / regulatory requirements of regulators and other bodies; in so far as they relate to the finance portfolio **Risk Management and Internal Control** k) to receive the relevant elements of the Board Assurance Framework and Corporate Risk Register and take lead responsibility for identified risks in respect of non-clinical and financial matters and standards: • to receive reports and assurance from the Trust Directors in respect of risks, considering the recommendations as appropriate from Executive Directors as

	to those risks which are significant and need to be included in the Board's Assurance Framework and Corporate Risk Register, • to receive reports and assurance from Trust Directors in ensuring divisional action plans mitigate risks and gaps in controls and assurance are implemented, • to assess any risks within the finance and performance portfolio brought to the attention of the Committee and identify those that are significant for escalating as appropriate l) to work with the Trust Directors and assess and advise on the financial and operational aspects of the Risk Management Strategy; **Business Cases** m) in accordance with Standing Financial Instructions consider the recommendations of the Directors' Team when considering business cases in respect of: • major service and strategic developments • replacement and / or new consultant or clinical posts submitted by the Trust Management. **Commercial and Business Development** n) to consider proposals for Commercial and Business Development activities, including review and approval of commercial tenders for new business and appraisal of the impact of service exits. **Digital** o) to consider proposals and seek assurance on the delivery of the digital strategy **Estates and Assets** p) to consider proposals for Estates and Assets and seeking assurance on the delivery of the Trust's Estates Strategy. q) To review and recommend the Health and Safety Strategy to the Board, ensuring that it is consistent with the needs of the organisation r) to receive assurance that, where appropriate, the Trust is compliant with guidance/legislation in respect of estate and health and safety matters. **Quality** s) to where a matter relating to finance has a significant quality implication the Committee will refer that matter to the Quality and Safety Committee
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting. • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item. • Reports and plans as per agreed Committee's work plan, in particular the monthly finance and operational report • IQPR report • Key policies and documents • Exception reports from designated sub-groups/committees • Performance reports from clinical services as required • Reports / formal correspondence from Regulators and key stakeholders

	• Delegated / transferred issues from Board and/or other Board level Committees
Outputs	• Minutes • Action log • Committee Chair's Assurance reports to the Board • Annual Report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors • Report to the Audit Committee on progress against Internal Audit recommendations
Closed Session	On specific occasions it may be necessary for the Finance and Performance Committee to meet in closed sessions. Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.
Other Matters	• Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. Deputies have no voting rights. • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit. • Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation.)
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	August 2022
Review Date	August 2023

Appendix A

Monitoring Compliance with the Terms of Reference for Finance and Performance Committee

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

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

ISSUE DATE	August 2022
REVIEW DATE	August 2023

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Finance & Performance Committee	Full review of format **Frequency of Meetings** Members required to attend 75% of diarised meetings per year Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting **Connectivity** The addition of the Chief Operating Officer or their deputy as an operational link between Committees **Estates and Assets** Point 'p' split into two separate points **Quoracy** Amended to two Non-Executive Directors, and one Executive Director in line with all other Committees **Inputs** Provision of agenda and supporting papers **Outputs** Committee Chair's Assurance reports **Appendix A** Monitoring by the Trust Secretary
2.1	August 2022	Board of Directors	**Duties and Responsibilities** **Estates and Assets** Committee to review and recommend the Health and Safety Strategy to the Board
2.2	April 2023	Finance & Performance Committee	**Duties and Responsibilities** **Estates and Assets** Addition of Estates and Health & Safety Reports

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Nominations and Remuneration Committee
Terms of Reference

Name	Nominations and Remuneration Committee	
Purpose	The Board of Directors has established a Nominations and Remuneration Committee to be responsible for considering and making recommendations on changes to the structure, size and composition required of the Board. The Committee is to satisfy itself that its recommendations fulfil the Trust's needs in terms of skills and experience. The Committee will determine the remuneration for Very Senior Managers (VSMs) and Board Executives and other conditions of service and will decide upon the continuation in office of any Board Executive as an employee of the Trust.	
Basis of Authority	The Board of Directors has provided delegated authority to the Nominations and Remuneration Committee to seek assurance in accordance with these terms of reference.	
Reports to	Trust Board	
Membership	**Members**	
	Chair	Chair (Non-Executive Director)
	Vice Chair	Non-Executive Director
	Members	All other Non-Executive Directors
	Attendees Meeting of the Nominations and Remuneration Committee may be attended by the: • Chief Executive • Director of People and Organisational Development • Trust Secretary **Invited as required** Any other person who has been invited by the Chair to attend a meeting of the Committee so as to assist in deliberation. The Trust Secretary will be responsible for the taking of minutes and will provide appropriate support to the Chair and Committee members.	
Connectivity	Sub-committees reporting to this Committee • None	

Frequency of Meetings and Location	Meetings will take place at least once during a calendar year and ad-hoc as required. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The Nominations and Remuneration Committee will be quorate when a minimum of four Non-Executive Directors (one of whom should be the Chair or Vice Chair) are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Committee are: **Nominations** a) Regularly review the structure, size and composition (including the skills, knowledge and experience) required of the Board and make recommendations to the Board with regard to any changes. b) Give full consideration to and make plans for succession planning for the Chief Executive and other Executive Board Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed, in particular on the Board in future. c) Be responsible for identifying and nominating for appointment candidates to fill posts within its remit as and when they arise, in accordance with relevant Department of Health and Social Care guidance. Such appointments would normally be confined to the Chief Executive and Executive Director posts but the remit of the Committee can be extended to other specified posts with the agreement of the Chair. d) Be responsible for identifying and nominating a candidate to fill the position of Chief Executive. The appointment will be subject to approval by the Council of Governors. e) Before an appointment is made, evaluate the balance of skills, knowledge and experience on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment. In identifying suitable candidates, the Committee shall; • use open advertising or the services of external advisers to facilitate the search; • consider candidates from a wide range of backgrounds; • consider candidates on merit against objective criteria. f) Consider any matter relating to the continuation in office of any Board Executive Director at any time including the suspension or termination of service of an individual as an employee of the Trust. g) To consider the engagement or involvement of any suitably qualified third party or advisers to assist with any aspects of its responsibilities. **Remuneration** h) To decide and review the terms and conditions of office of the Trust's Executive Directors [and Very Senior Managers on locally determined pay] in accordance with all relevant Trust policies and relevant Department of Health and Social Care guidance, including: (i) Salary, including any performance-related pay or bonus;

	(ii) Provisions for other benefits, including pensions and cars and; (iii) Allowances. i) To monitor and consider the performance of individual Executive Directors. j) To adhere to all relevant laws, regulations and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective. k) To advise upon and oversee contractual arrangements for Executive Directors, including, but not limited to, termination payments. **Special Payments** The Committee shall consider proposals from Executive Directors to seek approval for special payments including potential Employment Tribunal cases or redundancy from the appropriate body e.g., Treasury.
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting. • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item.
Outputs	• Annual report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its work plan. • The minutes of all meetings of the Committee shall be formally recorded by the Trust Secretary's office and will be retained confidentially by the same. • The Committee shall ensure that Board of Directors emoluments are accurately reported in the required format for the Trust's Annual Report.
Closed Session	The Committee meets in private.
Process for monitoring compliance with Terms of Reference	The Terms of Reference shall be reviewed by the Board of Directors at least annually.
Issue Date	August 2022
Review Date	August 2023

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

People Committee
Terms of Reference

Name	People Committee
Purpose	The Board of Directors has established a People Committee for the purpose of maintaining a strategic overview of the Trust's human resources and organisational development arrangements, ensuring the Trust is a great place to work, along with arrangements for staff communication and engagement with a view to: a) ensuring these are designed to provide a positive working environment for colleagues and; b) that the Trust has in place at all levels the right people systems and processes to deliver, from a patient and service user perspective, safe high quality care. The People Committee will seek assurance on: c) Delivery of the NHS Long Term Workforce Plan d) Trust's approach, plans and processes for the delivery of the People Strategy, e) Efficient and effective use of resources, f) Controls and systems in place to support line managers to make effective decisions in the deployment of staff, g) Redesign of the workforce so that it remains fit for the future, and h) Plans to recruit and retain staff at all levels and how this is reducing the reliance on temporary workers, i) Support and engagement with the 'unpaid volunteer' workforce so that their skills are safely and appropriately harnessed and j) Alignment of workforce transformation plans to deliver the NHS Long Term Plan, People Plan and People Promise, k) Plans for effective staff communication and engagement The Committee will oversee HR & OD and Communication and Engagement strategic actions to enable the Trust to deliver the Trust's Quality & Place Strategy and specifically the organisational objectives. In addition, the Committee will provide assurance to the Trust Board that the Strategic Objectives will support us to: • 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 • collaborate with partners and communities to improve equity in health outcomes and focus on the needs of those who are vulnerable and at-risk

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ensure the Trust is a great place to work by creating an environment for our staff to develop, grow and thrive
ensure that we use our resources in a sustainable and effective way
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
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

The Committee will provide assurance to the Trust Board on the management of risks related to our people.
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<tr><td>Basis of Authority</td><td>
The Board of Directors has provided delegated authority to the People Committee to seek assurance in accordance with this terms of reference.

It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust.

The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.
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<tr><td>Reports to</td><td>Trust Board</td></tr>
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<tr><td>Membership</td><td>
Members:
<table>
<tr><td>Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Vice Chair</td><td>Non-Executive Director</td></tr>
<tr><td>Management Lead</td><td>Director of People & Organisational Development*</td></tr>
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In addition:

Two other Non-Executive Directors
Chief Operating Officer*
Deputy Chief Executive/Chief Nurse*
Medical Director*

Attendees

Deputy Director of People & Organisational Development
Deputy Director of Communications & Engagement
Heads of: HR, OD and Education
Equality & Inclusion Manager
Library & Knowledge Services Manager (as per business cycle)
Trust Secretary
Staff-Side Chair

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	*Individuals flagged with * are required to send a deputy in the event of non-attendance.* **Observers** Council of Governors' Representatives Any other person with prior permission of the Chair **Invited as required** The Trust Chair may be invited to attend the Committee. Other staff will be invited as required by the Chair of the Committee for specific agenda items. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.

Connectivity	**Groups reporting to this Committee**
	• Medical & Dental Professional Governance
	• People Organisational Delivery Groups (PODs)
	  ○ Culture & Leadership
	  ○ Education & Professional Development
	  ○ Health & Wellbeing
	  ○ Recruitment & Retention
	• Flu Group
	There is an operational and governance link between this Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures.
	The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.

Frequency of Meetings and Location	Meetings will take place bi-monthly No fewer than five meetings are to be held within a calendar year. Each member is to attend at least 75% of the diarised meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting
Quoracy	The People Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the People Committee are: **Duties – decision making:** a) To provide overview and scrutiny in areas of workforce performance referred to the People Committee by the Trust Board

	b) Receive and consider the workforce plans and make recommendations as appropriate to the Trust Board c) To provide overview and scrutiny to the development and delivery of the People Strategy across all nine Strategic Priorities with Pledges. d) To ensure the People Strategy is designed, developed, delivered, managed and monitored appropriately and that it is in receipt of exception reports and updates e) To ensure that appropriate senior clinical leadership advice and involvement is provided on the impact of the delivery of the People Strategy f) To ratify employment policies and procedures on behalf of the Trust g) To receive the annual National Staff Opinion Survey Results and to provide a set of recommendations for action by the Trust h) To receive, agree and monitor the staff engagement activity in the Trust and employee reward in order to be assured of the effectiveness of these activities on improved morale; increased Staff FFT results and improved patient experience i) To ensure that all statutory and regulatory obligations are met in relation to Equality, Diversity & Inclusion agendas **Duties – advisory:** j) Consider any relevant 'people' risks within the Board Assurance Framework (BAF) and corporate level risk register as they relate to the remit of the People Committee, as part of the reporting requirements k) To ensure that the framework for Education Governance is supporting the management of risks associated with our people and the quality of care provided to our patients, reported through the People Operational Delivery Plan (POD) **Duties – monitoring:** l) To monitor the Trust's performance against national standards so far as they relate to employment m) To monitor the effectiveness of the Trust's workforce performance reporting systems ensuring that the Trust Board is assured of continued compliance through its annual reporting, reporting by exception where required n) To review the performance indicators relevant to the remit of People Committee o) To report any areas of significant concern to the Trust Board as appropriate via the Chair's Report p) To receive a report on Employee Relations Cases in respect of numbers, workforce demographics, emerging themes, workforce issues addressed through the Freedom to Speak Up route, lessons learned and in particular those cases where suspension/exclusion is involved q) To monitor the progress with the Internal Audit recommendations within the 'HR and Workforce Aspects' r) To receive communication and staff engagement reports, including Staff Survey results and action plans
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting. • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item. • 'PEOPLE' Hub and People Operational Delivery Groups (PODs) • Reports and plans as per agreed Committee's work plan

	• Exception reports for designated sub-groups/Committees i.e. HR Policy Review Group • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and/or Board level Committees
Outputs	• Minutes • Action log • Committee Chair's Report to the Board and Council of Governors • Annual Report to the Board on how the Committee has met its Terms of Reference and delivered on its work plan. • Report to Council of Governors (as requested) • Report to the Audit Committee on progress against Internal Audit recommendations by exception • Annual Freedom to Speak Up Report to Board • Annual Payroll Report • Bi-annual Doctors Disciplinary Report to Board
Closed Session	On specific occasions it may be necessary for the People Committee to meet in closed sessions (for example where there is a quality or safety issue relating to a specific individual or group). Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.
Other Matters	• Attendees are authorised and requested to appoint deputies or substitutes to act on their behalf when they are unable to attend meetings of the committee. Deputies or substitutes have no voting rights. • Other officers and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair sees fit. • Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation). • The Committee will receive items from the Audit, Q&S and F&P Committees on matters within the Terms of Reference.
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	AUGUST 2022
Review Date	AUGUST 2023

Appendix A

Monitoring Compliance with the Terms of Reference for People Committee

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

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

ISSUE DATE	AUGUST 2022
REVIEW DATE	AUGUST 2023

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	People Committee	Full review of format **Purpose** Addition of staff communication and engagement **Membership** Additional Non-Executive Director, Chief Operating Officer, Equality & Inclusion Manager and Library & Knowledge Services Manager Amended Deputy Director of Communications & Engagement title Number of Governor Representatives removed **Connectivity** Addition of Medical & Dental Professional Governance Addition of Chief Operating Officer or their deputy providing operational connectivity **Frequency of Meetings** Members required to attend 75% of diarised meetings per year **Duties and Responsibilities** Ensuring statutory and regulatory obligations are met in relation to Equality, Diversity & Inclusion agendas Receive communication and staff engagement reports, including Staff Survey results and action plans Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting **Outputs** Committee Chair's Assurance report to the Board, replaces Exception reports to the Board Removal of Exception Report to Audit Committee Amendments and additions to reports
2.1	June 2023	People Committee	**Purpose** Addition of ensuring the Trust is a great place to work Updated strategic objectives

			Added ‘Delivery of the NHS Long Term Workforce Plan’ **Membership** * Added to Chief Operating Officer **Connectivity** Removed ‘People Hub’ Removed ‘Freedom to Speak Up Guardian Group’ **Duties & Responsibilities** c) update five priority areas to 9 Strategic Priorities with Pledges o) removed ‘Key Issues’ from Chair’s Report **Outputs** Removed ‘assurance’ from Committee Chair’s Report and added Council of Governors Removal of: Annual Wellbeing Champion Report to Board Annual Occupational Health Service Report Removed ‘Pensions’ from Annual Payroll Service Report to reflect business cycle Added ‘by exception’ to progress report to Audit Committee on Internal Audit recommendations **Other Matters** Addition of Audit to Committees

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Quality and Safety Committee
Terms of Reference

Name	Quality and Safety Committee	
Purpose	The Board of Directors has established a Quality and Safety Committee for the purpose of: a) Advocating an active role in keeping the Trust's services safe b) Seeking assurance on safe and effective clinical governance in the Trust c) Ensuring that the Trust is compliant with relevant national standards and statutory legislation d) Ensuring continuous quality improvement in patient safety, clinical effectiveness and patient experience, including the wellbeing and safety of Trust employees e) Identifying risks and concerns to be escalated to the Board of Directors in accordance with the agreed assurance and escalation procedure referenced within the Board Assurance Framework f) To oversee and scrutinise the implementation of the Trust's Quality Governance framework	
Basis of Authority	The Board of Directors has provided delegated authority to the Quality and Safety Committee to seek assurance in accordance with this terms of reference. It is authorised to seek the information that it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Trust Board to obtain independent professional advice and to secure the attendance of people/organisations from outside the Trust. The Committee shall have a standing agenda item for matters delegated from the Trust Board or its Committees.	
Reports to	Trust Board	
Membership	**Members:**	
	Chair	Non-Executive Director
	Vice Chair	Non-Executive Director
	Management Lead	Deputy Chief Executive/Chief Nurse*

	In addition:death • Two other Non-Executive Directors • Medical Director* • Chief Operating Officer* **Attendees** Operational Leads as requested: • Deputy Chief Nurse • Director of Quality Governance • Trust Secretary • Workforce Representative *Individuals flagged with * are required to send a deputy in the event of non-attendance.* **Observers** The Committee is open to all Board members to attend as observers Council of Governors' Representatives Any other person with prior permission of the Chair **Invited as required** The Trust Chair may be invited to attend the Committee. Other staff will be invited as required by the Chair of the Committee, in particular for agenda items in relation to safeguarding, infection prevention and control, patient experience, risk management, medicines management, clinical audit. Corporate governance support will take minutes and provide appropriate support to the Chair and Committee members.
Connectivity	**Group reporting to this Committee** • Quality Council • Risk Management Council • Transformation Council in conjunction with Finance & Performance Council **Groups reporting to the Quality Council** • Corporate & Clinical Policy • Education Governance • Infection Prevention & Control • Medical Devices • Medicines Management • Patient Safety • Research & Clinical Audit • Resus Advisory Group • Safeguarding & Risk Assurance – by exception and the Annual Report • Serious Incident Review Panel plus Learning from Deaths • Time to Shine

	There is an operational link between this Committee and the Finance and Performance Committee and an operational and governance link between this Committee and the Audit Committee, particularly with reference to internal and external audits of the Trust's policies and procedures. The Chief Operating Officer or their deputy attends all Committees of the Board and provides operational connectivity.
Frequency of Meetings and Location	Meetings will take place bi-monthly. No fewer than five meetings are to be held within a calendar year. Each member is to attend at least 75% of the meetings within a calendar year. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting.
Quoracy	The Quality and Safety Committee will be quorate when at least two Non-Executive Directors, and one Executive Director, are present for a decision making meeting. If not quorate, the meeting may still take place but may not make decisions. Should the meeting not be quorate, and if required, an additional meeting would be arranged at an earliest opportunity for decision making purposes.
Duties and Responsibilities	The duties and responsibilities of the Quality and Safety Committee are: a) To oversee and scrutinise the effectiveness of the risks escalated in relation to Quality & Safety b) To oversee and scrutinise the effectiveness of the Patient Safety Group via the Quality Council, specifically in relation to serious incidents, patient experience and learning lessons c) To scrutinise the performance, adequacy and effectiveness of the Trust's clinical governance processes including patient safety, clinical effectiveness and patient experience and compliance with relevant national standards and statutory legislation, by way of receipt of the IQPR and quality indicators. To scrutinise and challenge the quality indicators in the IQPR d) To ensure that the Trust scrutinise and benchmark in relation to information by way of available information on quality, safety and patient experience, or other indicators, outcomes of Time to Talk and Quality Visits, serious untoward incidents, complaints, and reports from external bodies e) Receive and approve clinical audit and research programme and maintain oversight of it f) Where appropriate, to escalate to the Board, themes, trends and risks including those from Serious Incidents and the Trust's capacity to learn lessons g) To review and monitor the quality impact of Cost Improvement Plans, via Quality Impact Assessments, to ensure that processes are robust and effective and that risks to quality and safety are understood, considered, mitigated and monitored h) To refer activities and tasks to appropriate Board level Committees or Executive management as deemed appropriate by the Committee, having due consideration of the remit of those Committees and their business cycles i) To receive and accept delegated activities and tasks from the Board or other Board Committees by agreement j) To hold executive directors to account for the quality and safety of the Trust's clinical services and clinical risk management outcomes

	k) To have oversight and again assurance on the delivery of the Trust's Improvement Plan l) Ensure delivery and management of the agreed Committee business cycle, building in at least an annual review giving consideration to the business cycles of other Board level Committees m) To approve and monitor the delivery of strategies in relation to Quality & Safety n) To receive assurance on compliance with NICE guidance o) Have oversight on the delivery in relation to quality and safety related MIAA audits p) To have oversight and be the responsible committee on the Board Assurance Framework for BAFs, 2, 3 and 6 q) To review and monitor Learning from Deaths r) Receive an annual report on safeguarding for assurance s) Receive Infection Prevention Control assurance reports
Inputs	• An agenda and any supporting papers shall be sent to each Director in electronic form no later than five working days in advance of each meeting • Minutes of the previous meeting will be circulated with these papers for approval and this will be a specific agenda item • Reports and plans as per agreed Committee's business cycle • IQPR report • Key policies and documents relevant to clinical quality, safety, effectiveness and patient experience • Quality Impact Assessments of Cost Improvement Programmes • Exception reports from designated sub-groups • Reports / formal correspondence from Regulators & key stakeholders • Delegated / transferred issues from Board and / or Board level Committees
Outputs	• Minutes • Action log • Committee Chair's reports to the Board • Annual Report to the Audit Committee on how the Committee has met its Terms of Reference and delivered on its business cycle • Report to Council of Governors • Report to the Audit Committee on progress against Internal Audit recommendations
Closed Session	On specific occasions it may be necessary for the Quality and Safety Committee to meet in closed sessions (for example where there is a quality or safety issue relating to a specific individual or group). Where this is necessary the Chair will specifically approve that part of the meeting as closed. Attendance at the closed part of the meeting will be restricted to designated members of staff.

Other Matters	• Executive members are authorised and requested to appoint deputies to act on their behalf when they are unable to attend meetings of the committee. Deputies have no voting rights • Other Executive Directors and individuals who are deemed appropriate by the Committee shall be invited to attend meetings or part of meetings as the Chair of the Committee sees fit • Other invitees will be at the discretion of the Chair to present on a specific topic, present a paper or for developmental purposes. (This may be internal or external to the organisation.)
Process for monitoring compliance with Terms of Reference	See monitoring table (Appendix A)
Issue Date	August 2022
Review Date	August 2023

Appendix A

Monitoring Compliance with the Terms of Reference for Quality and Safety Committee

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

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

ISSUE DATE	August 2022
REVIEW DATE	August 2023

Version Control Sheet

Version	Date	Reviewed By	Comment
2.0	June 2022	Quality & Safety Committee	Full review of format **Connectivity** Operational link between this Committee and the Finance & Performance Committee Addition of the Chief Operating Officer or their deputy as an operational link between Committees **Duties and Responsibilities** Removal of oversight of quality aspects of the safer staffing reports **Frequency of Meetings and Location** Frequency of members attendance specified including reference to 75% of diarised meetings. Committee meetings will be held at Trust premises or via digital technology. If the latter, participation shall be deemed to constitute presence in person at the meeting **Inputs** Provision of agenda and supporting papers **Outputs** Addition of assurance in relation to Committee Chair's report to the Board **Appendix A** Monitoring by the Trust Secretary
2.1	June 2023	Quality & Safety Committee	Purpose Removal of 'and Escalation' from the Board Assurance Framework **Connectivity** Addition of Transformation Council Amendment of Resus Advisory Council to Group Duties and Responsibilities c) amendment of indications to indicators d) amendment of Board visits to Time to Talk and Quality Visits e) addition of research f) addition of 'including those…' h) amendment of work plans to business cycles

			l) amendment of work plan to business cycle m) removal as duplicate of f) **Inputs** Amendment of work plan to business cycle **Outputs** Removal of Assurance from Committee Chair's Report

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AUDIT COMMITTEE BUSINESS CYCLE 2023/24	ToR Clause	Lead	Action	27 Apr 2023	18 May 2023 *Extraordinary (Draft Annual Report & Accounts review)*	28 June 2023 *Extraordinary (Final Annual Report & Accounts review)*	6 July 2023	12 Oct 2023	11 Jan 2024
Welcome, Apologies and Previous Meetings									
Apologies	Membership	Chair	Information	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	Membership	Chair	Information	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting	Membership & Inputs	Chair	Information	✔	✔	✔	✔	✔	✔
Action Log	Outputs	Chair	Information	✔			✔	✔	✔
Urgent Items with the agreement of the Chair	Outputs	Chair	Approve	✔			✔	✔	✔
Items for escalation to Board / other Committees	All	Chair	Information	✔	✔	✔	✔	✔	✔
Review of meeting	Other Matters	Committee		✔	✔	✔	✔	✔	✔
Governance									
Review of Committee Terms of Reference	Appendix A	Trust Secretary	Recommend to Board				✔		
Review Committee Business Cycle (going forward proposed to move full review to January for the upcoming year and interim still in July)	Appendix A	Committee	Approve	✔			✔		✔
Review Board Assurance Framework and Corporate Risk Register	Duties & Responsilbities (D&R) a-d	Trust Secretary	Assurance	✔			✔	✔	✔
Produce Annual Audit Committee report	Outputs	Chair	Approve	✔					
Review of audited annual accounts and financial statements to include the Annual Governance Report	D&R y-aa	DOF	Recommend to Board for approval		✔	✔			
Review process for significant transactions (as identified by the Board)	D&R ii	Trust Secretary	Assurance						
Review of Freedom to Speak Up / Raising Concerns policy (next review January 2026)	D&R b	Chief Nurse	Assurance						
Self-assessment of Committee's effectiveness	D&R gg, hh & Outputs	Trust Secretary	Information						✔
Annual Report from each Committee to be received by April AC (governance, how many times met, quorate, TOR reviewed, workplan on track etc.)	D&R hh	Trust Secretary	Assurance	✔					
Item added 270423: Clinical Audit review (October & April with first review in October 2023)	D&R e	Chief Nurse	Assurance					✔	
Oversight of conducting a market testing exercise for the appointment of internal audit and anti fraud services * *Required every 5 years, Q2 or Q3 - last review in 2021	D&R k,q	DOF	Approval or Information						
Monitoring of the Well-Led Action Plan as delegated by the Trust Board	D&R ff	Trust Secretary	Assurance						
External Audit									
Agreement of External Audit plans and fees (recommendation to Council of Governors) *April - only if needed e.g., for additional fees	D&R r-x	External Audit	Approve	✔ *					✔
External Audit Progress report and sector update	D&R r-x	External Audit	Information	✔			✔	✔	✔
External Auditors Findings Report / ISA260	D&R r-x	External Audit	Recommend to Board		✔	✔			
VFM Risk Assessment (included in the Audit Plan)	D&R r-x	External Audit	Assurance	✔					
External Auditors Letter of Representation	D&R r-x	External Audit	Recommend to Board			✔			
Annual Review of Effectiveness of External Audit	D&R r-x	Trust Secretary	Information					✔	
Private discussions with External Audit (takes place as required but as a minimum once per year)	D&R r-x	Chair	Assurance	✔			✔		

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AUDIT COMMITTEE BUSINESS CYCLE 2023/24	ToR Clause	Lead	Action	27 Apr 2023	18 May 2023 *Extraordinary (Draft Annual Report & Accounts review)*	28 June 2023 *Extraordinary (Final Annual Report & Accounts review)*	6 July 2023	12 Oct 2023	11 Jan 2024
Internal Audit									
Annual Internal Audit Plan	D&R f	Internal Audit	Approve	✔					✔
Review of Audits with limited or no assurance	D&R g,h	Internal Audit	Approve	✔			✔	✔	✔
Internal Audit Progress Reports and Sector Updates	D&R g,h	Internal Audit	Information	✔			✔	✔	✔
Annual Internal Audit Report and Director of Audit Opinion	D&R f - k	Internal Audit	Approve	✔		✔			
Internal Audit Charter	D&R f - k	Internal Audit	Assurance	✔					
Annual Review of Effectiveness of Internal Audit	D&R j	Trust Secretary	Information						✔
Private discussions with Internal Audit (held as a pre meet as required but a minimum of once per year)	D&R f - k	Chair	Assurance						✔
Anti-Fraud									
Anti-Fraud Annual Plan	D&R l	Anti-Fraud	Approval	✔					✔
Anti-Fraud Progress Update	D&R m,n	Anti-Fraud	Information	✔			✔	✔	✔
Anti-Fraud Annual Report	D&R m,n	Anti-Fraud	Recommend to Board	✔					
Annual Review of Effectiveness of Anti-Fraud services	D&R p	Committee	Information					✔	
Private discussions with Anti-Fraud Services (held as required but as a minimum once per year)	D&R l-q	Chair	Assurance						✔
Registers									
Register of Declarations of Interests for reporting period	D&R bb	Trust Secretary	Assurance	✔			✔	✔	✔
Hospitality Register for reporting period	D&R bb	Trust Secretary	Assurance	✔			✔	✔	✔
Annual Review of Register of Interests	D&R bb	Trust Secretary	Assurance	✔					
Review of losses, write offs and special payments	D&R bb	DOF	Information	✔			✔	✔	✔
Financial Reporting									
Review of annual accounts progress	D&R y	DOF	Information	✔	✔	✔			✔
Review of other reports and policies as appropriate e.g. changes to Standing Orders and Standing Financial Instructions, changes to accounting policies, Standing Order Waiver Reports.	D&R bb - dd	DOF	Information	✔			✔	✔	✔

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FINANCE & PERFORMANCE COMMITTEE BUSINESS CYCLE 2023/24	May 2023	May 23	Jul 23	Sep 23	Nov 23	Jan 2024	Mar 2024
Welcome, Apologies and Previous Meetings							
Apologies	✔	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	✔	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting		✔	✔	✔	✔	✔	✔
Action Log		✔	✔	✔	✔	✔	✔
Urgent Items with the agreement of the Chair	✔	✔	✔	✔	✔	✔	✔
Finance Report							
Finance Report		✔	✔	✔	✔	✔	✔
Annual Report and Accounts	✔	✔					
Chair's report from CIP Council		✔	✔	✔	✔	✔	✔
Planning and financial arrangements	✔	✔			✔	✔	✔
Charitable Funds Report				✔			✔
National Cost Collection (reference costs)		✔		✔			✔
Service line reporting (SLR)		✔		✔		✔	
Grip and Control Checklist			✔				
Procurement report		✔		✔		✔	
Annual budget setting				✔			✔
Performance							
Performance Report IQPR		✔	✔	✔	✔	✔	✔
Chair's Report from Performance Council		✔	✔	✔	✔	✔	✔
Deep Dives - as required							
Digital/Information							
Chair's report from DIGIT		✔	✔	✔	✔	✔	✔
Annual SIRO Report			✔				
Business Continuity Arrangements				✔			
Information update report		✔		✔		✔	
Estates							
Estates and H&S Report			✔		✔		✔
Estates and H&S Strategy							✔
Green Plan							✔

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FINANCE & PERFORMANCE COMMITTEE BUSINESS CYCLE 2023/24	May 2023	May 23	Jul 23	Sep 23	Nov 23	Jan 2024	Mar 2024
Green Plan Update			✔		✔		✔
Audit							
Audit Recommendations Report		✔	✔	✔	✔	✔	✔
Risks							
Operational Risk Report		✔	✔	✔	✔	✔	✔
Board Assurance Framework		✔	✔	✔	✔	✔	✔
BAF workplan items not covered elsewhere - as required							
Committee Governance							
Business cycle			✔				✔
Items for escalation to Board and/or Committees	✔	✔	✔	✔	✔	✔	✔
Review of meeting	✔	✔	✔	✔	✔	✔	✔
Annual Review of Terms of Reference and Assessment of Committee Effectiveness			✔				
Strategies							
Digital Strategy							✔
Estates Strategy							✔

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NOMINATIONS & REMUNERATION COMMITTEE BUSINESS CYCLE 2023/24	08 Jun 2023	11 Nov 2023
Welcome, Apologies and Previous Meetings		
Apologies	✔	✔
Declarations of Interest in items on the agenda	✔	✔
Minutes from the previous meeting	✔	✔
Action Log	✔	✔
Urgent Items with the agreement of the Chair	✔	✔
Items of business		
Annual review of salaries, bonuses or changes, terms of office / terms and conditions for Board Directors & Very Senior Managers	✔	
Annual review of Executive performance / appraisal	✔	
Review of the size, structure and composition of the Board	✔	✔
Review of Terms of Reference	✔	
Succession planning for Executive and Non-Executive Directors	✔	

Ad hoc items		
Oversight of Board Director appointments		
Compromise agreements / special payments		

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PEOPLE COMMITTEE BUSINESS CYCLE 2023/24	Lead	10 May 2023	12 Jul 2023	13 Sep 2023	15 Nov 2023	17 Jan 2024	13 Mar 2024
Welcome, Apologies and Previous Meetings							
Apologies	Chair	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	Chair	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting	Chair	✔	✔	✔	✔	✔	✔
Action Log	Chair	✔	✔	✔	✔	✔	✔
Urgent Items with the agreement of the Chair	Chair	✔	✔	✔	✔	✔	✔
Delegated matters from Trust Board	Chair	✔	✔	✔	✔	✔	✔
Review of Committee Terms of Reference	Chair		✔				
Review of Committee Business Cycle March	Chair		✔	✔			✔
Committee Annual Activity Report	DoP&OD						✔
Committee Effectiveness Survey	Chair						✔
Director of People and Organisational Development Report	DoP&OD	✔	✔	✔	✔	✔	✔
Review Board Assurance Framework BAF 5 & 6	DoP&OD/CN	✔	✔	✔	✔	✔	✔
Risk Register: Leadership, Organisational Development and Education	EPDL	✔	✔	✔	✔	✔	✔
Risk Register: HR	HHR	✔	✔	✔	✔	✔	✔
Risk Register: Communications	DDoCE	✔	✔	✔	✔	✔	✔
IQPR: PEOPLE Indicators	DDoP&OD/ HoW	✔	✔	✔	✔	✔	✔
Review of the People Strategy: endorsement as per NHS People Plan	DoP&OD			✔			✔
People Strategy and People Plan - People Operational Delivery Plan Report - for assurance	DDoP&OD/ DDoCE		✔		✔		✔
Medical Appraisal and GMC Revalidation Report *(twice a year)*	MD			✔			✔
Responsible Officer Annual Report	MD			✔			
Chair's Report: Medical & Dental Professional Governance Meeting	MD			✔			✔
Policies and Procedures Report - as required	HHR	✔	✔	✔	✔	✔	✔
Employee Relations	HHR	✔	✔	✔	✔	✔	✔
Freedom to Speak Up Report	FTSUG	✔	✔	✔	✔	✔	✔
Freedom to Speak Up Annual Report	CN	✔					~~✔~~
National Staff Opinion Survey - Launch Report	DDoCE			✔			
National Staff Opinion Survey - Results Report and Action Plan	DDoCE	✔					✔
Equality, Diversity & Inclusion Strategy: Refresh - for approval	E&IM						✔
Equality, Diversity & Inclusion - Regulated reports (as required):							
Public Sector Equality Duty (PSED) for Workforce and Services Annual Report - within People Committee Chair's report to Board	E&IM					✔	~~✔~~
Gender Pay Report - within People Committee Chair's report to Board	E&IM		✔			~~✔~~	
Equality Delivery System - within People Committee Chair's report to Board	E&IM				✔	~~✔~~	
Workforce Race Equality Standard (WRES) Report and Action Plan - within People Committee Chair's report to Board	E&IM		✔				
Bank Workforce Race Equality Standard (BWRES) Report and Action Plan - within People Committee Chair's report to Board	E&IM		✔				
Medical Workforce Race Equality Standard (MWRES) Report and Action Plan - within People Committee Chair's report to Board	E&IM		✔				
Workforce Disability Equality Standard (WDES) Report and Action Plan - within People Committee Chair's report to Board	E&IM		✔				
Staff Networks Governance Assurance	E&IM					✔	
Facilities Time Off Annual Report	HHR				✔		
Leadership, OD, L&D and Staff Engagment Programmes - updates (as required)	DDoP&OD/ DDoCE						
Knowledge & Library Service Annual Report	K&LSM	✔					
PPDR and Statutory & Mandatory Training Compliance	EPDL	✔	✔	✔	✔	✔	✔
Apprenticeship Scheme and Levy	HoW	✔		✔		✔	
Talent Management & Succession Planning	HoOD		✔		✔		✔
Staff Engagement & Recognition Annual Report - March (with updates)	DDoCE		✔		✔		✔
Communication Update	DDoCE	✔		✔		✔	
Review of Staff Sickness Against Trust Target	HoW	✔	✔	✔	✔	✔	✔
Staffing System Implementation Update	CN/HoW	✔	✔	✔	✔	✔	✔
Annual Occupational Health Services Report	HHR	✔					
Payroll Provider Performance Review (annual update)	DDoP&OD				✔		
Review of SLA Performance for Transactional Training Services	DDoP&OD				✔		
Vaccination Campaign and Numbers - Staff	CN			✔	✔	✔	✔
Internal Audit Action Plans (Review of MIAA Audits within the remit of People Committee)	DDoP&OD/ DDoCE	✔	✔	✔	✔	✔	✔
Review of Meeting	Chair	✔	✔	✔	✔	✔	✔
Any items for escalation to Board or sharing with other Committees	Chair	✔	✔	✔	✔	✔	✔

Key:
CN - Chief Nurse
DDoCE - Deputy Director of Communication & Engagement
DoP&OD - Director of People & Organisational Development
DDoP&OD -Deputy Director of People & Organisational Development
EPDL - EPD Lead
E&IM - Equality & Inclusion Manager
HoOD - Head of Organisational Development
HoW - Head of Workforce
K&LSM - Knowledge & Library Services Manager
MD - Medical Director
FTSUG - Freedom to Speak Up Guardian

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QUALITY & SAFETY COMMITTEE BUSINESS CYCLE 2023/24	20 Apr 2023	22 Jun 2023	24 Aug 2023	26 Oct 2023	21 Dec 2023	28 Feb 2024
Welcome, Apologies and Previous Meetings						
Apologies	✔	✔	✔	✔	✔	✔
Declarations of Interest in items on the agenda	✔	✔	✔	✔	✔	✔
Minutes from the previous meeting	✔	✔	✔	✔	✔	✔
Action Log	✔	✔	✔	✔	✔	✔
Urgent Items with the agreement of the Chair	✔	✔	✔	✔	✔	✔
Duties and Responsibilities						
BAF 2, 3 & 6	✔	✔	✔	✔	✔	✔
Clinical Audit Plan and Research Assurance		✔			✔	
Infection Prevention & Control Assurance	✔		✔		✔	
IQPR	✔	✔	✔	✔	✔	✔
Learning from Deaths Monitoring		✔		✔		✔
Improvement Plans: Paediatric, Dermatology, Dental, Children's Transformation	✔	✔	✔	✔	✔	✔
QIA Report		✔		✔		✔
Quality Accounts - draft and final	✔	✔				
Quality Council Report, including Effectiveness of Patient Safety Group and NICE Guidance Compliance	✔	✔	✔	✔	✔	✔
Quality Priorities			✔			✔
Quality, Safety and Patient Experience	✔		✔		✔	
Review of MIAA Audits within the remit of Q&S Committee	✔	✔	✔	✔	✔	✔
Risk Management Council Report	✔	✔	✔	✔	✔	✔
Safeguarding Annual Report			✔			
Serious Incidents Oversight	✔	✔	✔	✔	✔	✔
Terms of Reference Review		✔				
Trust Improvement Plan		✔		✔		✔
Deep Dive Programme						
Consideration of future deep dive reports	✔	✔	✔	✔	✔	✔

Strategy Approval and Review Programme						
Carers Strategy		✔			✔	
Children's Strategy						✔
End of Life Strategy				✔		
Infection Prevention & Control Strategy	✔		✔			
Research & Development Strategy	✔					
Risk Management Strategy			✔			✔
Safeguarding Strategy						✔
Corporate Governance						
Annual Report						✔
Committee Effectiveness Review - annual						✔
Committee Business Cycle Review - six monthly		✔				✔
Items for Escalation to other Committees or Board	✔	✔	✔	✔	✔	✔

Items referred from other Commitees

Item
Date
Details

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**03 August 2023**
Agenda Item	**61/23iii**		
Report Title	**BOARD OF DIRECTORS BUSINESS CYCLE 2023-24**		
Executive Lead	Karen Bliss, Chair		
Report Author	Samantha Scholes, Head of Corporate Governance		
Presented by	Jan McCartney, Trust Secretary		
Action Required	☒ **To Approve**	☐ **To Assure**	☐ **To Note**

Executive Summary

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

Previously considered by:

☐ **Audit Committee**	☐ **Quality & Safety Committee**
☐ **Finance & Performance Committee**	☐ **Nominations & Remuneration 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**	**03 August 2023**
Agenda Item	**61/23iii**		
Report Title	**BOARD OF DIRECTORS BUSINESS CYCLE 2023-24**		
Report Author	Samantha Scholes, Head of Corporate Governance		
Purpose	To apprise the Board of the revised Board of Directors business cycle.		

1. SCOPE

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

2. SUMMARY

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

Appendix 1: Board of Directors Business Cycle

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BOARD OF DIRECTORS - PUBLIC MEETING, PART I, 2023-24	CONSIDERED BY	06 Apr 23	01 Jun 23	28 Jun 2023 Extraordinary	03 Aug 2023	05 Oct 2023	07 Dec 2023	08 Feb 2024
Welcome, Apologies and Previous Meetings								
Apologies		✔	✔	✔	✔	✔	✔	✔
Declarations of Interest in agenda items		✔	✔	✔	✔	✔	✔	✔
Minutes from the Previous Public Meeting		✔	✔		✔	✔	✔	✔
Action Log		✔	✔		✔	✔	✔	✔
Urgent Items with the Agreement of the Chair		✔	✔	✔	✔	✔	✔	✔
Patient Stories/Spotlight on Services		✔	✔		✔	✔	✔	✔
Key corporate messages		✔	✔		✔	✔	✔	✔
Equality, Diversity and Inclusion								
To actively promote equality, diversity and inclusion by creating the conditions that enable compassion and inclusivity to thrive (BAF 5)								
Equality, Diversity and Inclusion Annual Report	People	✔						
Gender Pay Gap Annual Report	People	✔						✔
WRES	People				✔			
WDES	People				✔			
Innovation and Collaboration								
To deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living (BAF 7)								
Organisational Strategy Review (Quality and Place)		✔	✔		✔	✔	✔	✔
Integration & Collaboration Report		✔	✔		✔	✔	✔	✔
Provider Collaborative		✔	✔		✔	✔	✔	✔
Provider Collaborative - Information and Update for Membership Trust Boards		✔	✔		✔	✔	✔	✔
People								
To be a highly effective organisation with empowered, highly skilled and competent staff (BAF 1,3,5,6, and 8)								
Chair's Assurance Report from People Committee	People	✔	✔		✔	✔	✔	✔
Escalated People Risks (ad hoc)	People							
Freedom to Speak Up Update Report	People						✔	
Freedom to Speak Up Annual Report	People		✔					
Medical Appraisal and Revalidation (annual)	People	✔						
People Plan	People	✔				✔		
Staff Survey Results and Action Plan	People	✔	✔					

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BOARD OF DIRECTORS - PUBLIC MEETING, PART I, 2023-24	CONSIDERED BY	06 Apr 23	01 Jun 23	28 Jun 2023 Extraordinary	03 Aug 2023	05 Oct 2023	07 Dec 2023	08 Feb 2024
Quality								
To deliver high quality, safe and effective care which meets both individual and community needs (BAF 2,3,5,6 and 8)								
Chair's Assurance Report from Quality & Safety Committee	Q&S	✔	✔		✔	✔	✔	✔
CQC Report, Compliance and Action Plan (ad hoc)	Q&S							
EPRR	Q&S					✔		
Escalated Quality & Safety Risks (ad hoc)	Q&S							
Integrated Quality Performance Report	Q&S	✔	✔		✔	✔	✔	✔
Learning from Deaths	Q&S	✔				✔		
Safeguarding Annual Report	Q&S					✔		
Winter Plans (Annual)	Q&S					✔		
Sustainability								
To deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability (BAF 1,4 6,7 and 8)								
Adaptive Reserve	F&P		✔					
Annual Accounts	Audit			✔				
Annual Anti-Fraud/Bribery Report	Audit		✔					
Annual Governance Statement	Audit			✔				
Annual Report	Audit			✔				
Chair's Assurance Report from Audit Committee	Audit	✔	✔		✔	✔	✔	✔
Chair's Assurance Report from Finance and Performance Committee	F&P	✔	✔		✔	✔	✔	✔
Escalated Finance & Performance Risks (ad hoc)	F&P							
Escalated Audit Risks (ad hoc)	Audit							
Finance Report	F&P	✔	✔		✔	✔	✔	✔
Financial Plan	F&P	✔	✔		✔	✔	✔	✔
Integration and Collaboration Update	F&P	✔	✔		✔	✔	✔	✔
Operational Plan	F&P	✔	✔		✔	✔	✔	✔

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BOARD OF DIRECTORS - PUBLIC MEETING, PART I, 2023-24	CONSIDERED BY	06 Apr 23	01 Jun 23	28 Jun 2023 Extraordinary	03 Aug 2023	05 Oct 2023	07 Dec 2023	08 Feb 2024
Corporate Governance								
Annual Audit Committee Report and Annual Audit Letter for Information	Audit			✔				
Annual Report by the SIRO	F&P					✔		
BAF Review/ Risk Management Framework / Risk Appetite							✔	
Board Assurance Framework (BAF) - each meeting	All Committees	✔	✔	✔	✔	✔	✔	✔
Board Effectiveness Review - annual		✔						
Business Cycle - Board		✔			✔			
Business Cycles -Committees of the Board					✔			
Elections to Council of Governors (may also be ad-hoc reports following any unexpected vacancies)								
Fit and Proper Annual Review			✔					
Items to be added to the BAF		✔	✔		✔	✔	✔	✔
Items to be delegated or shared with Board Committees		✔	✔		✔	✔	✔	✔
Provider Licence Compliance			✔					
Questions from Members of the Public		✔	✔		✔	✔	✔	✔
Resolution to confirm the affixing of the common seal according to the Register of Seals		✔				✔		
Review of Meeting		✔	✔		✔	✔	✔	✔
Sign off Corporate Objectives/Board Assurance Framework, and later half year review of progress		✔				✔		
Terms of Reference Review - Board					✔			
Terms of Reference Review - Committees of the Board	All Committees				✔			
Well Led Review	EMT/Audit		✔					