Bridgewater Community Healthcare NHS Foundation Trust

PUBLIC BOARD MEETING

Thursday 7 December 2023, 10am
Spencer House, Dewhurst Road, Birchwood, Warrington

AGENDA

Ref	Time	Item Title	BAF Ref	Action
78/23	10.00	(i) Apologies for Absence – Tina Wilkins (ii) Quoracy Statement (iii) Declarations of Interest in items on the agenda		Information Assurance
79/23 Page 3	10.00	Minutes of the last meeting: Board meeting held 5 October 2023		Assurance/ Approval
80/23 Page 13	10.05	Matters Arising from the Action Log		Assurance
81/23	10.10	Any urgent items to be taken at the discretion of the Chair		
82/23	10.10	Patient Story		Information
83/23 Page 18	10.30	Board Assurance Framework – presented by Executive Leads and Board Committee Chairs	ALL	Approval
84/23 Page 36	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				
85/23 (i) Page 43 (ii) Page 72 (iii) Page 81	10.55	(i) IQPR – presented by Executive Leads (ii) Report from the Quality and Safety Committee held on 26 October 2023 – presented by the Committee Chair (iii) EPPR Reassessment – presented by the Chief Operating Officer	ALL 2, 3 2	Assurance Assurance Approval
10.50 - 10 MINUTES BREAK				

RESOURCES: We will ensure that we use our resources in a sustainable and effective way				
86/23 (i) Page 169 (ii) Page 177 (iii) Page 183	12.00	(i) Finance Report, Month Seven – presented by the Director of Finance (ii) Report from the Finance and Performance Committee held on 23 November 2023 – presented by the Deputy Committee Chair (iii) Report from the Audit Committee held on 12 October 2023 – presented by the Committee Chair	4 4, 7, 8 1, 4	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				
87/23 Page 188	12.40	Integration and Collaboration Update – presented by the Programme Director of Integration and Collaboration	7	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				
88/23 (i) Page 195 (ii) Page 209 (iii) Page 216	12.55	(i) Report from the People Committee held on 15 November 2023 – presented by the Committee Chair (ii) Update on Anti-Racist Framework – presented by the Director of People and Organisational Development (iii) We each have a voice that counts – presented by the Director of People and Organisational Development	5, 6 5, 6 5, 6	Assurance Assurance Assurance
OVERARCHING CORPORATE GOVERNANCE ITEMS				
89/23 (i) Page 230 (ii) Page 243	1.30	(i) New Board Assurance Framework – presented by the Trust Secretary (ii) 2024/25 Corporate Calendar – presented by the Trust Secretary	1 1	Approval Approval
90/23	1.45	Review of meeting and Items to be added to the Board Assurance Framework		Information
91/23	1.50	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 8 February 2024, 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 5 October 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 and Deputy Chief Executive
Linda Chivers, Non-Executive Director
Nick Gallagher, Director of Finance
Abdul Siddique, Non-Executive Director (from item 67/23)
Martyn Taylor, Non-Executive Director (from item 72/23i)
Tina Wilkins, Non-Executive Director

In Attendance
Rob Foster, Programme Director of Integration and Collaboration
Jo Waldron, Deputy Director of People and Organisational Development
John Morris, Deputy Director of Estates (for items 72/23ii and 72/23iii)
Jan McCartney, Trust Secretary
Lynda Richardson, Board and Committee Administrator

For Patient Story (item 68/23 only)
Alison Anton, Operational Manager, Children's Specialist Services
Kathryn Royden, Operational Manager, Children's Specialist Services
Caroline Parker Holland, Patient Services Manager
Kate (patient parent)

Observers/members of the Public
Andrew Mortimer, Public Governor, Warrington
Peter Hollett, Public Governor, Halton
Jade, HR Graduate Trainee

The Chair welcomed all to the August 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 participate in, with the exception of questions that could be presented to the Board at the end of the meeting.

64/23 (i) APOLOGIES FOR ABSENCE
Paula Woods, Director of People and Organisational Development
Elaine Inglesby, Non-Executive Director

(ii) QUORACY STATEMENT

The Chair confirmed that the meeting was quorate.

(iii) DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

No declarations of interest were made.

65/23 MINUTES OF THE LAST MEETING

BOARD MEETING HELD 3 AUGUST

Page two, under matters arising from the action log under item 23/23i IQPR, the Chief Operating Officer clarified that the paper presented was not the new format of the IQPR but that it was a report setting out the changes that were proposed to be made to the IQPR.

Page seven, under item 60/23i Report from the People Committee held on 12 July 2023: minute to include the Board's approval of the proposed sickness and turnover targets.

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

66/23 MATTERS ARISING FROM THE ACTION LOG

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

88/22ii Update on Provider Collaboratives

The Trust Chair confirmed that a meeting would be taking place with Chairs and a nominated Non-Executive Director from across the member organisations of the collaborative on 18 October 2023. Non-Executive Director and Vice Chair, Linda Chivers would be attending on behalf of the Trust Chair, along with Non-Executive Director, Elaine Inglesby. Feedback would be provided to the Board following this meeting taking place.

58/23ii Adaptive Reserve Report

The Director of Finance confirmed that the report had not yet been circulated as relevant information was not yet available. The Director of Finance would share information that was available from earlier in the year, with a focus on the contribution of the Trust. Non-Executive Director, Linda Chivers asked that Value for Money information was included within the report. **The Board would need to consider if there was any further action to be taken following the circulation of the report.**

60/23ii Update on the North West Anti-Racist Framework

The Deputy Director of Workforce reported that the Task and Finish Group considering the framework had undertaken an initial assessment. The Trust was currently focussing on achieving Bronze Level. The Board agreed that it was content that this matter was being progressed and this would be monitored through the People Committee going forwards. Therefore, this action could now be rated as blue.

It was agreed that the following completed blue rated items could be removed from the action log:
55/22 Board Assurance Framework
23/23i IQPR
23/23ii Performance Framework
23/23iii Committee Chair's Report from the Quality and Safety Committee
23/23v Learning from Deaths

24/23i Finance Report – noted that the position concerning incentives being offered by other organisations would continue to be monitored with any further issues to be raised at Chief Executive level
27/23iii Staff Survey
41/23v Freedom to Speak Up (FTSU) self-assessment
42/23ii Fit and Proper Annual Review
49/23 Items to be added to the Board Assurance Framework
61/23iii Board business cycle

67/23 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.

68/23 PATIENT STORY – WARRINGTON COMMUNITY PAEDIATRIC SERVICE

The Board received a story from Kate in relation to her son Freddie who had been diagnosed as autistic. Kate described Freddie's journey through Trust services post diagnosis and whilst she felt that she had received a good service from Trust staff, Kate shared her view that there had been a disjointedness between the Health Visiting Service, Paediatric Community Medical Service, and Speech and Language Therapy Service. She had also needed to actively follow up with services to receive updates concerning Freddie's position on waiting lists. The Board acknowledged that this had been frustrating for Kate. The Board was informed by the Service Managers that improvements were being made to bring services such as Speech and Language Therapy and Paediatrics under one umbrella which would enhance communication and flow for patients. The need to improve communications with patients and families whilst they were waiting to be seen was acknowledged, and going forwards there would be letters sent at suitable intervals to those on waiting lists. Improvement work also included discussions with voluntary sector partners including CAMHS and the Local Authorities on areas that could be improved. It was recognised that patients and families being left in limbo post autism diagnosis was a key area to be addressed with changes to be made to communications and post diagnosis support that can be offered. There would also be improvements that could be made as part of collaboration work with partner organisations. Kate was invited and agreed to liaise with staff within the Trust to provide further detailed feedback which would be included in improvement work.

The Board thanked Kate for sharing her story and welcomed the work that was underway to address the issues that had been highlighted.

69/23 BOARD ASSURANCE FRAMEWORK

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

She particularly highlighted BAF8 in relation to digital services. She reported that this BAF was discussed at the Finance and Performance Committee meeting on 21 September, and the Committee recommended that the Trust increased the risk rating and the rationale to a score of 12. This was to reflect that the Chief Nursing Informatics Officer (CNIO) role remained vacant and the ongoing issues in relation to the EMIS patient records system and its licence. The Director of Finance reported that an appointment was expected to be made to the CNIO in the near future and that EMIS was being encouraged to sign up to a new reporting tool, which would supersede the existing one. He advised that discussions were taking place with local commissioners concerning the contract for EMIS and how this could be transferred to the Trust going forwards.

Board agreed the recommended changes and noted that BAFs 1,4 and 7 were currently at target.

70/23 KEY CORPORATE MESSAGES

The Chief Executive presented the report. He reflected upon the recent Annual Members Meeting and the Thank You Staff Awards with good feedback being received from this event from across the organisation. He advised that considerations were being given to the arrangements for those events for 2024. He also highlighted that October would be Freedom to Speak Up (FTSU) month, with significant actions and engagement taking place across the Trust to raise the profile of speaking up. He explained that the Trust had set an ambition to identify a FTSU Champion within every team across all services, both clinical and non-clinical.

A discussion took place concerning feedback from Time to Talk visits to services, visits attended by one Executive and one Non-Executive Director. This included debate on how the feedback was taken forwards and where this was reported to, and how it was followed up. **It was agreed that further consideration was required around this important information, including issues that should be able to be addressed at the source by line managers.**

The Deputy Director of People and Organisational Development provided an update concerning Trust's commitment to the NHS England Sexual Safety Charter. The Trust would ensure a zero tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours in the workplace. There were 10 core actions to support achievement of this with all of those to be met by July 2024. She explained that there would be a review of the Domestic Abuse Policy in addition to this, and there may be a need for a separate policy. All work would be routed through the People and Organisational Development (POD) Council with alignment to the Trust's dignity and respect programmes. A further update would be available on work following a meeting to take place on Monday 9 October.

The Chief Executive re-iterated the importance of Board members being informed concerning the NHS Fit and Proper Persons Test (FPPT) Framework for board members as an important part of the Trust governance framework. The timescale for the FFP framework was now to be brought forward in the light of the recent Letby case and conviction. This would include some changes that the Corporate Governance Team would be required to enact. The Trust Secretary highlighted that a paper would be taken to the Audit Committee at its next meeting, as that forum would have oversight of the FFPT implementation, and this would be circulated to all Board members to ensure sightedness.

The Board received the report.

71/23 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 Chief Operating Officer presented the report and highlighted that there had been 13 green rated indicators during month four. She reported that there had been one new red rated indicator in relation to the referrals to plan indicator, with one new green rated indicator for the Warrington Dermatology Cancer 31 day wait from diagnosis to first treatment. All cancer indicators were rated as green. She noted that performance within the red and green indicators had been variable and that this was due to the impact of seasonal pressures with staff taking annual leave over the summer and less onward referrals into services from referrers such as schools. In relation to Warrington Audiology and the number of six weeks diagnostic breaches, the Chief Operating Officer advised that there had been a decrease from 77 to 73 breaches. The children concerned were being managed as a result of the recall from the incident and the reception catch up work. It was anticipated that all patients

would be seen by the end of October 2023: a review was being undertaken of capacity and work resulting from the incident. Challenges had continued with Paediatric General Anaesthesia (GA) with an impact being seen as a result of sessions being cancelled. Patients waiting for Paediatric GA had increased, however paediatric inhalation sedation, IV anxious adults and minor oral surgery has decreased over the last few months. Actions were in place via all of the task and finish groups to address the waiting list pressures.

The Board noted the quality indicators rated as red for month four: three indicators were red: percentages of incidents of a low level impact had increased and this was as a result of good reporting: Duty of Candour (DoC) was reporting as red in relation to 10 day compliance and percentage of risks identified as high which was reflective of the challenges within services, particularly children's services. The Board noted that three of the five people indicators were red rated in month in relation to staff rolling turnover, overall organisational sickness rate and sickness absence rate: there had been a deterioration in staff turnover but an improvement had been seen concerning sickness rates.

A discussion took place concerning the increasing pressures for services and maintaining standards, whilst there was an impact as covid funding had been lost. Non-Executive Director, Linda Chivers noted that the Trust had been strict on its performing targets and that the Trust's performance was robust nationally even if it would like to see further improvements. She commented that cost pressures as a result of inflation was starting to have an impact and that CIP areas were now not CIP as cost inflation was having an impact. She acknowledged that this was a challenging time for organisations and a real issue for the Trust. The Director of Finance agreed that this was a particularly challenging time, and that there was no additional funding available. He commented that the challenge would be how the Trust could best spend what was available going forwards and this would be a challenge across the NHS.

The Medical Director referred to the position with dental waiting times. He explained that there had been a decrease in the waits that were in the control of the Trust but an increase in the ones that were outside of this and there had been an accumulative effect on theatre usage and from the strikes that had taken place. He advised that the right patients were on the right pathway however there would be a tranche of patients for General Anaesthesia with waits that would be problematic for a period of time. The Chief Executive informed the Board that the Executive Management Team had discussed this and highlighted that there was power in providers working together to address these types of challenges and those outlined as part of the earlier patient story: he commented that some services that the Trust provided for children including dental services needed to be more prominently highlighted with commissioners. There was an increasing appetite with partners to work together and address those issues and work on what can be directly impacted to make progress. The Chief Operating Officer added that the Trust had a responsibility to constantly champion community services and its role within the system and to challenge commissioners. The Trust Chair noted that the Trust's Strategy was focussed on prevention which was also an important element.

The Board received the report for assurance.

(ii) LISTENING TO STAFF VOICES AND FREEDOM TO SPEAK UP

The Chief Nurse presented a report which detailed work being undertaken across the Trust to ensure that staff voices were being listened to and how feedback would be provided and reported. The Board recognised that this was an important cultural journey: whilst the Trust had good processes in place it must ensure that there is an environment where staff can feel safe to ask questions and to be able raise any issues and/or concerns and feel listened to.

The Chief Nurse reported that ongoing work included the roll out of FTSU training which would be available going forwards for all new staff members with one module then being offered for existing managers and another for existing staff across the Trust.

The Chief Nurse advised that it would be fundamental to ensure that that staff groups felt confident to raise questions, to have professional curiosity and to never feel that they would suffer detriment for speaking up. She noted that there were Nurse Advocates across the Trust who were working to improve this, however they were only a small number of staff, and staff's professional supervision would also be a route to raise questions. This would feed into the Trust's Just Culture journey with Bridgewater being a questioning and learning organisation. It would also be important to ensure that the Trust's FTSU Guardian was available for a sufficient number of hours recognising the wide geography of the organisation including dental services.

The Chief Nurse advised that there would be elements to be strengthened in terms of providing feedback to staff such as around 'you said, we did' and feedback from the Time to Talk sessions with teams. This may include feedback via the Trust's intranet for wider issues or to contact a team or manager regarding a particular issue. The Chief Nurse also referred to the ambition as mentioned earlier in the meeting for each team to have its own FTSU champion. Options to encourage staff to take up this role would include protected time. She also informed the Board that it would be important to discuss feedback such as that from Time to Talk sessions with line managers and ensure that those line managers were listening and acting on information. She advised that changes would be made to patient safety incident meetings to draw out learning in those forums and to actively encourage staff to raise questions. In terms of monitoring and measuring the success of the work, this would be done in a number of ways: interventions would be targeted with the impact of those measured, pulse check surveys would also provide a route to monitor progress.

The Deputy Director of People and Organisational Development recognised that there were other areas of training that could be strengthened around FTSU such as operational and first line manager training which included elements such as just culture and speaking up, but would provide an opportunity to re-iterate and strengthen the FTSU processes within the Trust. The Chief Executive highlighted recent staff survey results which had indicated approximately 500 staff who did not feel confident that should they raise a clinical concern that it would be addressed. The Board agreed that this was a concerning picture and that it was of key importance that the Trust did not become complacent. The Chief Executive advised that engagement would continue team by team to stress that any issues must be raised. This would include seeking examples of where concerns had been raised but may not have been dealt with which would provide an analysis of areas of concern.

The Board received the update report and recognised that whilst work was being progressed, there was still work to be undertaken to further embed a culture where staff can feel safe to ask questions and to be able raise any issues and/or concerns and feel listened to.

(iii) EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) ANNUAL REPORT

The Chief Operating Officer presented the report to the Board for its approval. She explained that the EPRR report was proposed to be submitted to the ICB and that this paper was declaring partial compliance, however this was due to a change in measuring systems which had resulted in some organisations declaring partial compliance, when this would usually be substantial compliance. The Chief Operating Officer confirmed to Non-Executive Director, Gail Briers that actions were being taken on the outstanding amber rated areas and those would be monitored by the EPRR group. She advised that the Trust was comfortable with the position but acknowledged that there was further work to be undertaken. Non-Executive Director, Gail Briers suggested that a date **needed to be set around the outstanding areas as some were only noted as 'continuous'**. Non-Executive Director, Linda Chivers highlighted that **the MIAA internal audit plan next year could include the EPRR process. It was agreed that this would be captured as part of discussions early next year.**

The Chief Operating Officer confirmed to Non-Executive Director, Tina Wilkins that winter challenges would present additional stretch and the Trust would need to continue to be cautious to ensure robust plans were in place. The Trust was experienced in managing this and would need to refine work in the event of any issues and would continue to work with partners.

The Board received the EPRR report and agreed that the report would be submitted, declaring partial compliance, to the ICB.

(iv) WINTER PLAN

The Chief Operating Officer presented the report which was approved by the Board.
The Board recognised that there would be inevitable challenges during the winter period however it was recognised that the Trust had made as many preparations for this as possible. It was acknowledged that currently there would be no additional funding for winter due to the system deficit position, however discussions would continue with key partners on the Trust's important role to keep patients out of hospital and to demonstrate the benefits of virtual wards including discussions with across the system as to how contributions could be made collectively to maximise effectiveness in preventing admissions.

(v) LEARNING FROM DEATHS REPORT

The Medical Director presented the report and noted that there would be a review of policy in terms of the reporting of deaths going forwards. This would enable improved learning, reviewing a wider scope of deaths, including whether there had been coroner involvement. Non-Executive Director, Gail Briers suggested reviewing a sample of data around deaths to provide robustness and it was agreed that this would be included as part of the development of the report.

The Board recognised the progress made to date and received the report. The Medical Director advised that the next quarterly report would be in a similar vein to the one presented today, as some of the work to refine the report following the policy review may take some time including the reviewing of samples of data.

(IV) REPORT FROM THE QUALITY AND SAFETY COMMITTEE HELD ON 24 AUGUST 2023

The Board received a report for assurance from the Committee Chair, Gail Briers.

72/23 RESOURCES: We will ensure that we use our resources in a sustainable and effective way

(i) Finance Report

The Director of Finance reported on the Trust's financial performance for month five.
A discussion took place concerning the need for organisations to achieve a 5% CIP across the system and the significant challenges that this presented. The Chief Operating Officer highlighted that there was a need to balance the risk to deliver transformation, deliver services and ensure that patients were being kept safe. Discussions with the ICB were ongoing on this. The Director of Finance noted that there were external factors to be taken into account and the possibility to demonstrate that investing in some areas would provide savings in others to contribute to the CIP. Quality Impact Assessments (QIAs) would continue to have a key role in assessing the quality impact of any financial decisions.

A discussion took place on the potential for the Trust to be asked to contribute to the financial position of more than one ICB recognising its wide ranging geographical footprint encompassing Cheshire and Merseyside and Greater Manchester ICBs. There had also been a suggestion that Place may be asked to contribute to achieving a balance. **The**

Director of Finance agreed to source information for Warrington and Halton Place, collate and share this with the Board to ensure that it was sighted on the position.

The Board received the report, acknowledging that the current year would be challenging. The Board approved the plan to achieve mandatory cost submissions for 2022/23 and was assured that this was robust.

(ii) Green Plan

The Deputy Director of Estates presented an update on the Green Plan. He reported that the Trust was halfway through the timeline of its plan and was continuing to invest resources to meet its green plan commitments with regular updates on progress being presented to the Finance and Performance Committee. The outcome of the timeline was reflected within the circulated report with a strategic snapshot of the Trusts carbon dashboard. This set out that the Trust, on a like for like basis, had achieved significant improvements in its carbon footprint, reducing its calculated emissions by a third over the timeline. The Deputy Director of Estates advised that work continued to further improve those numbers, cognisant of both the timeline and national strategic direction in terms of achieving a net zero position.

The Board received the update for note. The Programme Director of Integration and Collaboration asked whether the dashboard would include the mileage of staff and types of mileage, along with the corresponding impact on Co2. The Deputy Director of Estates confirmed that the business mileage was able to be provided, however this was more challenging in relation to commuting. He advised that the future national strategic direction would be focussed around the use of electric vehicles with the necessary infrastructure , with the possibility for staff to lease electric vehicles.

(iii) Re-inforced Aerated Autoclave Concrete (RAAC) issues

The Deputy Director of Estates presented a report to the Board to affirm that confirmation had been received from Community Health Partnerships and NHS Property Services that none of the 60 buildings that the Trust occupied contained RAAC. The Trust had re-engaged Eric Wright Facilities Management to survey its freehold properties and to provide an updated level of documented assurance. The Trust had contacted all other landlords, primarily primary care landlords, seeking assurances in line with the national documentation. It was noted that primary care had only recently been asked to survey their property and results were not yet known across a number of properties, albeit given the nature and age of the buildings, they were considered to be low risk based on the known building characteristics where RAAC has been found in other sectors. He reported that the remaining landlords would be approached to confirm the outcome of the individual surveys. An appropriate risk assessment would be entered on Ulysses with a final position statement to be presented to Finance and Performance Committee.

The Chief Executive asked whether there had been any concerns expressed by staff concerning RAAC in areas where assurance was yet to be provided. The Deputy Director of Estates explained that there had not been any concerns, but this had been discussed at the last meeting of the Health and Safety Group, with a question asked regarding RAAC at the last Team Brief. In addition a Freedom of Information request had been received regarding the Trust's position.

(iv) Report from the Finance and Performance Committee held 21 September 2023

The Board received a report from the Finance and Performance Committee meeting held in September 2023 from Non-Executive Director and Committee Chair, Tina Wilkins for assurance.

73/23 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 Programme Director of Integration and Collaboration presented an update report concerning Place and the Provider Collaborative. This included an update on measuring and monitoring of the Trust's new strategy with a first draft of the performance dashboard that had been developed, directorate delivery plans, public and community engagement and partnership working across the system.

74/23 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 13 September 2023

The Committee Chair and Non-Executive Director, Abdul Siddique presented the report setting out the key considerations of the July meeting of the People Committee. Non-Executive Director, Martyn Taylor referred to a strike for Health Care Assistants that would be taking place across the 16 and 18 October. The Deputy Director of People and Organisational Development advised that this was in relation to a specific issue on banding discrepancies, but that this would not have any impact on staff.

(ii) 2022/23 Annual Appraisal and Revalidation and Medical Governance Report

The Medical Director presented the report noting that this had been approved by the People Committee in September and that the Board was asked to finally approve the paper. The Board agreed that the report provided assurance that the Trust had revalidated and appraised its doctors and that appropriate processes were in place to address any concerns that may be identified. The Medical Director highlighted that the number of revalidations was higher than expected and explained that this was due to one individual being revalidated on a number of occasions because of an ongoing issue.

75/23 OVERARCHING CORPORATE GOVERNANCE ITEMS

(i) Senior Information Risk Owner (SIRO) Report

The Board received a report from the Director of Finance which provided an overview of the Trust's compliance with the Information Governance and security agenda both nationally and locally. The Trust Secretary referred to the 82% of Freedom of Information requests (FOI) that were set out within the report as meeting the 20 working day standard; she advised that this figure was updated since the report was written and was in fact now over 90%, demonstrating an improvement from the previous year. The Trust Secretary confirmed to the Chair that most Freedom of Information requests were in relation to current affairs or organisations that were attempting to sell products or services to the Trust. There had also been some requests received related to paediatric audiology. She confirmed that there had been no themes identified from the requests received.

The Board was assured that the Information Governance Framework was established and that continual improvements would be made where required.

(ii) Application of the Trust Seal

The Board received a report presented by the Trust Secretary which provided detail of applications of the Trust Seal from 20 January to 22 September 2023.

76/23 REVIEW OF MEETING AND ITEMS TO BE ADDED TO THE BOARD ASSURANCE FRAMEWORK

No items to be added to the BAF.

77/23 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, Andrew Mortimer that the target percentages for flu vaccination uptake for the school aged immunisation programme differed between Warrington and Halton, with the Halton estimated uptake being lower. She clarified that the targets were set by NHS England. The Chief Operating Officer advised that the same approaches were taken across both areas.

DATE AND TIME OF NEXT MEETING

Thursday 7 December 2023, 10am, at Spencer House, Dewhurst Road, Birchwood, Warrington.

MOTION TO EXCLUDE

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

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

ACTION LOG

Key

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

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

Date	Minute Ref	Issue	Action	Director	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**	October 2023: meeting of Chairs & NEDs taking place 18 October 2023 Collaborative Board meeting early November 2023 Update to be provided to the Board following the 18 October meeting. Feedback is included in Key Corporate Messages paper.
03.08.23	57/23iii	Freedom to Speak Up (FTSU) Report	**The Board agreed that a set of approaches for taking FTSU forwards throughout the Trust would be taken through the Executive Management Team and the People Committee and would be presented back to the Board. This would be multi-factorial and would include the mandatory training module if this was felt to be appropriate.**	Lynne Carter	**BLUE**	October 2023: Report received.

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
03.08.23	58/23i	Finance Report	**It was proposed that the Board would receive information on the Green Plan. The Director of Finance would progress this with the Deputy Director for Estates. Some previous reports would be shared with the Board with a decision to be made on the information that the Board would like to see.**	Nick Gallagher	**BLUE**	October 2023: was part of Board Time Out session,7 September and a report is included on the agenda
03.08.23	58/23ii	Adaptive Reserve Report	**The Board agreed that an outcome analysis must be undertaken before the Trust committed to investing any further monies. There were important factors to be considered from year one such as assurances around value for money and benefit for patients and it would be important to understand the maturity of the arrangements in place for year two. This would be presented in October.**	Nick Gallagher	**BLUE**	October 2023: report will be considered at the closed Board for discussion and agreement.

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
03.08.23	60/23ii	Update on the North West Anti-Racist Framework	**The Board agreed that it would draw upon the expertise in the organisation to take this work forward in an inclusive way. Non-Executive Directors were invited to take part in a scoping exercise, to be driven by the Executive Management Team, to agree 'what good would look like'. It was agreed that an update on the work and progress would be presented back to the Board. The Director of People would link in with the Trust Secretary and the Chair to agree timescales for this.**	Paula Woods	**BLUE**	October 2023/November: w/c 13 September NW BAME implementation webinars took place and T&F Group to meet to engage NEDs. An update report is tabled for December's Board.

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
05.10.23	70/23	Key Corporate Messages	**A discussion took place concerning feedback from Time to Talk visits to services, visits attended by one Executive and one Non-Executive Director. This included debate on how the feedback was taken forwards and where this was reported to, and how it was followed up. It was agreed that further consideration was required around this important information, including issues that should be able to be addressed at the source by line managers.**	Paula Woods	**GREEN**	December 2023: Staff engagement update provided. The Time to Talk Process has been reviewed by the Executive Management Team. The new approach was referenced in November's Team Brief with communications planned imminently, at that time. The new approach has been launched and is in use. December's Team Brief will confirm this to staff.
05.10.23	71/23iii	Emergency Preparedness, Resilience and Response (EPRR) Annual Report	**MIAA internal audit plan next year to include EPRR process. This will be captured as part of discussions early next year.** **Outstanding areas must have a target date set.**	Jan McCartney/Audit Chair	**GREEN December 2023**	December 2023: Update report 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
05.10.23	72/23i	Finance Report	**The Director of Finance agreed to source information for Warrington and Halton Place, collate and share this with the Board to ensure that it was sighted on the position.**	Nick Gallagher	**GREEN**	December 2023: Update to be provided at the meeting by Director of Finance

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**83/23**		
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	07/12/2023
Agenda Item	83/23		
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 12 October and recommended the following updates:

- Update the DSPT and Risk Management Audits
- Add the annual effectiveness reviews of Anti-Fraud and External Audit
- Add the Quality Review: Patient feedback at service level – Moderate Assurance

The Committee agreed that there have been no updates that would change the risk rating and as such the risk rating remains at target.

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

The Quality & Safety Committee met on 26 October 2023 where the following changes were made.

- Risk 3187 in relation to the waiting times in Community Paediatrics was added

The Committee did not consider that any changes to the risk scorings were required at this time.

2.3 **BAF3 – Managing demand and capacity**

The Quality & Safety Committee met on 26 October 2023 where the following changes were made.

- Risk 3187 in relation to the waiting times in Community Paediatrics was added, and
- An update to the dermatology position

The Committee did not consider that any changes to the risk scorings were required at this time.

2.4 **BAF4 – Financial sustainability**

The Finance & Performance Committee met on 21 September 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 15 November 2023 where the Committee recommended:

a) Reference to the EDI correspondence from the Secretary of State for Health, under emerging risks.

No change was recommended to the risk rating which remains high at 12.

2.6 **BAF6 – Staffing levels**

The Quality & Safety Committee met on 26 October 2023; no changes were recommended.

The People Committee met on 15 November 2023; no changes were recommended.

Neither Committee recommended a change in the current risk rating.

2.7 **BAF7 – Strategy and organisational sustainability**

The Finance & Performance Committee met on 23 November 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 23 November 2023, no changes were recommended to this BAF and the risk rating remains unchanged.

3. RECOMMENDATION

3.1 The Board is asked to approve the changes recommended by the Committees and note that three of the BAF risks (BAF1, BAF4 and BAF7) remain at target.

3.2 The Board is also asked to approve that this version of the Board Assurance Framework is closed down and archived, providing the Board approve the revised BAF further on in the agenda.

Appendix A – Board assurance framework

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 24 November 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 3 (L) = 12, **high** Target risk rating 4(C) x 2 (L) = 8, **medium**

Board Assurance Framework (BAF) December 2023 – 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: October 2023 Audit Committee Last reviewed: October 2023 Risk Ratings reviewed: October 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 2022/23 2023 Well Led report and recommendations accepted	**Prevent Controls** • Trust Board • Governance structure, 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 (2023/24) • Board Assurance Framework Review – (2021/22) • Risk Management Audit – high assurance (2022/23) • DSPT Audit – substantial assurance (2022/23) • Quality Review: Patient Feedback at Service Level – Moderate Assurance – (2023/24)

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

Board Assurance Framework (BAF) December 2023 – 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: October 2023 Quality & Safety Committee Last reviewed: October 2023 Risk Ratings reviewed: October 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** 3187 – Community Paediatrics waiting times	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) • 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

Board Assurance Framework (BAF) December 2023 – 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: October 2023 Quality & Safety Committee last reviewed: October 2023 Risk Ratings reviewed: October 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** 3187 – Community Paediatrics, increased waiting times	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
Gaps in controls and assurance: (and mitigating actions) Dermatology – Action plans in place and position improving District Nursing – demand and capacity			

Board Assurance Framework (BAF) December 2023 – 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: November 2023 Finance & Performance Committee last reviewed: November 2023 Risk Ratings reviewed: November 2023	**Financial sustainability** If the Trust is unable to achieve and maintain financial sustainability. Due to the requirement to achieve a break-even budget against a backdrop of increasing system pressures may result in a deficit for 2023/24 and the potential loss of public and stakeholder confidence. **Risks on register 15 plus** No risks at this level	Financial governance arrangements in place Bi-monthly F&P Committee Break even budget 2022/23 achieved.	**Prevent Controls** • Accountability Framework and Standing Financial Instructions with limits approved by the Board. • Financial plan and budgets signed off by the Board and submitted to NHSI • Process around Capital and Revenue Business Cases • Robust temporary staffing expenditure control and monitoring – MIAA follow up in progress **Detect Controls** • F&P Committee review bi- monthly financial performance • Audit committee receives reports from internal audit and external audit • Exec team and Committees receive Audit Recommendations tracker • HCP/ICS control and reporting • NHSE/I monthly returns • CIP Council **Assurances** Monthly Finance Report including • Financial position / Forecast Position • Cash & Capital • Working Capital • CIP **Internal audit** reports including • Key Financial Systems (2020/21) and high and substantial assurance (2021/22 & 2022/23) • Board review of internal audit plan **External audit** • Audit review findings – Clean Unmodified Audit (2022/23) • Board review of external audit plan and annual accounts

Gaps in controls and assurance: (and mitigating actions)

The Trust 23/24 plan reflects a challenging CIP target. The Trust continues to identify and evaluate additional opportunities to bridge increase the recurrent target. Progress is monitored and reported via the CIP Council.
The Trust 23/24 plan also reflects an agency spend target of £4.2m. All divisions of the Trust are focussed on agency reduction and have been set reduction targets. Progress is monitored by DLT's.

Board Assurance Framework (BAF) December 2023 – 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: September 2023 People Committee Last reviewed: September 2023 Risk Ratings reviewed: September 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 agreed for Agenda for Change staff, no further negotiations being offered
Correspondence from Secretary of State for Health on EDI

Board Assurance Framework (BAF) December 2023 – 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: October 2023 Quality & Safety Committee Last review: October 2023 People Committee: November 2023 Risk Ratings reviewed: November 2023	**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** 3145 – District Nursing, demand and capacity 3064 – Safeguarding, demand and capacity	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)

Gaps in controls and assurance: (and mitigating actions)
District nursing, demand and capacity – safer staffing system to be rolled out in the Trust, currently in pilot phase.

Board Assurance Framework (BAF) December 2023 – 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: November 2023 Executive Team November 2023 F&P Committee Last reviewed: November 2023 Risk Ratings reviewed: November 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 • Senior 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) December 2023 – 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 3 (L) = 12**, high** Target risk rating: 4(C) x 2 (L) = 8, **medium**	**RISK APPETITE:** **SEEK**

Lead Director/ Lead Committee	**Principal risk**	**Rationale for current score**	**Prevent Controls & Assurances**
Director of Finance Last reviewed: November 2023 F&P Committee Last reviewed: November 2023 Risk Ratings reviewed: November 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. CNIO remains vacant Issues with EMIS patient record system	**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) December 2023 – Board FINAL
Appendix 1: BAF Tracker

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

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 or 3 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.

Board Assurance Framework (BAF) December 2023 – Board FINAL

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. +

Likelihood score & descriptor with examples				
Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**

Board Assurance Framework (BAF) December 2023 – Board FINAL

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	

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**84/23**		
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

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

☒ **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living

☒ **People** – to be a highly effective organisation with empowered, highly skilled and competent staff

☒ **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs

☒ **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability

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

☒ **BAF 1**	☐ **BAF 2**	☐ **BAF 3**	☐ **BAF 4**	☐ **BAF 5**	☐ **BAF 6**	☐ **BAF 7**	☐ **BAF 8**
Failure to implement and maintain sound systems of corporate governance	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**84/23**		
Report Title	**KEY CORPORATE MESSAGES**		
Report Author	Jan McCartney, Trust Secretary		
Purpose	To update the Board concerning key matters within the Trust and the NHS as a whole.		

1. NON-EXECUTIVE DIRECTOR UPDATES

1.1 The Trust Chair attended the following meetings:

- National meeting of Chairs of Community Trusts and CICs on 23 October.
- National NHS Confederation Chairs meeting on 30 October.
- NHS Providers North West Regional meeting on 7 November.
- Observed the People Committee on 15 November.

The Trust Chair attended a number of events, namely the Cheshire and Merseyside Prevention Pledge Summit on 26 September, the 'Health Beyond the Hospital' conference run by the NHS Confederation on 27 September, the launch of the Runcorn Family Hub on 25 October, the Round Table session 'Learning from Place-based working in England' which was facilitated by the Good Governance Institute on 8 November and the HSJ Awards in London on 16 November.

The Trust Chair also attended the new Governor induction session on 4 October and on 25 October Karen met with the Chair of Warrington & Halton Teaching Hospitals NHS Trust, Steve McGuirk and the Chair of the Warrington Health & Wellbeing Board, Cllr Paul Warburton to discuss collaboration in the Warrington Place.

On 20 November, The Trust Chair and the Programme Director of Collaboration & Integration met with Chris Carlin, Halton Transformation Manager, Claire Bradbury, Chief Executive of Power in Partnership in Halton, Jerr Comerford from the Princes Trust to explore the potential for the Trust to support care-leavers in Halton through employment/apprenticeship opportunities.

The Trust Chair accompanied the Chief Executive on the Time to Talk session with the Warrington Wheelchair Service and held a 1-1 meeting with the Director of People & OD.

On 22 November, The Trust Chair interviewed for the Audit Chair.

1.2 Non-Executive Director, Linda Chivers attended the following meetings:

- Cheshire and Mersey Audit Chairs Forum
- Monthly Non-Executive Director meetings
- Monthly catch-up meetings with MIAA in Internal Audit provision
- MHLDC Collaborative meetings for Chairs and Non-Executive Directors
- Trust Nomination & Remuneration Committee
- Chaired the Council of Governors meeting, in the absence of the Chair
- Observed the CIP Council
- Meeting with the Chief Executive to review the new BAF1 as part of the Board Assurance Framework refresh
- Meeting with KPMG for an update on External Audit provision

Linda participated in the recruitment of the new Audit Chair through speaking with a number of prospective candidates for an informal discussion, participated in the shortlisting and interviewing process.

As part of the 'buddying' arrangements, Linda met with the Director of People & OD on two occasions and accompanied her to a Time to Talk session with the Adult Safeguarding Team.

1.3 Non-Executive Director, Gail Briers attended the following meetings:

- Transformation Council reporting on 4 October
- Freedom to Speak Up Network meeting on 4 October
- Council of Governors meeting on 18 October

Gail also held meetings with the Chief Nurse to discuss BAF 2 and the Medical Director to discuss BAF 3.

On 22 November Gail joined the focus group for the Audit Chair recruitment process.

1.4 Non-Executive Director, Tina Wilkins attended the Time to Shine meeting held on 9 October and on 11 October attended the C&M Trust Chairs Bi-monthly meeting on behalf of the Chair.

Tina accompanied the Chief Nurse on two Time to Talk sessions, one with the Medicines Management Team on 28 September and one with the Finance Team on 12 October.

1.5 Non-Executive Director, Martyn Taylor attended the new Governors meeting on 4 October, the Safeguarding Trust Assurance Group on 9 October and the Safeguarding Seminar on 23 November.

Martyn also visited the Warrington Neuroscience Service based at Orford Jubilee Hub on 11 October with the Trust Secretary.

On 7 December, Martyn attended the HSJ Awards event in London and participated in the Audit Chair focus group on 22 November.

1.6 Non-Executive Director, Abdul Siddique attended the HSJ Awards event on 15 November in London, as the Trust was shortlisted for the 'Community Provider of the Year' award.

On 22 November, Abdul joined the Medical Director in a Time to Talk session with the Community Equipment Stores Team, based at Europa Point.

1.7 Non-Executive Director, Elaine Inglesby attended the following meetings/events:

- Chair & Non-Executive MHLDC meeting on 18 October. The purpose of the meeting was to ensure all were aware of the collaborative, its aims and objectives, structure, governance arrangements and workstreams. It was agreed that a further meeting would take place within the next 6 months to ensure all are kept up to date with the progress and challenges of the collaborative and that there should be Non-Executive representation on the MHLDC Provider Collaborative Board. An agreement has been reached for 5 Non-Executive Directors to join the Board to represent the broader Non-Executive community. A reminder of the workstreams for the MHLDC Collaborative was provided: Access to Care; Community Urgent Care; Population Health Management; Community Services for CYP; Community Workforce; Mental Health transformation and Virtual Ward.
- Anti Racism Framework meeting on 24 October.
- Chair & Non-Executive National Induction Day on 31 October.
- On 22 November, participated in the focus group for the Non-Executive recruitment.

On 8 November Elaine accompanied the Director of Finance on the Time to Talk with the Wellbeing Nursing Team and on 21 November accompanied the Chief Nurse on the session with the Communications Team.

Elaine held a 1-1 meeting with the Medical Director on 11 October.

1.8 The NExT Director Scheme

The NexT Director Scheme is a development programme created and designed by NHS England to help find and support the next generation of talented people from groups who are currently under-represented on NHS boards into non-executive roles. The Trust is delighted that Amena Patel has been placed with the Trust for a period of 12 months to allow her to gain insight, experience and expose of the role of non-executive director. Amena will be given access to board and committee meetings and benefit from the support of an experience non-executive mentor.

2. EXECUTIVE UPDATES

2.1 The Chief Executive, along with the Medical Director attended the launch of the Runcorn Family Hub on 25 October.

2.2 On 8 November, the Chief Executive attended the NHS Leadership event in London.

2.3 The Chief Executive met with the Chief Executive and the team from St Rocco's Hospice in Warrington on 20 November where an excellent example of the virtual ward was presented and a discussion took place about future opportunities for partnership working.

2.4 On 22 November, the Chief Executive participated in a focus group for the Audit Chair interviews.

2.5 The Chief Executive attended the Safeguarding Conference on 23 November.

2.6 **Executive and Senior Team Engagement**

A monthly programme of 'Time to Talk' sessions has been set up to allow the Executive Team to update staff on Trust news, ask questions about the teams and service and to take an interest in staff health and wellbeing. It also provides an opportunity for staff to share good news stories and to ask any questions of the executive team.

The following Time to Talk sessions have taken place since the last Board meeting:

2.6.1 On 2 November, the Chief Executive met with the Warrington Wheelchair Services team based at Europa Point. The Trust Chair accompanied Colin on this visit.

2.6.2 The Chief Nurse met with the Medicines Management Team on 28 September. On 12 October, the Chief Nurse met with the Finance Team and was accompanied by Non-Executive Director, Tina Wilkins and on 21 November met the Communication Team and was accompanied by Non-Executive Director, Elaine Inglesby.

2.6.3 On 22 November, the Medical Director held a face to face Time to Talk session with the Community Equipment Stores based at Europa Point and was accompanied by Non-Executive Director Abdul Siddique.

2.6.4 The Director of Finance visited the Wellbeing Nursing Team based at The Bridges, Widnes. Non-Executive Director, Elaine Inglesby was also in attendance.

2.6.5 The Director of People & OD held a virtual session with the Paediatric Audiology Team on 26 October and a face to face session with the Adults Safeguarding Team on 16 November. Non-Executive Director, Linda Chivers joined both sessions.

2.6.6 On 18 October, the Chief Operating Officer met with the Halton Safeguarding Children's Team based at Lister Road. Non-Executive Director, Gail Briers also joined the session. The Chief Operating Officer also held a Teams session with the Paediatric Bladder and Bowel Team on 14 November.

2.6.7 The Trust Secretary met with the Warrington Neuroscience Service on 11 October, with Non-Executive Director Martyn Taylor.

2.7 Board Sessions/Events

2.7.1 A Board Time-Out session took place on 9 November. The Board reviewed the new Board Assurance Framework and discussed the 2023/24 CIP and 2024/25 planning. Josie Winter from MIAA was invited to the afternoon session to discuss CQC Preparation.

2.8 Celebrating Success

2.8.1 The Trust were shortlisted finalists in the HSJ Awards category of 'Primary and Community Care Provider of the Year'. The event took place at the Evolution venue in London on Thursday, 16 November with a number of Bridgewater 'Thank You' Staff Award winners in attendance, and although we were not successful in bringing the prize back, those in attendance had a fabulous night of celebration.

2.9 Memorandum of Understanding (MoU) with The University of Central Lancashire (UCLan)

2.9.1 The Trust has entered into an MoU with the University of Central Lancashire to establish a collaborative working relationship. The purpose of the agreement is threefold:

1. To further develop our honorary teaching contribution within the UCLan School of Heath, Social work and Sport, this includes honorary professorships for the Chief Executive Officer and the Medical Director;

2. To promote a research relationship, building on and extending our current research relationship, and;

3. To explore collaboration around Population Health with a focus on reducing health inequalities and promoting health equity.

3. DIRECTORS' FEEDBACK FROM TIME TO TALK SESSIONS

3.1 Monthly feedback from the Time to Talk sessions are collated from the Executive Team. An example of feedback is provided below:

"There was good engagement and discussion around patient safety and how the team were supporting the organisation. The staff were keen to discuss developments across their portfolio."

"The full team attended, they were open and honest. Impressed with the passion and dedication demonstrated. Also impressed with the external funding secured to improve and increase the services to patients. Great feedback from apprentices within the team."

"The team were clearly well integrated and cohesive, both professionally and personally. They were extremely proud of their Service and the care they offer to their patients and each other."

"The team is a cohesive, patient-focused team that has won staff awards in each of the last two years. They are very proud of what they do, enjoy being part of the trust."

These sessions provide an opportunity for staff to raise concerns and for these to be escalated to the appropriate manager. Examples of recent concerns are estates issues relating to hygiene, access and equipment, interpreter service difficulties, and clinical leadership challenges. For all of these and any other issues raised it is crucial that the staff receive feedback and this can be done direct to the teams and via "You said….We did" which

is wider across the Trust. This also enables the executive team to consider priorities and where there are increased risks. This also encourages staff to raise other issues of concern and for the Trust to respond positively and promptly."

4. EXTERNAL PUBLICATIONS AND REPORTS

4.1 NHS Providers – Stat of the Provider Sector

NHS Providers have published their findings in relation to their annual state of the provide sector survey, which shares trust leaders' top concerns around winter, workforce challenges, financial pressures and industrial action.
State of the provider sector 2023 (nhsproviders.org)

4.2 NHS Providers' briefing: Provider Selection Regime (PSR) draft guidance

NHS England and the Department of Health and Social Care have announced that the Provider Selection Regime (PSR) – the new framework for the procurement of health services – will launch on 1 January 2024. The draft statutory guidance sets out the scope of the new procurement regime as well as the various award processes decision-making bodies may use in their procurement of healthcare services. This briefing gives an overview of the statutory guidance's contents and also includes NHS Providers' view of the PSR and the implications of the new regime for trusts. It can be found here.

4.3 The Health Foundation – Addressing the leading risk factors for ill health

A review of government policies tackling smoking, poor diet, physical inactivity and harmful alcohol use in England
Addressing the leading risk factors for ill health | Health Foundation

5. RECOMMENDATIONS

5.1 The Board is asked to note the report.

NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Integrated Quality and Performance Report

Information Team

Reporting Period: September 2023 (Month 6)

Contents

Introduction

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

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

Indicators have been reviewed and refreshed to ensure that they are relevant and are in line with the System Oversight Framework metrics and the new service lines which are delivered.

This month's report describes activity in September 2023.

Within this Report

1. KPI Amendments

A significant number of KPIs have been amended in this report. These were agreed at the Finance and Performance Committee, the Quality and Safety Committee, the People Committee and the Trust Board. Details of the changes can be found in the papers that were presented.

2. Recommendations:

The Board are asked to:

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

Trust Overview

Executive Summary

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

The indicator Proportion of Urgent Community Response referrals reached within two hours, the September figure is subject to change following the refresh submission in November.

The September figure for the indicator Data Quality Maturity index (DQMI) Quarterly published score (2 months in arears), is based on June 2023 data.

Responsive (Operations)

There are 15 green indicators in month 6 and 18 red indicators. There is one new red indicator this month pertaining to the ‘Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment’ indicator.

All operational red indicators are being monitored by the operational teams and plans are in place to improve the performance of these indicators with a particular focus on waiting lists over 18 weeks including Halton and Warrington Community Paediatrics, Warrington Paediatric Speech and Language Therapy and Halton Podiatry.

Trust Overview

Executive Summary

Safe, High-Quality Care (Quality)

There are 21 green indicators and 5 red indicators in month 6. A number of the red indicators only have one data point which is red so they will need to be monitored closely moving forward to see if this is consistent.

People

3 out of the 5 people indicators are red in month 6 with actual sickness reporting as red this month following achievement of the target last month.

Making Good Use of Resources (Finance)

There are a number of amber indicators around the financial position particularly in relation to agency spending which is being managed with tight controls in place. Delivery of the CIP plan is a particular area of focus for the operational teams.

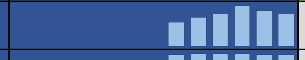
Operations

Trust Scorecard

Operations																
Code	KPI Name	Target	Trend Line	Sep 22	Oct 22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23
OP02	Warrington Dermatology Cancer 2 week referrals (urgent GP)	93%		93.93% (▲)	31.25% (▼)	92.34% (▲)	94.39% (▲)	98.84% (▲)	99.55% (▲)	98.16% (▼)	96.82% (▼)	97.78% (▲)	98.59% (▲)	98.67% (▲)	98.42% (▼)	96.56% (▼)
OP03	Warrington Dermatology Cancer 31 day 2nd treatment comprising surgery	94%		100% (►)	100% (►)	100% (►)	83.33% (▼)	100% (▲)	75% (▼)	100% (▲)	100% (►)	71.43% (▼)	100% (▲)	100% (►)	80% (▼)	100% (▲)
OP04	Warrington Dermatology Cancer 31 day wait from diagnosis to 1st treatment	96%		100% (▲)	80% (▼)	100% (▲)	100% (►)	100% (►)	83.33% (▼)	100% (▲)	100% (►)	100% (►)	92.86% (▼)	100% (▲)	100% (►)	87.5% (▼)
OP05	Warrington Dermatology Cancer 62 day for 1st Treatment (urgent GP Referral)	85%		92.31% (▲)	100% (▲)	100% (►)	100% (►)	93.33% (▼)	87.5% (▼)	75% (▼)	77.27% (▲)	86.67% (▲)	95.83% (▲)	90% (▼)	87.5% (▼)	88.46% (▲)
OP06	28 day faster diagnosis	75%		75.19% (▲)	79.17% (▲)	73.02% (▼)	75.29% (▲)	75.95% (▲)	81.14% (▲)	91.01% (▲)	86.96% (▼)	82.91% (▼)	84.47% (▲)	87.57% (▲)	86.71% (▼)	89.74% (▲)
OP07	A&E: Total time in A&E (% of pts who have waited < 4hrs)	95%		96.48% (▼)	92.66% (▼)	87.43% (▼)	82.48% (▼)	93.72% (▲)	96.01% (▲)	98.1% (▲)	96.8% (▼)	97.53% (▲)	98.42% (▲)	97.2% (▼)	98.53% (▲)	96.84% (▼)
OP08	Total time in A&E 95th Percentile (Mins)	4 Hrs		03:55 (▼)	04:31 (▼)	05:11 (▼)	06:06 (▼)	04:27 (▲)	03:57 (▲)	03:31 (▲)	03:51 (▼)	03:52 (▼)	03:40 (▲)	03:51 (▼)	03:34 (▲)	03:48 (▼)
OP09	Total time in A&E Median (Hour:Mins)	4 Hrs									01:30 (►)	01:30 (▲)	01:20 (▲)	01:32 (▼)	01:26 (▲)	01:27 (▼)
OP10	A&E Time to treatment decision (median) < 60 mins (Mins)	60 Mins		00:09 (▼)	00:10 (▼)	00:12 (▼)	00:14 (▼)	00:10 (▲)	00:08 (▲)	00:08 (▼)	00:09 (▼)	00:09 (▲)	00:08 (▲)	00:09 (▼)	00:07 (▲)	00:09 (▼)
OP11	A&E Time to treatment decision 95th percentile < 60 mins (Mins)	60 Mins									00:25 (►)	00:25 (▼)	00:24 (▲)	00:27 (▼)	00:21 (▲)	00:23 (▼)
OP12	A&E Unplanned re attendance rate < 5%	5%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0.03% (▼)	0% (▲)	0.03% (▼)	0% (▲)	0% (►)
OP13	A&E left without being seen <=5% (left before trx completed)	5%		0.23% (▲)	0.08% (▲)	0.27% (▼)	0.89% (▼)	0.13% (▲)	0.03% (▲)	0.09% (▼)	0.09% (▼)	0.18% (▼)	0.19% (▼)	0.06% (▲)	0.18% (▼)	0.08% (▲)
OP14	Percentage referred onto A+E (UTC)	5%									12.37% (►)	13.02% (▼)	10.66% (▲)	12.17% (▼)	12.13% (▲)	12.33% (▼)
OP15	Data Quality Maturity Index (DQMI) (monthly internal reporting)	95%		95.36% (▼)	99.83% (▲)	99.83% (►)	99.82% (▼)	99.71% (▼)	99.71% (►)	99.73% (▲)	99.73% (►)	99.7% (▼)	99.7% (►)	99.72% (▲)	84.52% (▼)	84.15% (▼)
OP16	Data Quality Maturity index (DQMI) Quarterly published score (2 months in arrears)	95%		83.8% (▼)	85% (▲)	86.7% (▲)	56.4% (▼)	88.8% (▲)	88.7% (▼)	88.6% (▼)	89.4% (▲)	88.7% (▼)	88.8% (▲)	90.3% (▲)	90.8% (▲)	89.8% (▼)

Operations

Trust Scorecard

Operations															
Code	KPI Name	Target	Trend Line	Sep 22	Oct 22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23
OP32	Percentage of DNAs/Was not brought Childrens	3%		4.66% (▲)	4.09% (▲)	4.78% (▼)	5.46% (▼)	3.66% (▲)	4.99% (▼)	4.92% (▲)	5.3% (▼)	5.2% (▲)	5.33% (▼)	4.67% (▲)	6.31% (▼)	4.49% (▲)
OP33	Percentage of DNAs/Was not brought Warrington Adults	3%		3.86% (▼)	3.65% (▲)	3.47% (▲)	3.71% (▼)	3.62% (▲)	3.02% (▲)	3.31% (▼)	3.55% (▼)	3.35% (▲)	3.45% (▼)	3.39% (▲)	3.39% (▲)	3.15% (▲)
OP34	Percentage of DNAs/Was not brought Halton Adults	3%		1.1% (▲)	1.31% (▼)	0.93% (▲)	1.89% (▼)	1.9% (▼)	1.04% (▲)	0.98% (▲)	0.61% (▲)	0.72% (▼)	0.55% (▲)	0.73% (▼)	0.8% (▼)	1.01% (▼)
OP35	Proportion of Urgent Community Response referrals reached within two hours	70%			97.62% (►)	97.14% (▼)	95.88% (▼)	94.92% (▼)	96.62% (▲)	88.81% (▼)	97.52% (▲)	91.07% (▼)	91.18% (▲)	97.3% (▲)	87.2% (▼)	70.7% (▼)
OP36	Audiology Number of 6 weeks diagnostic breaches	0		3 (▼)	2 (▲)	4 (▼)	4 (►)	1 (▲)	5 (▼)	9 (▼)	67 (▼)	85 (▼)	77 (▲)	73 (▲)	87 (▼)	62 (▲)
OP38	Referrals to plan - Childrens	95%		124.7% (▲)	124.63% (▲)	123.75% (▲)	121.82% (▲)	122.9% (▼)	122.8% (▲)	122.93% (▼)	101.89% (▲)	114.87% (▼)	122.78% (▼)	122.55% (▲)	118.08% (▲)	118.23% (▼)
OP39	Referrals to plan - Warrington Adults	95%		80.25% (▼)	81.17% (▲)	81.58% (▲)	81.04% (▼)	81% (▼)	80.77% (▼)	80.45% (▼)	75.88% (▼)	78.75% (▲)	81.64% (▲)	81.27% (▼)	81.08% (▼)	80.48% (▼)
OP40	Referrals to plan - Halton Adults	95%		104.35% (▲)	103.4% (▲)	102.13% (▲)	101.09% (▲)	100.83% (▲)	100.37% (▲)	99.42% (▼)	100.32% (▲)	98.84% (▼)	118.82% (▼)	116.52% (▲)	117.37% (▼)	116.17% (▲)
OP41	% of patients waiting under 18 weeks RTT Non-Admitted (Incomplete pathway)	92%		43.21% (▼)	39.74% (▼)	35.29% (▼)	34.75% (▼)	39.76% (▲)	41.49% (▲)	57.99% (▲)	58.67% (▲)	67.55% (▲)	69.21% (▲)	65.29% (▼)	67.59% (▲)	65.39% (▼)
OP42	% of waiters over 52 weeks consultant Led	0%		0.26% (▲)	0.32% (▼)	0.29% (▲)	0.28% (▲)	0.11% (▲)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	0.17% (▼)	0.03% (▲)	0.12% (▼)
OP43	% of waiters over 78 weeks consultant Led	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
OP44	% of waiters over 104 weeks consultant Led	0%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	0% (►)
OP45	All waiters % waiting over 52 weeks (also include Dental)	0%									0.57% (►)	0.69% (▼)	0.77% (▼)	0.96% (▼)	0.84% (▲)	0.78% (▲)
OP46	All waiters % waiting under 18 weeks(also include Dental)	92%									69.49% (►)	71.53% (▼)	70.92% (▲)	70.79% (▲)	69.47% (▲)	69.23% (▲)
OP48	Warrington Adults Activity Variance	3%		19.75% (▼)	18.83% (▲)	18.42% (▲)	18.96% (▼)	19% (▼)	19.23% (▼)	19.55% (▼)	24.12% (▼)	21.25% (▲)	18.36% (▲)	18.73% (▼)	18.92% (▼)	19.52% (▼)
OP49	Warrington Childrens Activity Variance	3%		5.06% (▼)	7.56% (▼)	7.73% (▼)	5.81% (▲)	7.19% (▼)	7.98% (▼)	9.44% (▼)	2.7% (▲)	16.42% (▼)	25.87% (▼)	24.54% (▲)	18.44% (▲)	18.99% (▼)
OP50	Halton Adults Activity Variance	3%		4.35% (▲)	3.4% (▲)	2.13% (▲)	1.09% (▲)	0.83% (▲)	0.37% (▲)	-0.58% (▲)	0.32% (▼)	-1.16% (▲)	18.82% (▼)	16.52% (▲)	17.37% (▼)	16.17% (▲)
OP51	Halton Childrens Activity Variance	3%		79.13% (▲)	69.49% (▲)	64.61% (▲)	63.76% (▲)	64.36% (▼)	62.26% (▲)	58.95% (▲)	0.12% (▲)	11.09% (▼)	15.07% (▼)	17.36% (▼)	17.12% (▲)	16.11% (▲)

Operations

Trust Scorecard

Operations																	
Code	KPI Name	Target	Trend Line	Sep 22	Oct 22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23
OP52	Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above - Halton					27 (▼)			23 (▼)			66 (▲)			60 (▼)	
OP53	Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Halton	95%				74.64% (▲)			91.64% (▲)			87.55% (▼)			84.72% (▼)	
OP54	Percentage of children who received a 6 8 week review by the time they were 8 weeks Halton	90%				79.87% (▲)			85.38% (▲)			91.21% (▲)			89.04% (▼)	
OP55	Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months Halton	85%				66.93% (▲)			89.11% (▲)			89.14% (▲)			82.93% (▼)	
OP56	Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months Halton	85%				86.46% (▲)			90% (▲)			92.81% (▲)			92.68% (▼)	
OP57	Percentage of children who received a 2 2½ year review, by the age of 2½ years Halton	90%				81.1% (▲)			69.55% (▼)			70.59% (▲)			71.26% (▲)	
OP58	Percentage of children who received a 2 2½ year review in the quarter, using ASQ 3 Halton	90%				94.94% (▼)			93.25% (▼)			90.55% (▼)			86.53% (▼)	
OP59	Number of mothers who received a first face to face antenatal contact with a health visitor at 28 weeks or above Warrington					53 (▼)			177 (▲)			267 (▲)			265 (▼)	
OP60	Percentage of births that receive a face to face NBV within 14 days by a Health Visitor - Warrington	95%				89.84% (▲)			93.13% (▲)			90.05% (▼)			94.27% (▲)	
OP61	Percentage of children who received a 6 8 week review by the time they were 8 weeks Warrington	90%				97.51% (▲)			96.11% (▼)			95.75% (▼)			95.67% (▼)	
OP62	Percentage of children who turned 12 months in the quarter, who received a 12 month review, by the age of 12 months Warrington	85%				90.34% (▼)			94.36% (▲)			94.63% (▲)			95.03% (▲)	
OP63	Percentage of children who turned 15 months in the quarter, who received a 12 month review, by the age of 15 months Warrington	85%				95.77% (▲)			95.61% (▼)			98.38% (▲)			98.11% (▼)	
OP64	Percentage of children who received a 2 2½ year review, by the age of 2½ years Warrington	90%				93.62% (▲)			93.46% (▼)			94.46% (▲)			93.9% (▼)	
OP65	Percentage of children who received a 2 2½ year review in the quarter, using ASQ 3 Warrington	90%				99.26% (▲)			99.63% (▲)			98.62% (▼)			98.21% (▼)	

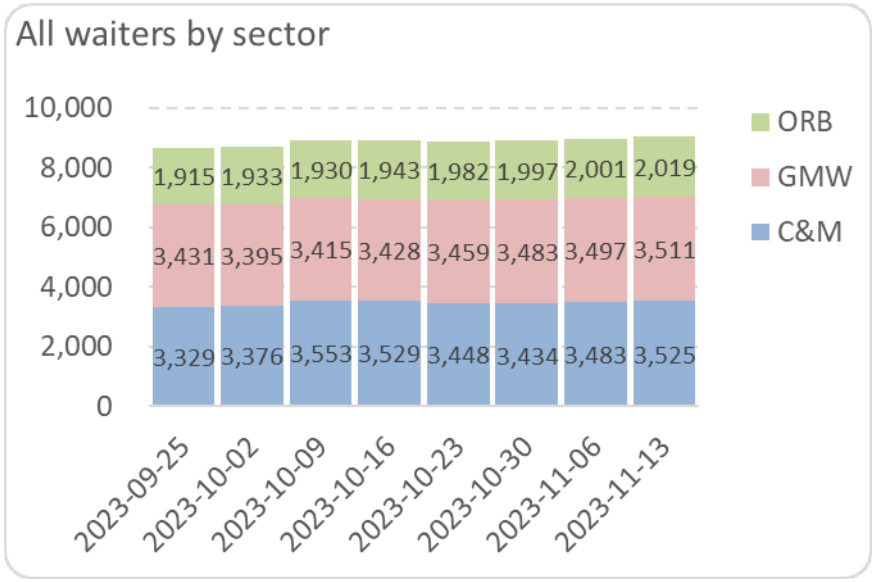
Operations: Exception Reporting

Flagged Indicators

OP06	28 day faster diagnosis		Points above upper control limit
OP15	Data Quality Maturity Index (DQMI) MHSDS quarterly score (monthly internal reporting)		Points below lower control limit
OP36	Audiology - Number of 6 weeks diagnostic breaches		Points above upper control limit
OP48	Warrington Adults Activity Variance		Points above upper control limit
OP49	Warrington Childrens Activity Variance		Points above upper control limit
OP50	Halton Adults Activity Variance		Points above upper control limit

Operations: Exception Reporting

Chart



Issue

Dental - Patients waiting by Sector

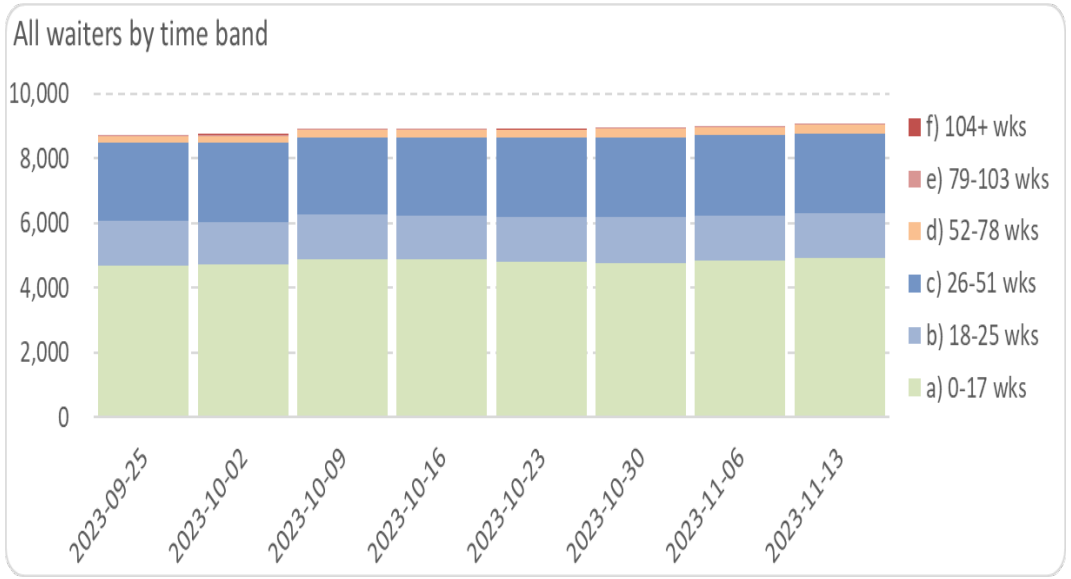
The number of patients waiting for dental treatment has increased in all sectors but most significantly in Cheshire and Merseyside.

The increase in the number of waiters in Cheshire and Merseyside is due to an increase in the referrals for oral surgery.

Four task and finish groups are undertaking actions to support the waiting list pressures and to ensure that appropriate referrals are received into the service. Clinicians and Operational Managers are working together to implement a number of actions as a result of this work which we hope to see an impact on the waiting list.

Operations: Exception Reporting

Chart



Issue

Dental – Waiters by time band

There are now no patients waiting over 104 weeks to be seen. There are 5 patients waiting from 78 to 104 weeks and 271 patients waiting to be seen from 52 to 78 weeks. The service plan to clear all over 65 week waits by 1st April 2024 and are prioritising appointments so that these patients can be seen.

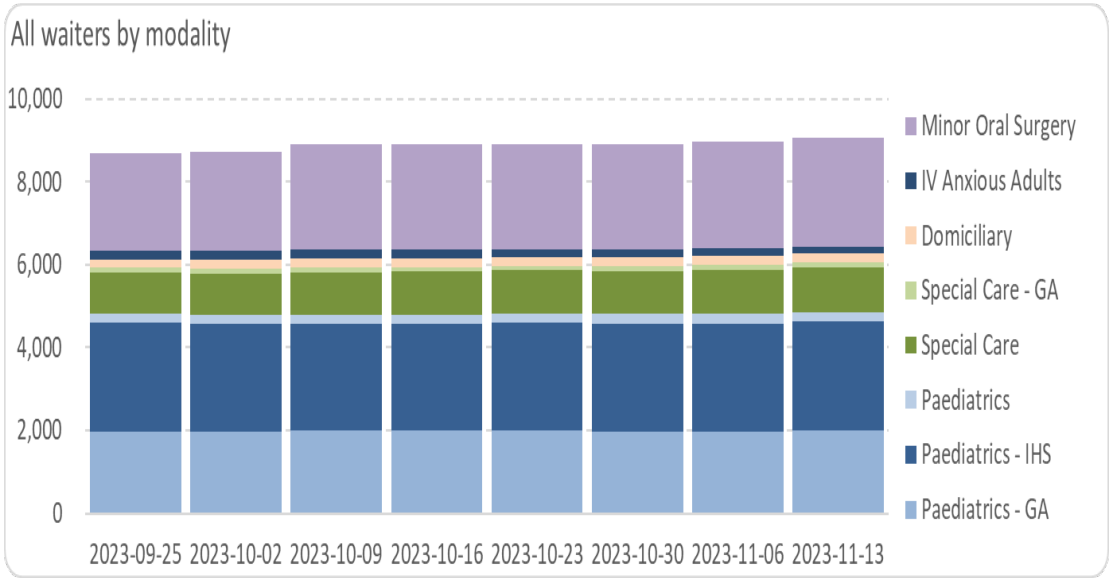
Operations: Exception Reporting

Dental – Waiters by time band

	Waiters by time band					
	Metric					
	a) 0-17 wks	b) 18-25 wks	c) 26-51 wks	d) 52-78 wks	e) 79-103 wks	f) 104+ wks
2023-09-25	4,675	1,389	2,403	204	4	0
2023-10-02	4,728	1,315	2,435	221	4	1
2023-10-09	4,886	1,373	2,394	240	5	0
2023-10-16	4,895	1,339	2,423	238	5	0
2023-10-23	4,816	1,381	2,432	254	5	1
2023-10-30	4,766	1,426	2,464	252	6	0
2023-11-06	4,851	1,373	2,500	251	6	0
2023-11-13	4,913	1,384	2,482	271	5	0

Operations: Exception Reporting

Chart



Issue

Dental - Patients waiting by treatment

The number of patients on the majority of treatment bands has remained fairly static except for minor oral surgery which has seen over a 10% increase in waiters and special care has also seen an increase in the number of patients waiting.

The increase in referrals for minor oral surgery is being discussed with Commissioners and the impact of the lack of access to General Dental Practitioners is being considered.

Quality

Executive Summary

There are 5 Quality indicators reporting as red and 21 green indicators in September 2023.

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

- % of incidents causing harm (levels 3-5) – Increase in Month
- % of medication incidents that caused harm – New in Month
- Percentage of risks identified as 12 or above – Improvement in Month
- % of falls identified as serious – New in Month
- Falls per 1,000 bed days - bed based – New in Month

Quality: Exception Reporting

Trust Scorecard

Quality															
Code	KPI Name	Target	Trend Line	Sep 22	Oct 22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23
QU01	Number of Never Events	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU05	% of incidents causing harm (levels 3-5)	2%		28.61% (▲)	24.03% (▲)	24.33% (▼)	22.53% (▲)	20.57% (▲)	26.05% (▼)	29.89% (▼)	18.58% (▲)	24.54% (▼)	23.04% (▲)	27.2% (▼)	19.89% (▲)	24.68% (▼)
QU09	% - Compliance with reporting time frames for StEIS within 48 hours	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU10	RCA investigations compliance submitted to ICB within 60 day time frame	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU11	DOC (Duty of Candour) - 10 day compliance (part 1)	100%		100% (▲)	100% (►)	75% (▼)	75% (►)	100% (▲)	100% (►)	100% (►)	100% (►)	50% (▼)	100% (▲)	85.71% (▼)	100% (▲)	100% (►)
QU14	% of incidents that are medication incidents	10%		11.9% (▼)	11.37% (▲)	9.25% (▲)	12.09% (▼)	8.61% (▲)	8.68% (▼)	11.21% (▼)	12.68% (▼)	8.62% (▲)	7.09% (▲)	13.5% (▼)	9.6% (▲)	7.64% (▲)
QU16	% of medication incidents that caused harm	2%		0% (►)	4.55% (▼)	2.63% (►)	0% (►)	2.78% (▼)	3.45% (▼)	2.56% (►)	2.33% (►)	6.06% (▼)	0% (►)	6.12% (▼)	0% (►)	9.09% (▼)
QU18	Information Governance Training	95%		92.67% (▼)	92.37% (▼)	91.21% (▼)	91.47% (▲)	90.79% (▼)	88.59% (▼)	89.31% (▲)	88.86% (▼)	90.23% (▲)	91.83% (▲)	97.22% (▲)	97.26% (▲)	96.89% (▼)
QU19	Safeguarding Childrens Level 1	90%		90.85% (▲)	92.04% (▲)	92.55% (▲)	92.32% (▼)	92.68% (▲)	93.76% (▲)	93.99% (▲)	92.69% (▼)	93.89% (▲)	96.13% (▲)	98.46% (▲)	98.65% (▲)	98.49% (▼)
QU20	Safeguarding Childrens Level 2	90%		85.3% (▼)	85.96% (▲)	84.87% (▼)	85.94% (▲)	87.15% (▲)	89.61% (▲)	91.23% (▲)	89.97% (▼)	91.8% (▲)	94.24% (▲)	97.4% (▲)	98.58% (▲)	98.47% (▼)
QU21	Safeguarding Childrens Level 3	90%		82.84% (▼)	83.44% (▲)	83.77% (▲)	89.37% (▲)	86.44% (▼)	89.19% (▲)	93.13% (▲)	93.84% (▲)	94.6% (▲)	97.17% (▲)	98.18% (▲)	96.54% (▼)	96.21% (▼)
QU22	Safeguarding Adults Level 1	90%		89.72% (▼)	92.45% (▲)	92.9% (▲)	92.87% (▼)	93.49% (▲)	94.43% (▲)	94.79% (▲)	93.57% (▼)	94.82% (▲)	96.32% (▲)	98.39% (▲)	98.97% (▲)	98.56% (▼)
QU23	Safeguarding Adults Level 2	90%		71.19% (▼)	76.22% (▲)	77.18% (▲)	80.67% (▲)	83.45% (▲)	86.47% (▲)	88.86% (▲)	88.79% (▼)	90.83% (▲)	92.41% (▲)	97.07% (▲)	97.95% (▲)	98.17% (▲)
QU24	Safeguarding Adults Level 3	90%		67.24% (▲)	69.36% (▲)	69.21% (▼)	77.16% (▲)	76.26% (▼)	78.45% (▲)	76.09% (▼)	79.72% (▲)	83.6% (▲)	84.43% (▲)	92.01% (▲)	93.03% (▲)	92.94% (▼)

Quality: Exception Reporting

Trust Scorecard

Quality																
Code	KPI Name	Target	Trend Line	Sep 22	Oct 22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23
QU32	% of risks managed in line with policy	100%		84.15% (▲)	90.34% (▲)	87.07% (▼)	92.05% (▲)	98.73% (▲)	93.94% (▼)	84.21% (▼)	89.02% (▲)	73.48% (▼)	94.38% (▲)	88.21% (▼)	85.48% (▼)	88.2% (▲)
QU33	Percentage of risks identified as 12 or above	10%		12.8% (▲)	11.72% (▲)	17.01% (▼)	16.56% (▲)	12.1% (▲)	11.52% (▲)	12.87% (▼)	16.18% (▼)	14.36% (▲)	13.48% (▲)	15.38% (▼)	10.75% (▲)	10.67% (▲)
QU36	% of falls identified as serious	5%		0% (►)	0% (►)	0% (►)	0% (►)	0% (►)	4% (▼)	4.76% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)	6.25% (▼)
QU37	Falls per 1,000 bed days - bed based	14		10.13 (▼)	14.61 (▼)	11.72 (▲)	11.39 (▲)	8.65 (▲)	11.63 (▼)	6.7 (▲)	12.66 (▼)	5.71 (▲)	5.85 (▼)	9.71 (▼)	10.51 (▼)	15.15 (▼)
QU41	Total number of pressure ulcers	27		33 (▲)	18 (▲)	29 (▼)	25 (▲)	33 (▼)	31 (▲)	36 (▼)	15 (▲)	27 (▼)	15 (▲)	19 (▼)	11 (▲)	21 (▼)
QU46	% of Category 4 Pressure Ulcers acquired in Bridgewater	20%		6.06% (▼)	0% (▲)	0% (►)	0% (►)	3.03% (▼)	6.45% (▼)	0% (▲)	6.67% (▼)	0% (▲)	0% (►)	0% (►)	0% (►)	0% (►)
QU47	% of Cat 3 & Unstageable Pressure Ulcers acquired in Bridgewater	20%		15.15% (▼)	11.11% (▲)	17.24% (▼)	20% (▼)	21.21% (▼)	16.13% (▲)	25% (▼)	6.67% (▲)	0% (▲)	13.33% (▼)	26.32% (▼)	9.09% (▲)	0% (▲)
QU48	MRSA - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU49	C.Diff - Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU50	E Coli- Total Number of outbreaks (Community)	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU51	Bacteraemia - Total Number of outbreaks	0		0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)	0 (►)
QU55	Complaints that are managed within the policy timelines	100%									100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU60	National Patient Safety Alerts opened and managed in line with policy timescales	100%		100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)	100% (►)
QU70	Overall CQC rating (Yearly)	Good					Requires mprovement (►)									
QU72	Flu vaccinations for frontline healthcare workers (CQUIN01)	80%							59.89% (►)			61.3% (▲)				
QU73	Malnutrition screening for Community Hospital Inpatients (CQUIN14)	90%				100% (►)			100% (►)			100% (►)			100% (►)	
QU74	Assessment, diagnosis and treatment of lower leg wounds (CQUIN13)	50%				39.6% (▲)			41.18% (▲)			66.67% (▲)			64.71% (▼)	
QU75	Assessment and documentation of pressure ulcer risk (Community Hospital Inpatients) (CQUIN12)	85%				100% (►)			98.59% (▼)			100% (▲)			100% (►)	

Quality: Exception Reporting

Flagged Indicators

QU16	% of medication incidents that caused harm		Points above upper control limit
QU18	Information Governance		Points above upper control limit
QU19	Safeguarding Childrens Level 1		Points above upper control limit
QU20	Safeguarding Childrens Level 2		Points above upper control limit
QU21	Safeguarding Childrens Level 3		Points above upper control limit
QU22	Safeguarding Adults Level 1		Points above upper control limit
QU23	Safeguarding Adults Level 2		Point above upper control limit
QU24	Safeguarding Adults Level 3		Point above upper control limit

People

Executive Summary

Three out of five People indicators are shown as red in September 2023.

The three indicators which were red in September are as follows:

- Staff turnover (rolling) – Improvement in Month
- Percentage Overall organisation sickness rate (rolling) – Improvement in Month
- Sickness absence rate (Actual) – New in Month

People

Trust Scorecard

People																
Code	KPI Name	Target	Trend Line	Sep 22	Oct 22	Nov-22	Dec-22	Jan 23	Feb 23	Mar 23	Apr-23	May-23	Jun-23	Jul 23	Aug-23	Sep 23
PO01	% Headcount of new starters attending induction programme	95.00%		99.4% (▲)	99.47% (▲)	99.34% (▼)	99.74% (▲)	99.6% (▼)	99.8% (▲)	99.61% (▼)	99.36% (▼)	99.29% (▼)	99.36% (▲)	98.94% (▼)	99.68% (▲)	99.29% (▼)
PO02	Staff turnover (rolling)	12.00%		33.57% (▲)	28.67% (▲)	28.47% (▲)	28.54% (▼)	27.91% (▲)	27.61% (▲)	13.25% (▲)	12.69% (▲)	14.69% (▼)	12.04% (▲)	12.22% (▼)	12.3% (▼)	12.04% (▲)
PO03	% Overall Organisation Sickness rate (rolling)	5.50%		6.96% (▲)	6.88% (▲)	6.81% (▲)	6.75% (▲)	6.52% (▲)	6.41% (▲)	6.3% (▲)	6.07% (▲)	5.9% (▲)	5.89% (▲)	5.65% (▲)	5.66% (▼)	5.56% (▲)
PO04	Sickness absence rate (Actual)	5.50%		5.77% (▼)	5.81% (▼)	6.1% (▼)	7.11% (▼)	6.19% (▲)	5.26% (▲)	5.5% (▼)	5.16% (▲)	5.06% (▲)	5.24% (▼)	5.38% (▼)	5.45% (▼)	5.57% (▼)
PO05	% of staff with a current PDR	85.00%		67.42% (▲)	63.71% (▼)	67.44% (▲)	66.09% (▼)	70.13% (▲)	72.57% (▲)	70.56% (▼)	71.62% (▲)	72.85% (▲)	77.23% (▲)	91% (▲)	89.99% (▼)	87.59% (▼)

People: Exception Reporting

Flagged Indicators

PO02	Staff turnover (rolling)		Point below lower control limit
PO03	% Overall Organisation Sickness rate (rolling)		Point below lower control limit
PO05	% of staff with a current PDR		Points above upper control limit

Finance

Month Five 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 September 2023 (Month 06). The Trust was given the opportunity to revise the 2023/24 Plan during month 5, recognising the additional income and expenditure associated with the pay award. Some other minor changes were also made to adjust the plan, reflecting the year to date performance and amending the plan profiles accordingly. No change has been made to the overall breakeven planned position. All references in this report will be to the updated plan.

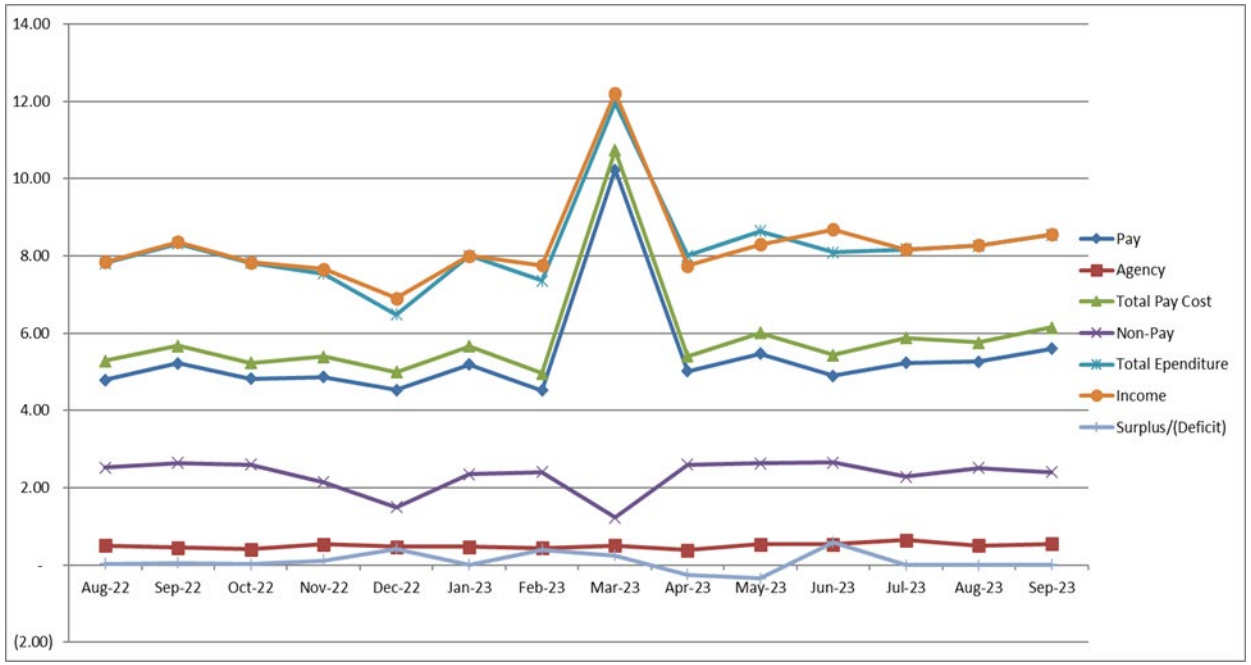
Summary Performance Month 06 2023-24	Month 6 Plan (£M)	Month 6 Actual (£M)	Month 6 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.12)	(8.55)	0.44	(49.28)	(49.72)	0.44	(97.94)	(98.63)
Expenditure - Pay	5.46	5.60	(0.13)	31.38	31.48	(0.10)	64.15	64.15
Expenditure - Agency	0.24	0.55	(0.31)	2.80	3.16	(0.36)	4.22	4.22
Expenditure - Non Pay	2.39	2.41	(0.01)	14.95	15.04	(0.09)	29.26	30.05
EBITDA	(0.03)	(0.00)	(0.03)	(0.16)	(0.05)	(0.11)	(0.31)	(0.21)
Financing	0.03	(0.01)	0.03	0.16	0.04	0.12	(0.31)	(0.21)
Normalised (Surplus)/Deficit	(0.00)	(0.01)	0.00	(0.00)	(0.01)	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)	(0.01)	0.00	(0.00)	(0.01)	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)	(0.01)	0.00	(0.00)	(0.01)	0.00	(0.00)	(0.00)
CIP	0.43	0.46	0.03	2.57	2.45	(0.12)	5.15	5.15
Capital	0.47	0.06	0.41	0.75	0.35	0.40	2.10	2.10
Cash	26.56	18.72	(7.84)	26.56	18.72	(7.84)	24.66	22.36
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 six are as follows:

- The Trust is reporting a breakeven position, in line with the 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 £2.45m against a plan of £2.57m.
- Income is £49.72m for the year-to-date against a plan of £49.28m.
- Expenditure is £49.72m against a plan of £49.28m.
- Pay is £31.48m against a plan of £31.38m.

Finance

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

- Agency spend £3.16m against a plan of £2.80m.
- Non pay expenditure is £15.04m against a plan of £14.95m.
- Capital charges are £0.12m below plan.
- Capital expenditure is £0.35m at month six, planned spend is £0.75m.
- Cash is £18.72m.

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: 20/10/2023

NHS Oversight Framework - Organisation Detail

Org Type	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
MHPRV	BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST (RY2)	MH Provider	S000a: NHSOF Segmentation	Month	2023 08	2: Flexible support					29/69
		MH Provider	S035a: Overall CQC rating	Month	2023 08	Requires Improvement					61/69
		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 08	Requires Improvement					53/69
		MH Provider	S063a: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from a) managers	Annual, calendar year	2022	7.28%	11.1%		↑		23/71
		MH Provider	S063b: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from b) other colleague	Annual, calendar year	2022	13.4%	20%		↓		26/71
		MH Provider	S063c: Staff survey bullying and harassment score - Proportion of staff who say they have personally experienced harassment, bullying or abuse at work from c) patients / service users, their relatives or other	Annual, calendar year	2022	22.8%	27.8%		↑		18/71
		MH Provider	S067a: Leaver rate	Month	2023 06	6.72%	8.07%		↑		7/71
		MH Provider	S068a: Sickness absence rate	Month	2023 04	5.27%	4.57%		↓		53/71
		MH Provider	S069a: Staff survey engagement theme score	Annual, calendar year	2022	7.16/10	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%	↑	↑	25/69
		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
		MH Provider	S133a: Staff survey - compassionate and inclusive theme score.	Annual, calendar year	2022	7.65/10	7.23/10		↑		22/71
		MH Provider	S134a: Relative likelihood of white applicants being appointed from shortlisting across all posts compared to BME applicants (WRES).	Annual, calendar year	2023	1.4		1	↑		29/69
		MH Provider	S135a: Relative likelihood of non-disabled applicants being appointed from shortlisting compared to disabled applicants (WDES)	Annual, calendar year	2023	1		1	↑		39/69

Rank Banding

- Highest performing quartile
- Interquartile range
- Lowest performing quartile

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Thank You


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Committee Chair's Report

Bridgewater Community Healthcare NHS Foundation Trust

Name of Committee/Group:	Quality and Safety Committee		**Report to:**	Board of Directors
Date of Meeting:	Thursday 26 October 2023		Date of next meeting:	28 February 2024
Chair:	Gail Briers, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Gail Briers, Non-Executive Director and Committee Chair Martyn Taylor, Non-Executive Director Abdul Siddique, Non-Executive Director Lynne Carter, Chief Nurse Sarah Brennan, Chief Operating Officer Ted Adams, Medical Director	**In attendance:** Jeanette Hogan, Deputy Chief Nurse Mark Charman, Assistant Director of Transformation Tania Strong, Head of Human Resources Kathryn Royden, Operational Manager, Children's Specialist Services (for Parent Feedback on Paediatric Services item) Jan McCartney, Trust Secretary Lynda Richardson, Board and Committee Administrator **Observers**: Christine Stankus, Public Governor, Rest of England Claire Barton, Staff Governor	**Key Members not present**:	**Apologies received from:** Susan Burton, Deputy Chief Nurse Elaine Inglesby, Non-Executive Director

Key Agenda Items:	**BAF**	**RAG**	**Key Points/Assurance Given:**	**Action/decision:**
Urgent items: Community Paediatrics Risk Rating	2, 3		A verbal update was provided by the Chief Operating Officer concerning two risks scoring 15 on the risk register related to demand and capacity in the Halton service and the shortage of ADHD medications and its impact. Demand and Capacity: The service had a current waiting list with 765 children with a wait time of 62 weeks. There was an improvement board I place in Halton to help to manage some of the pressures. The Committee noted that there had been a five-fold increase in referrals into the Halton service which was becoming increasingly challenging, with an increasing number of complaints being received. There was an action plan in place which was being monitored including actions around how the waiting list could be reduced. There was some locum capacity within the Warrington	The Committee received the report and it was agreed that a further update paper would be provided. Further discussion would take place at the pre-meet as to the requirements. The report however must ensure full detail on the risks and the potential impacts, including whether the risks were being managed effectively and the progress being made to reduce the

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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

			Service which had helped to support a reduction in that service. One of those locums had been transferred to the Halton service to help to support the current challenges. ADHD Medications: The Committee acknowledged that this was a current national issue. One clinic per week had been cancelled in Warrington and one clinic per fortnight in Halton to manage the increase in prescribing. It was noted that the shared care arrangements around prescribing were not in place within Warrington and Halton as they were within most areas. This had caused significant challenges and the Trust was continuing to work with the ICB to attempt to implement those arrangements. The Trust was now unable to initiate any children onto ADHD medication, with those who had commenced with medication being moved onto other medications due to the lack of availability. The Medicines Management Team were continuing to provide close support, providing information and sessions with parents and carers to look at how issues could be managed.	scoring, whether the harms reviews and mitigations in place were sufficient and if not what other/further actions would be put into place. It was acknowledged that there was also a Finance and Performance Committee element to be recognised in relation to insufficient funding for the level of demand and the prescribing of expensive medications.
District Nursing Improvement Plan	2, 3		The Committee received a report which highlighted the issues within the District Nursing Service in both Halton and Warrington; related to the increased demand post pandemic, as well as increased complexity of patients with a background of reduced capacity in relation to national and local recruitment and retention issues. There had been significant risks within the service that had emerged following a quality summit that took place in April 2023 with an improvement plan developed to address the three key areas where it was considered that significant improvements could be achieved to improve quality, support for staff and safety for patients. There were no items to be escalated to the Committee at this time or any items by exception that would be reported as an area of concern. Work to address the actions within the plan were progressing well, with improvements in relation to recruitment, with a new band six post advertised and recruitment to band three and four level posts and support for newly qualified recruits, with work to secure support from community matrons and other teams to deliver a full service.	The Committee received the report and noted the progress that had been made on the improvement plan and despite work still progressing, there was a good level of confidence in its full delivery.

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Committee Chair's Report

Serious Incidents Compliance Report	2, 3		From 1 August to 30 September 2023, there had been five serious incidents recorded with pressure ulcers remaining as the most commonly reported type of serious incident, with a reduction in incidents being reported over the time period. The position was being closely monitored and work was ongoing to ensure that actions identified in serious incident investigations were completed within agreed time scales, and that assurance was being provided to the ICB concerning the actions taken to prevent further incidents. In addition, the Trust's Patient Safety Incident Response Plan and Patient Safety Incident Response Policy had been approved by the ICB, which would enable the Trust to proceed with the implementation of the Patient Safety Incident Response Framework (PSIRF). The 'go live' date for PSIRF was currently 1 November 2023. Work to enable the Trust Risk Management System (Ulysses), to interface with the Learning from Patient Safety Events (LFPSE) Service had been completed and the Trust was now submitting patient safety incidents to the LFPSE portal. Live reporting of incidents had begun on 4 October 2023, in line with the time scales required by NHS England. The system was now embedding, and amendments would be made when issues were identified as it was anticipated that there would be a period when amendments would be required for systems and processes regarding incident reporting. It was highlighted that detail was required around two non-pressure ulcer incidents – the next report to the Committee would ensure detail of all reported serious incidents. The Committee noted that there would be changes to future reporting from the New Year with the implementation of new systems.	The Committee was assured that the systems and processes in place were effectively managing serious incidents reported within the Trust. It acknowledged the progress in relation to PSIRF and LFPSE. It was agreed that the next report would set out a proposal/outline for the reporting of incidents following the implementation of PSIRF for approval to ensure that this would meet the Committee's requirements.

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Committee Chair's Report

Summary Report for Risks Relating to Quality and Safety	2, 3		It was reported that there were 10 risks with a scoring of 12 and above with timely review dates in place. During August, there had been five risks that had passed their review dates, however by September there were no risks that were out of date. There were three risks that were scoring 15 and above: a number of those had been discussed by the Committee in relation to the impact of reduced staffing in Warrington District Nursing Service, the impact of decreased capacity for the Warrington Multi-Agency Safeguarding Hub (MASH) to meet demand and capacity challenges within Community Paediatric Services. However the risk concerning MASH was related to some elements that were outside of the control of the Trust. There had been some risks de-escalated to a scoring below 12 related to demand and capacity and diagnostics, clinical diagnostics and clinical assessments. A copy of the corporate risk register had not been included within the report following the discussion at the previous meeting.	Following a discussion, the Committee received the report for assurance with the caveat that going forwards, there would be a new format report for quality and safety risks which would enable the Committee to be able to scrutinise and receive assurance that the individual risks were being effectively managed. It was acknowledged that the Committee should not be receiving assurance that the risk registers and risk management process was being effectively managed as this would be a function of the Audit Committee.
IQPR	2, 3, 6		Two red rated indicators were noted in relation to the percentage of incidents reported and further work had been undertaken in the new IQPR report around this target and making the indicators SMART. The percentage of risks identified as high were noted which was acknowledged as being reflective of some of the current pressures that the Trust was under from a waiting list, activity and financial position. It was likely that this would increase looking at some of the current issues and pressures that the Trust was managing across it services. All of the training indicators were currently green rated and as per the action from the Finance and Performance Committee, it was confirmed	The Committee received the report and noted the highlighted areas. It endorsed the increase in the compliance rate for safeguarding training to 90% which had already been actioned and would receive a new format report with month six information to

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			that the safeguarding training target would be increased to 90% compliance. This was endorsed by the Committee. A draft of the new format IQPR report would be taken through the next meeting of the Performance Council later in October and it was expected that the new report would be available for this Committee in December.	its next meeting in December 2023.
Report from the Quality Council	2, 3		The Committee received a report detailing the key considerations of the Quality Council held on 25 September 2023. This included: Community Nursing Safer Staffing Tool: Positive progress had been made with the implementation of this tool and this would link into the District Nursing Improvement Plan. Wheelchair Service: A risk had been escalated to the Council concerning prescribing wheelchairs for children who were not necessarily immobile, and it was questioned whether this was the most appropriate and safe course of action for them. There had been work through the Quality and Risk Councils on this and a new framework was now in place to guide clinicians on this matter. Lone Worker Devices: Further progress had been made with work undertaken to move towards a new device and ensuring that staff who required them were wearing/using them appropriately. Palliative Care and End of Life Annual Report: This was under review in line with the Cheshire emergency strategy. Discussions had been reflective of the issues and pressures within district nursing. The Halton District Nursing end of life audit had been completed but the review could not be progressed due to the pressures in the service, and this would now be undertaken in November. The Quality Council had been assured that adequate progress was being made. Warrington Borough Issues: An update was received on virtual wards and frailty of patients in the borough. It was noted that there were two significantly different and separate models in Warrington and Halton. Both had been commissioned differently and there was an internal virtual	It was questioned whether annual reports such as the Palliative and End of Life Care Annual Report should be presented to the Committee or to the Board to ensure sightedness of the work undertaken. Following discussion, it was agreed that the Quality Council would recommend any such future annual reports to this Committee for final ratification. The Committee received the report for assurance.

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			ward programme chaired by the Medical Director, that was monitoring the impact of each model. Work was exploring whether the virtual wards could be utilised as a 'step up' opposed to a 'step down' and the ICB quality group had been involved. It was noted that the Halton service was ahead of the Warrington service due to a number of elements and work was being undertaken to review those areas.	
QIA Report – quarter one	2, 3		Within quarter one, there had been five QIAs approved and closed to the QIA Panel as it was agreed that they had been fully mitigated. Those included waiting lists within paediatric continence services, development of the dental service with digital improvements, Halton Virtual Wards and Junior Doctors Industrial Action. One QIA was scheduled to return to the panel as further information was required regarding the pause that the ICB had requested on the recruitment for the Virtual Wards in Warrington. QIAs would also incorporate any schemes in relation to innovations and/or transformations regarding cost improvement measures to be proposed or introduced within the organisation going forwards.	The Committee discussed the frequency of the QIA reports being presented to the Committee and it was agreed that reports would be provided on a bi-monthly basis going forwards and the business cycle would be amended accordingly.
Parent Feedback on Paediatric Services	2, 3		Kathryn Royden, Operational Manager, Children's Specialist Services presented a report which detailed work undertaken to review how the Warrington service supported and signposted families whilst they were waiting for appointments, and its responsiveness when parents contacted the service with questions and/or requests for further support and guidance. The majority of the feedback had been positive, with specific areas of concern centred around website usefulness/accessibility, clarity of communication and signposting. A plan was now in place to improve communication and responsiveness within Children's Specialist Services whilst patients were awaiting an appointment.	The Committee received the report for assurance.
Dermatology Update Report			The Committee received an update report from the Chief Operating Officer which provided assurance that the service was continuing to effectively manage risks. It recognised the reduction in the number of risks and the significant progress that had been made. It was agreed that	The Committee agreed to accept the recommendations from the report: to accept the

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Committee Chair's Report

			it was not necessary for the Committee to continue to receive a monthly update, but it must be ensured that mechanisms in place for governance would feed any issues or challenges back into the Committee should they emerge.	contents as assurance and that dermatology would be now monitored as part of business as usual and in the event of any further issues or concerns that they would be escalated to this Committee.
Paediatric Audiology Incident Action Plan Update			It was confirmed that all but one patient (due to issues around patient choice) had been recalled for further testing. Results would be discussed at a meeting on 31 October 2023 after which the service would look to identify any harms experienced due to prior testing that had been undertaken. Any children who were identified as having bi-lateral hearing loss would also be reported as a STEiS incident. This would also be reported as part of the serious incident report to the Committee.	The Committee acknowledged the position and accepted the content of the report as assurance that the incident was being managed and actions had been taken to recall children to undergo further testing to assess any potential harms. The Committee agreed to step down the monthly detailed report and note on its action log to receive a verbal update to its December 2023 meeting on the outcome of the meeting to consider the testing results.
CQC Update Report			A meeting had taken place with the CQC on 9 October with updates provided on all of the key points discussed during the Committee meeting earlier. A comprehensive overview had been provided on quality and operational issues, including Audiology and operational pressures. The CQC had asked for updates in relation to the Trust's current status around pressure ulcer incidents and the quarter four 2022 and quarter	The Committee received the update for information.

	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

			one 2023 reports had been provided. There were no further issues raised or outstanding queries to be resolved.	
Trust Improvement Plan Update	2, 3		A report was provided to the Committee to confirm that there had been a reduction in the number of plans from 28 down to 10. 18 plans had been realigned and would no longer be reported on as they were being monitored by the Transformation Group. Of the 10 workstreams in the plan, two plans had demonstrated positive progress, with six plans having no movement. Overall progress had been made, but it was not sufficient to adjust the indicators. An update was provided concerning red rated areas which were either still in development, with actions pending, or areas requiring a further review following actions being completed which was expected to improve the ratings.	The Committee received the report and agreed that it was assured that the Trust Improvement Plan was being routinely monitored along with the individual action plans and that any exceptions were being reported to the Quality Council.
Review of MIAA and Clinical Audits with Limited or Moderate Assurance: Systems and Process Review for Patient Feedback at Service Level Audit 2022/23			The Committee received an update report: The audit had received a moderate assurance level with 11 areas of improvement required. The main issues had been that whilst there were systems and processes in place, when patient feedback was received via complaints processes, there was a lack of robustness around assurances that actions from the action plan were SMART and that learning was embedded and sustainable from within the services themselves and whether this was disseminated adequately. Work had been undertaken liaising with the patient experience team to ensure that action plans were SMART and achievable, with work also undertaken with Directorate Leadership Teams (DLT) to monitor patient experience with an action plan to be monitored via the DLT and borough meetings to ensure that actions as a result of patient feedback had been progressed. An audit would also be undertaken at service level by the patient services team in March 2024 to ensure that any changes due to a complaint had been discussed with staff and that there was evidence of any changes required at an operational or service level.	It was agreed that the Committee's role would be to ensure that the next patient experience report was reflective of the comments made by MIAA. This would then provide another layer around the patient feedback and the actions that had been taken. Future patient experience reports needed to reflect that internal audit has stated that they could not locate evidence that the Trust was taking action based on patient feedback and therefore the structure of that report must be more focussed

	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

				around the outputs because of the actions taken by the Trust.
Strategies – Risk Management Strategy/Framework	2,3		The Committee was assured that the framework was current and up to date. However some amendments were required concerning information within the document related to the reporting structure and sources of risks and the inclusion of the Risk Management Council. The Committee discussed the expectations/purpose of receiving strategies and frameworks as part of its business cycle.	The Committee agreed that clarity around the purpose of the Committee receiving strategies/frameworks would be provided, other than the initial approval of new strategies/frameworks.
Board Assurance Framework (BAF) and New Board Assurance Framework	2,3,6		The Committee reviewed BAF2, 3 and 6 agreed that two risks scoring 15 would be added to BAF2 and 3: Community Paediatrics concerning capacity and demand and lack of ADHD medication. It was agreed that no changes needed to be made to the risk rating scores.	
Assurance Reports Required	1, 2, 3, 6		The Committee agreed that there were no items that required an assurance report. The Committee Chair noted the earlier action for a report with further information to be presented concerning issues within the Community Paediatrics Service.	
Items to be shared with the Board or other Committees	1		Feedback would be provided to the Finance and Performance Committee in November 2023 to confirm that this Committee endorsed the increase in the compliance rate for safeguarding training to 90% which had already been actioned.	
Review of meeting	1		All participants and observers were invited to comment on the meeting.	
Risks Escalated: **None from this meeting**				

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

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

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**85/23iii**		
Report Title	**EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) REPORT RE-SUBMISSION**		
Executive Lead	Sarah Brennan, Chief Operating Officer, Accountable Emergency Officer		
Report Author	John Morris, Deputy Director Estates / EPRR		
Presented by	Sarah Brennan, Chief Operating Officer, Accountable Emergency Officer		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Executive Summary

The Board last received a report on the outcome of the 2023-24 assurance process at its meeting in October 2023. Following a self-assessment process, the Trust declared full compliance against 47 standards, 9 partial compliance and 2 non-compliant against the 58 applicable standards.

The self-assessment was submitted alongside all the relevant evidence which was reviewed by the NHSE EPRR team. The NHSE EPRR team fed back that they were not in agreement with the self-assessment and reassessed the Trust to non-compliant against the overall standards with 1 standard fully compliant, 55 partial compliant and 2 non-compliant against the 58 applicable standards.

This process has been followed across the whole of the Cheshire and Merseyside Integrated Care System and all Trusts have received a much-reduced compliance position with the standards and as is explained in the Overview for Boards document the process which was undertaken in the Midlands system in 2022.

Working groups are now in place internally and with other community providers to address the deficits in the standards identified. This will be subject to 3 monthly monitoring with the aim of significantly increasing compliance for the 2024-25 assurance process.

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	7 December 2023
Agenda Item	85/23iii		
Report Title	EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR) REPORT RE-SUBMISSION		
Report Author	John Morris, Deputy Director Estates / EPRR		
Purpose	To inform the Board of the final outcome of the EPRR assurance process for 2023-24		

1. SCOPE

1.1 The NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) are the minimum standards which commissioners and providers of NHS funded services must meet.

1.2 Stephen Groves, Director of NHS Resilience, wrote to Accountable Emergency Officers in May 2023 setting out the 2022-23 EPRR assurance process.

1.3 Local Health Resilience Partnerships (LHRPs) lead the assurance process on behalf of NHS England and the ICB.

1.4 Providers of NHS funded care are required to undertake a self-assessment against the relevant individual core standards and rate their compliance.

1.5 NHSE wrote to all providers in mid July 2023 confirming changes to the 2023-24 process, insofar as, organisations are now required to submit data evidence to a national database. Each standard assessed needs to be cross referenced to appropriate documentation which should obviously provide the assurances in terms of the compliance rating. These ratings are then used to inform the organisation's overall EPRR annual assurance rating which should be presented at a public Board meeting.

1.6 The self-assessed data was submitted to NHSE on the 30/09/23, for review by NHSE colleagues.

2. PURPOSE

2.1 The purpose of the paper is to inform the Board of:

- The NHSE review of the Trust's 2023-24 self-assessment against the NHS Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and the level of compliance achieved.

3. BACKGROUND AND DESCRIPTION OF THE ISSUE

3.1 Each ICB, on behalf of NHSE, is now responsible for leading and co-ordinating EPRR across its health system. This includes seeking assurance that NHS funded organisations are able to respond to and be resilient against emergencies and meet the requirements of the Civil Contingencies Act 2004 and all NHS England EPRR guidance, including the NHS Core Standards for EPRR.

3.2 The Trust provides annual EPRR assurance to the Cheshire & Merseyside ICB.

3.3 The Board last received a report on the outcome of the 2023-24 assurance process at its meeting in October 2023. At this time the Trust declared full compliance against 47 standards, 9 partial compliance and 2 non-compliant against the 58 applicable standards.

3.4 The review process and subsequent feedback received has resulted in a revised assessment insofar as the Trust is now reporting 1 fully compliant, 55 partial compliant and 2 non-compliant against the 58 applicable standards.

3.5 This revised assessment results in the Trust reporting a non-compliant assessment against the overall standard.

4. OUTCOME

4.1 The Head of EPRR carried out the self-assessment against the 58 EPRR core standards and deep-dive standards relevant to community providers.

4.2 Evidence was submitted to the SharePoint dataset to support the initial assessment, and this was reviewed by NHSE EPRR colleagues. Feedback received has identified shortfalls in the evidence submitted and the Trust, following various meetings with NHSE, has accepted this feedback. Feedback received, for example, includes the Trust not having an approved EPRR policy, AEO job description not including EPRR duties, no reference to community or national risk registers within Ulysses, communications policy specific to EPRR.

4.3 The Trust has met with Mr Paul Dickens, Regional Head of EPRR, NHSE Northwest to go through the feedback. Mr Dickens re-iterated that the process had been subject to a hard reset (following recommendations from the Manchester Arena enquiry) and was an honest and open assessment of where the NHS, across all sectors, was and where it needed to be. He referenced the need for a continuous improvement cycle, collective responsibility whilst also acknowledging it was not about a performance management directive. He has subsequently shared the document “Core Standards Overview for Boards” which is shown in Appendix B.

4.4 The Trust has also attended EPRR meetings where all organisations have confirmed their re-assessed status as the same as Bridgewater’s, with 14 out of the 15 organisations having previously submitted a full, substantial or partial compliance self-assessment.

4.5 Therefore, the re-assessed Bridgewater position for 2023-24 is as follows, *1 of the 58 core standards has been assessed as fully compliant, 55 as partially compliant and 2 as non-compliant*. A summary of the scores is referenced below.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	0	6	0	0
Duty to risk assess	2	0	2	0	0
Duty to maintain plans	11	0	11	0	0
Command and control	2	0	2	0	0
Training and exercising	4	0	4	0	0
Response	5	0	5	0	2
Warning and informing	4	0	4	0	0
Cooperation	4	0	4	0	3
Business continuity	10	1	9	0	1
Hazmat/CBRN	10	0	8	2	9
Total	58	1	55	2	15

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	6	4	0	0
Total	10	6	4	0	0

4.6 The Trust is therefore showing nil compliance against the core standards in the enclosed Statement of Compliance (Appendix A).

Percentage Compliance	2%
Overall Assessment	Non-Compliant

4.7 The results of the deep dive do not contribute to the overall compliance rating. Of the 10 applicable deep dive standards, 4 have been assessed as amber (partially compliant) and 0 red (non-compliant). Arrangements are in place to achieve full compliance over the next 12 months and are included in the action plan.

5. NEXT STEPS

5.1 Following review and approval by the Board, the approved documents will be re-submitted to the ICB. These will then be assessed, peer reviewed, amended if appropriate and submitted, on behalf of the wider North West Region to NHSE by the 29th of December 2023.

5.2 The core standards action plan will be monitored and kept under review by the Accountable Emergency Officer via the LHRP, on a 3 monthly continuous improvement cycle.

5.3 Existing resource has been reprioritised to support the wider EPRR agenda (the previous full time EPRR wte was subject to MARS approx. 3 years ago) and an internal EPRR group has now been established reporting directly into EMT. This situation will be monitored as if the existing capacity is challenged a decision may be needed at Executive Management

Team (EMT) about whether a bespoke resource to deliver the EPRR agenda on behalf of the Trust.

5.4 This group will also oversee in-year work-streams associated with the wider themes, including documentation review, exercise planning and formal reporting to the Board. The action plan will also be incorporated into the Boost programme format and subject to the appropriate programme process and procedures.

6. RECOMMENDATION

6.1 The Board / Committee is asked to receive this report and agree the statement of compliance (Appendix A) and note the supporting documents:

- The completed statement of compliance (**Appendix A)**
- NHSE EPRR Core standards overview for Boards. **(Appendix B)**
- Feedback letter dated 19/10/23 **(Appendix C)**
- Feedback letter dated 06/11/23 **(Appendix C)**
- Feedback letter dated 15/11/23 **(Appendix C)**
- Compliance Assessment framework **(Appendix D**)

APPENDIX A

Cheshire and Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2023-2024

STATEMENT OF COMPLIANCE

Bridgewater Community Healthcare NHSFT has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool.

Where areas require further action, Bridgewater Community Healthcare NHSFT will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer		**Date signed**
07/12/2023	07/12/2023	02/09/2024
Date of Board/governing body meeting	Date presented at Public Board	Date published in organisations Annual Report

Appendix B

Applicable to – NHS organisations in the North East & Yorkshire and North West regions Content – Overview of changes to the NHS England EPRR Core Standards assurance process in the North East & Yorkshire and North West for the 2023/24 assurance cycle Version – 1.0 FINAL November 2023 Contact – england.eprrney@nhs.net or england.eprrnw@nhs.net

The rationale for change

Over recent years the Emergency Preparedness Resilience & Response (EPRR) world has seen both significant disruption and major change – from our exit from the European Union to the COVID-19 pandemic, Manchester Arena attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professionals and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

In the wake of lessons identified from recent incidents and a number of public inquiries (Manchester Arena, Grenfell & the ongoing COVID-19 inquiry – as well as the recent verdict in the Letby trial and the announcement of the Thirlwall Inquiry), it is clear that the standard which organisations must achieve, and the burden of proof in regard to robust governance, proactive planning and tried & tested plans is one which requires a dedicated assurance framework which can ensure our collective system resilience

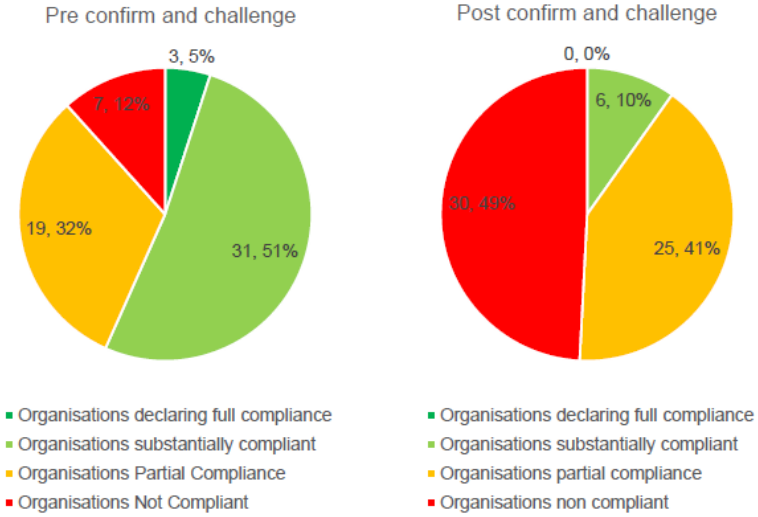
The 2023/24 EPRR Assurance model

In 2022, colleagues in the Midlands Region undertook an amended EPRR assurance process. This pilot, involved a new and detailed analysis of compliance evidence against each core standard, alongside the organisations self-assessment.

This model required commissioners and providers of NHS commissioned care to submit evidence, which went through a formal review and subsequent check and challenge, whereby they were given the opportunity to submit supplementary evidence against any challenges before finalising their assurance position.

The Midlands results, as detailed in the diagrams below, clearly demonstrated that despite the efforts of organisations in delivering their EPRR responsibilities, there were substantial differences between the self-assessment results and the evidential review of the organisations documentation.

Levels pre and post confirm and challenge



The position before and after the confirm and challenge shows the value in this step of the process in assuring the wider NHS of the positions being self reported.

NHS England recognises several organisations were already very open with the positions they had with 5 organisations not moving in position.

The highlighting of issues assists the whole of the system manage and improve.

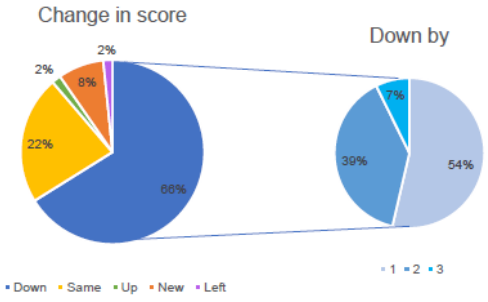
The maximum of accepted challenges to an organisational assessment was 30 standards.

OFFICIAL – SENSITIVE

Change from 2021/22

Breaking down the change into positive or reduced positions.

- 8% of organisations had a first assessment
- 2% increased in position
- 22% remained in the same assessment position
- 66% decreased on the previous assessment, of these:
  - 7% dropped three compliance levels (full to non compliance)
  - 39% dropped two compliance levels (full to partial or Sub to non)
  - 54% dropped one compliance level (Full to Sub, Sub to partial or Partial to Non)



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

Implementation of the same model within the North East & Yorkshire and North West regions was agreed with the intention to undertake an open, honest and transparent, review of evidence associated with the core standards in order to assess evidential compliance with the objective of improving our collective resilience for patients and communities.

NHS England worked with ICB colleagues through the summer to provide guidance and clarity on the assessment requirements and highlighted that it was likely we may see the same compliance shift that Midlands colleagues had seen in 2022.

Introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The way forward

Following completion of the evidence reviews, provider organisations will undertake a check & challenge via their Local Health Resilience Partnership (LHRP), this will give an opportunity for peer discussion and for ICBs to seek assurance ahead of their own system level check & challenge via the Regional Health Resilience Partnership (RHRP).

Organisations will be required to participate in ongoing assurance against their action plans, this will follow pre-existing arrangements that are well established across both regions –

- **Fully compliant** – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- **Substantially compliant** – formal updates against action plans every 6 months.
- **Partially compliant** – formal updates against action plan every 3 months.
- **Non-compliant** - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

The intention of the revised process is absolutely intended to be constructive, and to allow organisations to reflect on the robustness of the plans they have in place, what more they could or should be doing to improve their resilience, and to demonstrate that position to their Boards.

The collective focus over the coming months, will be to identify common themes and the NHS England EPRR teams will continue to proactively support opportunities to collaboratively address areas for improvement in order to enhance system preparedness, patient outcomes, and opportunities to share best and notable practice. This will deliver greater resilience at provider level, for place based systems and across the regions, with greater interoperability and opportunities to undertake collective planning.

It is recognised that the change in process has come at a very difficult time for EPRR professionals across organisations given the competing pressures, and that Boards may be concerned by the reduction in compliance ratings. However, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

Following completion of this years process, it is important to take time to come together and reflect on the lessons identified through this process. This will enable opportunities to collectively provide greater guidance to colleagues where questions have been raised (e.g. annual review of plans and policies), ensure that areas which have worked well in this process are embedded in future years, and to identify improvements in the assurance process ahead of next year's assurance cycle.

NHS England North West

To:
Sarah Brennan
Accountable Emergency Officer (AEO)
Bridgewater Community Trust

Date: 19 October 2023

Dear Sarah

In June this year we confirmed to Integrated Care Boards (ICB's), and health organisations, a revised process for the 2023-24 EPRR Assurance Process which would see an evidence submission included as part of the annual assurance process.

NHS England and ICB colleagues have now undertaken a review of the evidence submitted by your organisation in order to understand your self-assessment position. Each core standard has been independently reviewed against the EPRR Assessment guidelines and rated as to whether they are –

- Green/Compliant – the evidence contains all required components.
- Amber/Partial - evidence is missing one or more required components of the assessment criteria.
- Red/Non-compliant - evidence does not meet the required components.

The findings of this review are detailed within this letter, and subsequently confirms whether the review "accepts" or "challenges" your organisations initial self-assessment against each standard -

- Accepted – both the self-assessment and check & challenge have reached a consensus on the compliance rating for that core standard, or
- Challenged – the check & challenge has identified a lack of evidence to support the organisations self-assessment compliance rating and is requesting additional information to support the organisations RAG.

Where a standard has been identified as "challenged", we are requesting any supplementary evidence you are able to provide, in order to support your submission.

Where a standard has been accepted, and there is no recommendation these standards are not listed in the letter, however where a rating has been accepted but a recommendation is being made, you will also find this include within this summary.

You will find details outlining the reason(s) behind the challenge outlined as demonstrated in the example below –

CS	Domain	Standard	Detail of standard	Self assessment rating	Check & Challenges rating	Accepted or challenged	Concern raised as part of Check & Challenge	Action required
1	Governance	Senior Leadership	"The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to			CHALLENGED	No evidence of named AEO submitted.	Requesting information relating to AEO in line with compliance requirements (slide 4 of assessment guidance)

			direct the EPRR portfolio.					
11	Duty to plan	Incident response plan				ACCEPTED		Recommendation – Trust is advised to ensure plans are reviewed annually and align with terminology held in the National Incident Response Plan.

Should you have any questions, please contact the regional EPRR team who will endeavour to answer them, alternatively should you wish to discuss challenges raised in more detail ahead of your supplementary evidence submission, please email england.eprrnw@nhs.net who will advise you of the time slots available.

Any supporting information you wish to provide in response to challenges raised, should be uploaded to your organisations repository folder **within 5 working days** of receipt of this letter, in order for it to be included in the supplementary evidence review. In order for us to review this efficiently please ensure that the relevant section of any supplementary evidence is clearly highlighted in the document, or a commentary sheet added detailing the page and paragraph(s) you believe is relevant to this core standard.

For your organisation this means that any additional evidence needs to be uploaded before close of play Thursday 26th October 2023.

We ask you to confirm by email to england.eprrnw@nhs.net when all additional information has been uploaded, in order that we can begin our final documentation review.

A review of any additional evidence submitted will take place within 5 working days of receiving your confirmation email, and we will write out to confirm the final check and challenge position, and timeline for submission of your final self-assessment and statement of compliance.

We want to take the opportunity to thank you, and your EPRR lead(s), for your support and engagement in this year's amended assurance process, and in continuing to commit to driving improvements across the NHS in preparing for, responding to and learning from incidents and events in service of our patients.

Kind Regards

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions
NHS England

Cc Anthony Middleton, AEO, Cheshire & Merseyside Integrated Care Board
Beth Warburton, Head of EPRR, Cheshire & Merseyside Integrated Care Board
John Morris, EPRR Lead, Bridgewater Community Trust

Appendix 1 – Initial self-assessment review and supplementary evidence requests

CS	Domain	Standard	Detail of standard	Self assessment rating	Check & Challenge rating	Accepted or challenged	Concern raised as part of Check & Challenge	Action required	Comments or Recommendations
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	A	Challenged	Evidence submitted does not include job description or assurance that role is approved by board.		Advisory for 2023/Compulsory for 2024 - The organisation should outline how the role will be maintained in the absence of the AEO (sickness or leave), noting the requirement to have post held at executive level No detail on how the role will be maintained in the absence of the AEO. Documents need to be updated to reflect arrangements.
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	G	A	Challenged	No evidence of EPRR policy. The Major Incident Policy doesn't meet the criteria required to meet this standard e.g. alignment to organisational objectives, governance and oversight groups		
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	Challenged	Evidence submitted is to audit committee and not to board.		
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	G	A	Challenged	Evidence submitted does not include EPRR Policy or work programme		
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	G	A	Challenged	Evidence submitted does not provide detail to demonstrate		

							that board are satisified that there is sufficient and appropriate EPRR resource to fully discharge the organisations EPRR duties.		
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	A	Challenged	Evidence submitted demonstrates attendance at ICB events. No evidence of organisational process for capturing learning and how it is embedded.		
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	G	A	Challenged	Evidence submitted does not detail risk assessment policy and how it aligns to national and community risk register.		
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	G	A	Challenged	Evidence submitted does not detail how risks are assessed and escalated.		
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	A	Challenged	Evidence submitted doesn't detail engagement with wider stakeholders in planning arrangements. Whilst there is a screenshot of winter plans there is no evidence of any plans that are current and up to date.		
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	A	Challenged	Evidence submitted is out of date and uses incorrect terminology e.g. PHE, NHSE North. Version control is not up to date		

11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	A	Challenged	Evidence submitted does not align to current national plan and guidance.		Version control needs to match on footers with the published version number. Action cards need to be updated to current national guidance.
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	G	A	Challenged	Although the Outbreak Control Plan is dated as being current the content is out of date and incorrect. Pandemic Influenza plan still refers to HPA. IPC guidance refers to PDM 2009 and is out of date. Hyperlinks in the plan are out of date. Plans refer to countermeasures being held by NWAS which is incorrect.		Pg 7 of outbreak control plan states that police will request CCDC will request STAC is convened - SCG will make the request. Format of version control does not make clear the changes made in each version. The detail in the plan is not always reflected in the action cards.
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	G	A	Challenged	Although the Outbreak Control Plan is dated as being current the content is out of date and incorrect. Pandemic Influenza plan still refers to HPA. IPC guidance refers to PDM 2009 and is out of date. Hyperlinks in the plan are out of date. Avian influenza supply of anitvirals plan is draft.		
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	G	A	Challenged	Although the Outbreak Control Plan is dated as being current the		

							content is out of date and incorrect. Pandemic Influenza plan still refers to HPA. IPC guidance refers to PDM 2009 and is out of date. Hyperlinks in the plan are out of date. Plans refer to countermeasures being held by NWAS which is incorrect.		
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	A	Challenged	Evidence submitted does not meet the core standard requirements. It doesn't detail the Trust arrangements for responding to an incident including the Trust plan, mutual aid arrangments etc.		
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	A	A	Accepted			
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	G	A	Challenged	Evidence submitted is a policy and not a plan. The evidence doesn't include alternative ICC arrangements, doesn't clearly state who is authorised to invoke a plan. Bomb threat plan doen't include action cards. Refers to a form in annexe 2 but there is no annexe 2		

18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	G	A	Challenged	Evidence submitted does not relate to the relevant core standard regarding protected individuals.		
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	G	A	Challenged	Evidence submitted makes no reference to mass fatality arrangements.		
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	G	A	Challenged	Terminology in evidence provided does not align to the EPRR Framework 2022.		
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A	A	Accepted			
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	G	A	Challenged	TNA doesn't include an analysis of the numbers of staff needed. No evidence of how the TNA links to the MOS for EPRR.		
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	G	A	Challenged	No exercise programme linked to local or organsisational risk profile. Evidence submitted relates to exercises run by other organisations rather than Bridgewater.		
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	G	A	Challenged	Evidence submitted does not meet the requirement of the standard. Does not include TNA detail of how many staff are required. Evidence does not link to MOS. Training evidence		

							does not link to EPRR role specific training.		
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	A	Challenged	Although induction training has been submitted as evidence it contains a number of factual inaccuracies e.g. the presentation states ICB is a Category 2 responder when it is a category 1.		Training content must be correct and delivered by someone who is current, competent and qualified.
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	G	A	Challenged	No evidence of ICC plan outlining roles and responsibilities, layout or structure and arrangements for extended operation. No demonstration of resilience in the event or loss of services. No evidence of ICC checklist for checking and maintaining ICC equipment. No evidence of arrangements being tested.		
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	G	A	Challenged	Introduction to EPRR is factually incorrect as per Core Standard 25. No evidence of how plans are managed as electronic and hard copies or archived and who is responsible for these arrangements		
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	A	Challenged	Evidence provided does not detail authority to invoke BC plans.		

							Although induction training has been submitted as evidence it contains a number of factual inaccuracies e.g. the presentation states ICB is a Category 2 responder when it is a category 1.		
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	G	A	Challenged	Evidence submitted does not detail activation procedures or management of protracted incidents. No evidence of training or of testing any call out procedures e.g. comms test records.		
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	A	Challenged	Evidence submitted does not outline roles and responsibilites for completion and sign off of sitreps in and out of hours.		
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	G	A	Challenged	No communications plan submitted. No details of how comms aligns with EPRR planning and activity. No agreed pre-prepared lines.		Action card job titles need to be aliggned to EPRR MOS
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	G	A	Challenged	No incident communication plan received. Major incident plan lacks details on incident communication.		

35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	A	Challenged	Although the evidence submitted gives an example of a stakeholder briefing it doesn't detail which stakeholders have been communicated with. No strategy is detailed.		
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	G	A	Challenged	No evidence of a media strategy has been submitted. No TNA or any records of staff receing media training. No process for appropriate sign off of media messaging.		
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	G	A	Challenged	Evidence submitted does not demonstrate engagement or attendance of the AEO at LHRP. No evidence that demonstrates engagement with development of LHRP work programme.		
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	G	A	Challenged	No evidence submitted		
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	A	A	Challenged	No evidence submitted		
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.						
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	A	A	Challenged	No evidence submitted		

44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	A	A	Challenged	See comments for CS28		
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	G	A	Challenged	No evidence of a BCMS for the organisation.		
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	G	A	Challenged	Evidence submitted contains no details of analysis e.g tolerable thresholds, no recovery time objectives		
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	G	A	Challenged	See comments for CS28 Plans submitted are out of date or in draft.		
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	A	Challenged	No evidence of training and exercise schedule.		
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	A	Challenged	Not fully compliant with DPST. Moderate compliance with continuity planning.		
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	A	Accepted			
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	A	A	Accepted			
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	A	Accepted			
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	Accepted			

55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	A	Challenged	Evidence submitted doesn't detail roles and responsibilities in relation to HAZMAT/CBRN.		
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	A	Accepted	No HAZMAT/CBRN policy or risk assessment for self-presenters. Evidence submitted is out of date.		
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	A	Challenged	Although contact numbers have been provided there is no evidence of training of staff on escalation to seek advice and how to manage advice once received.		
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	A	A	Accepted			
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	G	A	Challenged	Evidence submitted is an order form for Covid PPE. The list doesn't relate to any risk assessment.		
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets	G	A	Challenged	No evidence submitted		

			- Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks							
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	R	R	Accepted	No evidence submitted			
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	R	R	Accepted	No evidence submitted			
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	G	A	Challenged	No evidence of the details of training including selection of correct PPE.			
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	G	A	Challenged	Evidence submitted does not relate to exercising of plans.			

To:
Sarah Brennan
Accountable Emergency Officer (AEO)
Bridgewater Community Trust

Date: 6th November 2023

Dear Sarah,

As you will be aware NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the EPRR Annual Assurance process, and for 2023/24 we described how we would further enhance our assurance arrangements using the EPRR Core Standards, by introducing an evidence-based check and challenge process, whereby organisations would be required to submit evidence which supported their self-assessment.

Check & Challenge findings.

For the 2023/24 period, your organisation submitted a provisional self-assessment of –

Self Assessment assurance rating	Partially	Percentage compliance	81%
Core standard position after organisation self assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non compliant
58	47	9	2

Colleagues from the North West have now completed a full review of evidence submitted through both primary and supplementary submission periods.

Following completion of the check and challenge process, and review of any supplementary evidence we have identified the following proposed assurance position –

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non compliant
58	0	56	2

The final findings of the check and challenge review, along with the rationale and specifics of any challenges raised, are detailed within this letter, and subsequently

confirms whether the check and challenge team “accept” or “challenges” your organisations provisional self-assessment.

Final Assurance position

Upon receipt of this letter, Accountable Emergency Officers are requested to re-assess their self-assessment scoring based on feedback and any residual challenges. A copy of their final self-assessment and statement of compliance should be returned to your ICB and copied to the regional team (england.eprrnw@nhs.net) within 10 days of receipt of this letter.

For your organisation this means that your final submission self-assessment and annual statement of compliance should be received by close of play on 15th November 2023.

Governance via Local Health Resilience Partnerships

Once your final self-assessment and statement of compliance has been completed, these are required to be signed off by your Board by 31st December 2023.

Your ICB will liaise with you to agree a schedule for Local Health Resilience Partnership (LHRP) meetings, where the normal schedule of confirm and challenge sessions will take place.

At these sessions each organisation will be required to outline their overall compliance level and an action plan for any partially or non-compliant standards.

Where an agreement has not been reached in support of an assurance rating, or where an organisation chooses to submit a higher level of assurance than has been identified through the check and challenge review, a strong rationale must be discussed with peers and their lead ICB as part of the LHRP session, and ahead of a final assurance discussion at the Regional Health Resilience Partnership (RHRP).

Continuous Improvement Cycle - Governance

As with previous years, organisations will be required to provide updates against their EPRR Assurance action plans through their LHRP. The schedule for these updates is linked to the final level of compliance reported by the organisation and in line with our revised approach, the ongoing governance for continuous improvement will require ICBs to review evidence submitted against the organisation’s assurance action plan as part of this process –

- Fully compliant – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- Substantially compliant – formal updates against action plan every 6 months.
- Partially compliant – formal updates against action plan every 3 months.

- Non-compliant - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

Continuous Improvement Cycle – Collaborative Working

We recognise and understand the significance of undertaking the evidence-based review process this year, and the demands and challenges this has placed across the system.

We will be looking to schedule debrief sessions for AEO's and EP leads following completion of the assurance process in order to –

- Identify what elements worked well and could be used in future assurance processes or as part of continuous improvement throughout the year.
- Identify what elements need improvement and require further review and amendment ahead of next year's assurance cycle.
- Identify areas of good practice which can be shared across the system in order to improve our collective resilience and
- Identify where there are consistent themes and trends across domains and services to explore opportunities for collaborative work to enhance collective resilience and reduce burdens on individual agencies.

We hope that colleagues have found the process a useful opportunity to reflect on areas which would further enhance their organisations own preparedness, as well as opportunities to work collaboratively with partners to address common areas of concern.

Finally, we want to again take the opportunity to thank you, and your EPRR lead(s), not only for your engagement in the amended assurance process, but in your support through another challenging year in the world of resilience, and amidst a backdrop of a number of concurrent issues and incidents, not least the prolonged planning and response to the ongoing industrial action.

Kind Regards

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions
NHS England

Cc Anthony Middleton, AEO, Cheshire & Merseyside Integrated Care Board
Beth Warburton, Head of EPRR, Cheshire & Merseyside Integrated Care Board
John Morris, EPRR Lead, Bridgewater Community Trust

NHS England North West

Appendix 1 – Organisations summary sheet

Organisation name	Bridgewater			2022/23 Assurance Rating (and % compliance)		Substantially - 89%
Initial self assessment rating (2023/24)		Partially		If the organisations accept the challenges identified in the check & challenge process their compliance rating would be		Non-Compliant
Initial self assessment percentage compliance		81%		Check & challenge percentage compliance	0%	Variance ( ) 81%

CS	Domain	Standard	Detail of standard	Self assessment rating	Check & Challenges rating	Accepted or challenged	Comments
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	A	Challenged	
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	G	A	Challenged	Supplementary evidence submitted is an EPRR policy dated 24th October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	Challenged	Agenda of board meeting submitted but the report that went to the public board has not been submitted. The original evidence submission included a report that was submitted to audit committee. The content of the report would not have met the compliance criteria had it gone to board as it did not include details of training & exercising, incidents since the last report, lessons and learning.

4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	G	A	Challenged	Supplementary evidence submitted is an action plan and not a work plan.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	G	A	Challenged	
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	A	Challenged	Incident reporting policy submitted is out of date. The example of best practice for future IA does not meet the following compliance criteria: A clear process for identifying lessons from incidents and exercises should be in place which ensures these are captured in a single place and embedded across the organisation The process should be documented as part of the EPRR policy A clear ownership of recording lessons and stages in this process should be owned Monitoring of lesson completion should be included as part of process and evidenced Processes should also meet the requirements of any local or regional lessons processes Reporting on progress on lessons to LHRP should be in place and in accordance with guidance
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	G	A	Challenged	Evidence submitted does not meet the following compliance criteria: Evidence of EPRR risks on the organisations risk register(s) and review sequence for these Clear evidence of alignment of assessments from the LHRP risk register and community risk registers, and how these are used to update risks Risks must have been reviewed in past 12 months

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	G	A	Challenged	Evidence submitted does not meet the following compliance criteria: Process describing who is responsible for raising risks to the Local Health Resilience Partnership and/or Local Resilience Forum Policy documents explicitly state how EPRR only risks will be managed The role with the responsibility for managing risks is clearly described, with clarity on the process and governance arrangements
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	A	Challenged	Evidence submitted does not relate to collaborative planning for EPRR. Following compliance criteria not met: Organisational plans have undergone a clearly described consultation process (within Policy or management system) Organisations should be able to demonstrate membership and engagement within planning groups and how these groups are used to identify stakeholders to engage and consult with Records should be maintained of those consulted with or consultations participated within Any changes to plans as a result of consultations should be clearly documented and outlined as part of the sign off process Where the organisation chooses not to implement consultation feedback this rationale should also be included when signing off the document
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	A	Challenged	Supplementary evidence submitted does not include a current incident response plan that aligns to current national guidance.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	A	Challenged	Evidence submitted is the national guidance and not a current Trust plan that aligns to the national guidance.
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	G	A	Challenged	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	G	A	Challenged	

14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	G	A	Challenged	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	A	Challenged	Evidence submitted is a Community Outbreak/Mass Treatment Plan and is not relevant. It may have been intended as evidence for a different standard but it must be noted that it would not meet the compliance requirement for any standard as the document does not detail the ratification/sign off for the plan.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	A	A	Accepted	
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	G	A	Challenged	Supplementary evidence does not detail alternative ICC arrangements or who is authorised to invoke the lockdown plan.
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	G	A	Challenged	Supplementary evidence submitted is dated October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	G	A	Challenged	
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	G	A	Challenged	Evidence submitted does not meet the following compliance criteria: Expectations should be established within the EPRR policy or standalone on call policy On call arrangements should be tested and have the ability to receive all alerts and escalate within the expected time frames (within 15 minutes of receipt of call)

21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A	A	Accepted	
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	G	A	Challenged	Supplementary evidence of TNA submitted was created 20th October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	G	A	Challenged	No evidence of a training and exercising programme showing all types of exercises and their required participants. No attendance records submitted as evidence. No evidence of exercise reports measuring effectiveness of the exercises against the aim and objectives. No evidence of exercises linking to local risk profile.
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	G	A	Challenged	Supplementary evidence of TNA submitted was created 20th October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	A	Challenged	Supplementary evidence of updated induction PowerPoint was created after the original deadline of 30th September. The PowerPoint still contains some inaccuracies.
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external	G	A	Challenged	No evidence of ICC plan outlining roles and responsibilities, layout or structure and arrangements for extended operation. No evidence of ICC checklist for checking and maintaining ICC equipment.

			hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.				
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	G	A	Challenged	No details of where hard copies of documents are stored and who is responsible for management of these.
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	A	Challenged	Evidence submitted is out of date and does not align to the EPRR Framework 2022. Evidence provided does not detail authority to invoke BC plans.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	G	A	Challenged	Evidence submitted does not detail activation procedures or management of protracted incidents. No evidence of training or of testing any call out procedures e.g. comms test records.
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	A	Challenged	Evidence submitted does not outline roles and responsibilities for completion and sign off of sitreps in and out of hours.
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	G	A	Challenged	Evidence submitted is out of date and terminology does not align to the EPRR Framework 2022. In a level 1 incident the Trust is responsible for their own statements but support can be given by ICB and region if appropriate. Evidence submitted does not meet the following compliance criteria: Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an

							incident. This should include on call arrangements. Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. Those needing communications training are identified in the Training Needs Analysis (TNA) Organisations should identify roles which require communications training, and hold the records to evidence who has received it. No agreed pre-prepared lines.
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	G	A	Challenged	No Incident Communication Plan submitted as evidence.
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	A	Challenged	Supplementary evidence of Incident Response - Communication Plan submitted was created in October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	G	A	Challenged	Supplementary evidence of Incident Response - Communication Plan submitted was created in October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	G	A	Challenged	Supplementary evidence submitted demonstrates that the AEO and the Trust have not been in attendance at LHRP.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	G	A	Challenged	
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should	A	A	Accepted	

			include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.				
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	G	A	Challenged	Evidence submitted does not detail arrangements for sharing information in incident response. No evidence of ICC processes for ensuring information is not shared unnecessarily or without protections in place. Authorisation processes are not reflected in incident roles and descriptions. No documented or signed information protocols submitted as evidence.
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G	A	Challenged	Evidence submitted is out of date and does not align to the EPRR Framework 2022. Evidence provided does not detail authority to invoke BC plans. Policy is not approved by the board.
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	G	A	Challenged	
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	G	A	Challenged	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	G	A	Challenged	

48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	A	Challenged	
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	A	Challenged	Evidence submitted shows that Trust is approaching standards and has not met standards yet.
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	A	Accepted	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	A	A	Accepted	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	A	Accepted	
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	Accepted	
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	A	Challenged	

56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	A	Accepted	
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	A	Challenged	
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	A	A	Accepted	
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	G	A	Challenged	
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and	G	A	Challenged	

			replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks				
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	R	R	Accepted	
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres)	R	R	Accepted	

			Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented				
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	G	A	Challenged	
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	G	A	Challenged	

To:
Sarah Brennan
Accountable Emergency Officer (AEO)
Bridgewater Community Trust

Date: 15th November 2023

Dear Sarah,

As you will be aware NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to deliver critical services.

This is achieved through the EPRR Annual Assurance process, and for 2023/24 we described how we would further enhance our assurance arrangements using the EPRR Core Standards, by introducing an evidence-based check and challenge process, whereby organisations would be required to submit evidence which supported their self-assessment.

Check & Challenge findings.

For the 2023/24 period, your organisation submitted a provisional self-assessment of –

Self Assessment assurance rating	Partially	Percentage compliance	81%
Core standard position after organisation self assessment			
Number of core standards applicable	Fully compliant	Partially compliant	Non compliant
58	47	9	2

Colleagues from the North West have now completed a full review of evidence submitted through both primary and supplementary submission periods.

Following completion of the check and challenge process, and review of any supplementary evidence we have identified the following proposed assurance position –

Core standard position recommendation after check and challenge process			
Number of core standards applicable	Fully compliant	Partially compliant	Non compliant
58	1	55	2

The final findings of the check and challenge review, along with the rationale and specifics of any challenges raised, are detailed within this letter, and subsequently

confirms whether the check and challenge team “accept” or “challenges” your organisations provisional self-assessment.

Final Assurance position

Upon receipt of this letter, Accountable Emergency Officers are requested to re-assess their self-assessment scoring based on feedback and any residual challenges. A copy of their final self-assessment and statement of compliance should be returned to your ICB and copied to the regional team (england.eprrnw@nhs.net) within 10 days of receipt of this letter.

For your organisation this means that your final submission self-assessment and annual statement of compliance should be received by close of play on 15th November 2023.

Governance via Local Health Resilience Partnerships

Once your final self-assessment and statement of compliance has been completed, these are required to be signed off by your Board by 31st December 2023.

Your ICB will liaise with you to agree a schedule for Local Health Resilience Partnership (LHRP) meetings, where the normal schedule of confirm and challenge sessions will take place.

At these sessions each organisation will be required to outline their overall compliance level and an action plan for any partially or non-compliant standards.

Where an agreement has not been reached in support of an assurance rating, or where an organisation chooses to submit a higher level of assurance than has been identified through the check and challenge review, a strong rationale must be discussed with peers and their lead ICB as part of the LHRP session, and ahead of a final assurance discussion at the Regional Health Resilience Partnership (RHRP).

Continuous Improvement Cycle - Governance

As with previous years, organisations will be required to provide updates against their EPRR Assurance action plans through their LHRP. The schedule for these updates is linked to the final level of compliance reported by the organisation and in line with our revised approach, the ongoing governance for continuous improvement will require ICBs to review evidence submitted against the organisation’s assurance action plan as part of this process –

- Fully compliant – formal updates annually, with any changes or reduction in compliance reported 6 monthly.
- Substantially compliant – formal updates against action plan every 6 months.
- Partially compliant – formal updates against action plan every 3 months.

- Non-compliant - formal updates against action plan every 3 months, and monthly progress discussions to take place between the provider and their lead ICB.

Continuous Improvement Cycle – Collaborative Working

We recognise and understand the significance of undertaking the evidence-based review process this year, and the demands and challenges this has placed across the system.

We will be looking to schedule debrief sessions for AEO's and EP leads following completion of the assurance process in order to –

- Identify what elements worked well and could be used in future assurance processes or as part of continuous improvement throughout the year.
- Identify what elements need improvement and require further review and amendment ahead of next year's assurance cycle.
- Identify areas of good practice which can be shared across the system in order to improve our collective resilience and
- Identify where there are consistent themes and trends across domains and services to explore opportunities for collaborative work to enhance collective resilience and reduce burdens on individual agencies.

We hope that colleagues have found the process a useful opportunity to reflect on areas which would further enhance their organisations own preparedness, as well as opportunities to work collaboratively with partners to address common areas of concern.

Finally, we want to again take the opportunity to thank you, and your EPRR lead(s), not only for your engagement in the amended assurance process, but in your support through another challenging year in the world of resilience, and amidst a backdrop of a number of concurrent issues and incidents, not least the prolonged planning and response to the ongoing industrial action.

Kind Regards

Paul Dickens
Regional Head of EPRR for the North East & Yorkshire and North West Regions
NHS England

Cc Anthony Middleton, AEO, Cheshire & Merseyside Integrated Care Board
Beth Warburton, Head of EPRR, Cheshire & Merseyside Integrated Care Board
John Morris, EPRR Lead, Bridgewater Community Trust

NHS England North West

Appendix 1 – Organisations summary sheet

Organisation name	Bridgewater			2022/23 Assurance Rating (and % compliance)		Substantially - 89%
Initial self assessment rating (2023/24)	Partially			If the organisations accept the challenges identified in the check & challenge process their compliance rating would be		Non-Compliant
Initial self assessment percentage compliance	81%			Check & challenge percentage compliance	2%	Variance ( ) 79%

CS	Domain	Standard	Detail of standard	Self assessment rating	Check & Challenges rating	Accepted or challenged	Comments
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	G	A	Challenged	
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	G	A	Challenged	Supplementary evidence submitted is an EPRR policy dated 24th October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	G	A	Challenged	Agenda of board meeting submitted but the report that went to the public board has not been submitted. The original evidence submission included a report that was submitted to audit committee. The content of the report would not have met the compliance criteria had it gone to board as it did not include details of training & exercising, incidents since the last report, lessons and learning.

4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	G	A	Challenged	Supplementary evidence submitted is an action plan and not a work plan.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	G	A	Challenged	
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	G	A	Challenged	Incident reporting policy submitted is out of date. The example of best practice for future IA does not meet the following compliance criteria: A clear process for identifying lessons from incidents and exercises should be in place which ensures these are captured in a single place and embedded across the organisation The process should be documented as part of the EPRR policy A clear ownership of recording lessons and stages in this process should be owned Monitoring of lesson completion should be included as part of process and evidenced Processes should also meet the requirements of any local or regional lessons processes Reporting on progress on lessons to LHRP should be in place and in accordance with guidance
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	G	A	Challenged	Evidence submitted does not meet the following compliance criteria: Evidence of EPRR risks on the organisations risk register(s) and review sequence for these Clear evidence of alignment of assessments from the LHRP risk register and community risk registers, and how these are used to update risks Risks must have been reviewed in past 12 months

8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	G	A	Challenged	Evidence submitted does not meet the following compliance criteria: Process describing who is responsible for raising risks to the Local Health Resilience Partnership and/or Local Resilience Forum Policy documents explicitly state how EPRR only risks will be managed The role with the responsibility for managing risks is clearly described, with clarity on the process and governance arrangements
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	G	A	Challenged	Evidence submitted does not relate to collaborative planning for EPRR. Following compliance criteria not met: Organisational plans have undergone a clearly described consultation process (within Policy or management system) Organisations should be able to demonstrate membership and engagement within planning groups and how these groups are used to identify stakeholders to engage and consult with Records should be maintained of those consulted with or consultations participated within Any changes to plans as a result of consultations should be clearly documented and outlined as part of the sign off process Where the organisation chooses not to implement consultation feedback this rationale should also be included when signing off the document
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	G	A	Challenged	Supplementary evidence submitted does not include a current incident response plan that aligns to current national guidance.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	G	A	Challenged	Evidence submitted is the national guidance and not a current Trust plan that aligns to the national guidance.
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	G	A	Challenged	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	G	A	Challenged	

14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	G	A	Challenged	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	G	A	Challenged	Evidence submitted is a Community Outbreak/Mass Treatment Plan and is not relevant. It may have been intended as evidence for a different standard but it must be noted that it would not meet the compliance requirement for any standard as the document does not detail the ratification/sign off for the plan.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	A	A	Accepted	
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	G	A	Challenged	Supplementary evidence does not detail alternative ICC arrangements or who is authorised to invoke the lockdown plan.
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	G	A	Challenged	Supplementary evidence submitted is dated October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	G	A	Challenged	
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	G	A	Challenged	Evidence submitted does not meet the following compliance criteria: Expectations should be established within the EPRR policy or standalone on call policy On call arrangements should be tested and have the ability to receive all alerts and escalate within the expected time frames (within 15 minutes of receipt of call)

21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	A	A	Accepted	
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	G	A	Challenged	Supplementary evidence of TNA submitted was created 20th October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	G	A	Challenged	No evidence of a training and exercising programme showing all types of exercises and their required participants. No attendance records submitted as evidence. No evidence of exercise reports measuring effectiveness of the exercises against the aim and objectives. No evidence of exercises linking to local risk profile.
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	G	A	Challenged	Supplementary evidence of TNA submitted was created 20th October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	G	A	Challenged	Supplementary evidence of updated induction PowerPoint was created after the original deadline of 30th September. The PowerPoint still contains some inaccuracies.
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external	G	A	Challenged	No evidence of ICC plan outlining roles and responsibilities, layout or structure and arrangements for extended operation. No evidence of ICC checklist for checking and maintaining ICC equipment.

			hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.				
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	G	A	Challenged	No details of where hard copies of documents are stored and who is responsible for management of these.
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	G	A	Challenged	Evidence submitted is out of date and does not align to the EPRR Framework 2022. Evidence provided does not detail authority to invoke BC plans.
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	G	A	Challenged	Evidence submitted does not detail activation procedures or management of protracted incidents. No evidence of training or of testing any call out procedures e.g. comms test records.
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	G	A	Challenged	Evidence submitted does not outline roles and responsibilities for completion and sign off of sitreps in and out of hours.
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	G	A	Challenged	Evidence submitted is out of date and terminology does not align to the EPRR Framework 2022. In a level 1 incident the Trust is responsible for their own statements but support can be given by ICB and region if appropriate. Evidence submitted does not meet the following compliance criteria: Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an

							incident. This should include on call arrangements. Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. Those needing communications training are identified in the Training Needs Analysis (TNA) Organisations should identify roles which require communications training, and hold the records to evidence who has received it. No agreed pre-prepared lines.
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	G	A	Challenged	No Incident Communication Plan submitted as evidence.
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	G	A	Challenged	Supplementary evidence of Incident Response - Communication Plan submitted was created in October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	G	A	Challenged	Supplementary evidence of Incident Response - Communication Plan submitted was created in October 2023. This is new evidence rather than supplementary evidence as it was created after the original deadline of 30th September.
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	G	A	Challenged	Supplementary evidence submitted demonstrates that the AEO and the Trust have not been in attendance at LHRP.
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	G	A	Challenged	
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should	A	A	Accepted	

			include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.				
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	G	A	Challenged	Evidence submitted does not detail arrangements for sharing information in incident response. No evidence of ICC processes for ensuring information is not shared unnecessarily or without protections in place. Authorisation processes are not reflected in incident roles and descriptions. No documented or signed information protocols submitted as evidence.
44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	G	A	Challenged	Evidence submitted is out of date and does not align to the EPRR Framework 2022. Evidence provided does not detail authority to invoke BC plans. Policy is not approved by the board.
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	G	A	Challenged	
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	G	A	Challenged	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	G	A	Challenged	

48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	G	A	Challenged	
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	G	G	Accepted	Evidence submitted shows that Trust is approaching standards and has not met standards yet. This standard was changed to green, approved by PD following receipt of email on 15/11/23 with URL embedded that covers the requirements.
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	A	A	Accepted	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	A	A	Accepted	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	A	A	Accepted	
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	A	A	Accepted	
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	G	A	Challenged	

56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	A	A	Accepted	
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	G	A	Challenged	
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	A	A	Accepted	
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	G	A	Challenged	
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and	G	A	Challenged	

			replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks				
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	R	R	Accepted	
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres)	R	R	Accepted	

			Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented				
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	G	A	Challenged	
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	G	A	Challenged	

Version Control
2.1 28/07/23

Please choose your organisation type

Community Service Providers

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Governance	6	0	6	0	0
Duty to risk assess	2	0	2	0	0
Duty to maintain plans	11	0	11	0	0
Command and control	2	0	2	0	0
Training and exercising	4	0	4	0	0
Response	5	0	5	0	2
Warning and informing	4	0	4	0	0
Cooperation	4	0	4	0	3
Business continuity	10	1	9	0	1
Hazmat/CBRN	10	0	8	2	9
Total	**58**	**1**	**55**	**2**	**15**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
EPRR Training	10	6	4	0	0
Total	**10**	**6**	**4**	**0**	**0**

Interoperable Capabilities for NHS Ambulance Service Providers only

Interoperable Capabilities	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant
HART Capability	3	0	0	0
HART Human Resources	8	0	0	0
HART Administration	10	0	0	0
HART Response time standards	4	0	0	0
HART Logisitics	7	0	0	0
SORT Capability	4	0	0	0
SORT Human Resources	10	0	0	0
SORT Administration	13	0	0	0
SORT Response Times	14	0	0	0
MassCas Capability	7	0	0	0
MassCas Equipment	7	0	0	0
Gen C2	4	0	0	0
Resource C2	6	0	0	0
Decision Making C2	3	0	0	0
Recording Keeping C2	3	0	0	0
C2 Learning Lessons	1	0	0	0
Competence C2	19	0	0	0
JESIP	13	0	0	0
Total	**136**	**0**	**0**	**0**

Percentage Compliance	2%
Overall Assessment	**Non Compliant**

Assurance Rating Thresholds
- Fully Compliant 100%
- Substantially Compliant 99 89%
- Partially Compliant 88 77%
- Non Compliant 76% or less

Calculated using the number of FULLY COMPLIANT EPRR Core

Notes
- Please do not delete rows or columns from any sheet as this will stop the calculations
- Please ensure you have the correct Organisation Type selected
- The Overall Assessment excludes the Deep Dive questions
- Please do not copy and paste into the Self Assessment Column (*Column T*)
- The Action Plan copies all 'Partially Compliant' and 'Non Compliant' standards

Ref	Domain	Standard name	Standard Detail	Community Service Providers	Supporting Information including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) Not compliant with the core standard. The organisation s work programme shows compliance will not be reached within the next 12	Action to be taken	Lead	Timescale	Comments
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Y	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	SB (Chief Operating Officer) is the Trust AEO. Signed off by the Board. Orgainsational structure acknowledges roles within job titles. Statement contained within the Major Incident Plan.	Partially Compliant	JD will be amended to incorporate	AEO and HR	31/12/2023	
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	Y	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Statements of purpose and identified processes are referenced in the Trust's Major Incident Plan, On call guidance, intranet overview, induction slides and various supporting documents	Partially Compliant	Updated policy to go through internal goverance authorisation process	EPRR	31/01/2024	
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	Y	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	Referenced in the Annual report and separate compliance assessment report presented to the Board on an annual basis. EPRR board development day scheduled in September.	Partially Compliant	Future Board report will include annual review as required	AEO	30/09/2024	
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Y	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Annual work plan presented to the Board included within the compliance assesment report	Partially Compliant	Work plan to be presented to EPEE group	EPRR	31/12/2023	
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Y	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Statements of purpose and identified processes are referenced in the Trust's Major Incident Plan, On call guidance, intranet overview, induction slides and various supporting documents	Partially Compliant	Updated policy to go through internal goverance authorisation process	EPRR	31/01/2024	
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Y	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Attendance at ICB meetings. Separate lessons learnt reports submitted to Executives i.e. Industrial Action arrangements/planning. Post exercise debriefs held.	Partially Compliant	Updated policy to go through internal goverance authorisation process	EPRR	31/01/2024	

Ref	Domain	Standard name	Standard Detail	Community Service Providers	Supporting Information including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) Not compliant with the core standard. The organisation s work programme shows compliance will not be reached within the next 12	Action to be taken	Lead	Timescale	Comments
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	Y	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Member of Risk Council. Appropiate risks recorded on the system.	Partially Compliant	Risk Council agenda to include. Internal risk assessment to be undertaken to align.	EPRR	31/01/2024	
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Y	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Member of Risk Council. Appropiate risks recorded on the system. Separate section in the Major Incident Plan and reference is made on the intranet pages of EPRR.	Partially Compliant	Risk Council agenda to include. Internal risk assessment to be undertaken to align.	EPRR	31/01/2024	
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Y	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Contact made with PLACE organisations re Industrial Action action. Regular PLACE meetings take place to assess organisational capability. Joint executive meetings. PLACE updates at LHRP meetings. PLACE winter plans available to staff via TEAM's channel.	Partially Compliant	PLACE partnership working to be developed as part of future improvement cycle	AEO/EPRR	31/03/2024	
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Y	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	24/7 365 on-call rota in place incorporating senior managers. Documentation access through dedicated TEAM's channel. Live command and control structure in place for COVID response. Incident team in place to deal with Industrial Action. Impact paper including lessons learnt submitted to the Board.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	28/02/2024	
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Y	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	All documentation accessed via TEAM's channel. Attendance at UKHSA launch and revised arrangements in corporated into heatwave/cold weather plans. Healthwatch emails cascaded via internal comms.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	30/11/2023	
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Documentation updated and accessed via TEAM's channel. In year operational response to Avian Flu process and procedure, working in partnership with ICB, UKHSA, Council Public Health and acute.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	31/01/2024	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Documentation updated and accessed via TEAM's channel. In year operational response to Avian Flu process and procedure, working in partnership with ICB, UKHSA, Council Public Health and acute.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	31/01/2024	

Ref	Domain	Standard name	Standard Detail	Community Service Providers	Supporting Information including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) Not compliant with the core standard. The organisation s work programme shows compliance will not be reached within the next 12	Action to be taken	Lead	Timescale	Comments
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to support mass countermeasure distribution locally, this will be dependant on the incident.	Documentation updated and accessed via TEAM's channel. Classed as a hospital hub site for Covid vaccine programme. Site assessment included operational capability for surge response. Cohot of vaccinators across multi services. Sites/rooms identified. Responded to Avian flu outbreak and worked with ICB/UKHSA to develop business processes.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	31/01/2024	
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Documentation updated and accessed via TEAM's channel. Community provider with no inpatient facilities, mortuary, theatres etc. Weekly sitrep calls with acute providers. Staff redeployment consideration	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	28/02/2024	
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Documentation updated and accessed via TEAM's channel. Whilst lockdown procedure references evacuation process, the Trust needs to develop (and test) plans and alternative shelter arrangements. Acknowledge within the process, the Trust does not have any inpatient beds. The Trust occupies circa 60 sites so proportional response to building size.	Partially Compliant	Evacuation plans to be referenced as a separate policy and/or in business continuity plans	AEO/EPRR	31/12/2023	
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Updated lockdown policy circulated to staff and held on the staff intranet.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	31/01/2024	
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Y	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referenced in on-call documentation and business continuity process.	Partially Compliant	Updated policy to go through internal goverance authorisation process	EPRR	31/01/2024	

Ref	Domain	Standard name	Standard Detail	Community Service Providers	Supporting Information including examples of evidence	Organisational Evidence	Self assessment RAG Red (non compliant) Not compliant with the core standard. The organisation s work programme shows compliance will not be reached within the next 12	Action to be taken	Lead	Timescale	Comments
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Y	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Referenced as an appendix within the Major Incident Plan. The Trust does not have inpatient, mortuary facilities and would work with PLACE organisations to offer workforce support.	Partially Compliant	Current plans to be updated in line with national guidance	EPRR	28/02/2024	
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	Y	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	On call documentation all held on TEAMs channel.	Partially Compliant	Updated policy to go through internal goverance authorisation process	EPRR	31/01/2024	
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	Y	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	Compared to the recently published competency portfolios, the majority of on call staff require additional training	Partially Compliant	Members do not meet mandated standards. TNA to be completed and annual training cycle will be developed for each individual/role.	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Y	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	TNA established for all on call members.	Partially Compliant	Revised TNA to be presented to EPPR internal group	EPRR	31/12/2024	
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Y	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. <u>Evidence</u> • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Command and control structures were operated during COVID. Incident group established during Industrial Action (RGN) which included business continuity arrangements and action cards. Exercise Chester and Rogan trust communication exercises. Participant in Exercise Artic Willow and Hedrig coordinated by the ICB.	Partially Compliant	Separate work programme to be established identifying internally led and partner/PLACE led exercises	AEO/EPRR	Continous process	

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24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Y	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	Training sub folder within TEAM's information. EPD maintain training record,s as per other mandatory training requirements, which is linked to ESR/OLM system. Info presented via Trust Qlik front end system.	Partially Compliant	Revised TNA to be presented to EPPR internal group	EPRR	31/12/2024	
25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	Y	As part of mandatory training Exercise and Training attendance records reported to Board	Duties of on-call staff included within supporting information accessible via TEAM's channel. Induction material and intranet pages. Action cards and record templates contained within Major Incident Paln.	Partially Compliant	Revised TNA to be presented to EPPR internal group	EPRR	31/12/2024	
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	Y	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Primary and Secondary ICC identified. Separate postcode areas. Separate IT link. Separate action cards referenced in on-call documents and Major Incident Plan.	Partially Compliant	ICC arrangements to be validated as per national guidance checklist	EPRR/Estates/IT	31/01/2024	
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Y	Planning arrangements are easily accessible - both electronically and local copies	Detail referenced in the Major Incident plan and separate arrangements for out of hours arrangements referenced. All available on the On-call/EPRR teams channel and intranet.	Partially Compliant	On call internal process documentation to be updated.	EPRR	31/12/2023	
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	Y	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Business Continuity policy. Separate intranet folder holding all business continuity plans.	Partially Compliant	Work programme identifies separate task and finish group aligned to BCMS objectives	AEO/OPS	31/01/2024	
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	Y	• Documented processes for accessing and utilising loggists • Training records	On-call staff have access to loggists in the event of a Major Incident. Details separately identified within the Team's channel.	Partially Compliant	Loggist numbers increased and attended course	EPRR	30/11/2023	
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	Y	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Command and control structures including daily sit rep reporting in place during covid and recent Industrial Action.	Partially Compliant	On call internal process documentation to be updated.	EPRR	31/12/2023	
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.		Guidance is available to appropriate staff either electronically or hard copies						
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)		Guidance is available to appropriate staff either electronically or hard copies						

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33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	Y	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Stakeholder documentation produced and circulated.	Partially Compliant	Work programme identifies separate task and finish aligned to communication processes	AEO/EPRR	31/03/2024	
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	Y	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Major Incident Plan contains communication action cards.	Partially Compliant	Work programme identifies separate task and finish aligned to communication processes	AEO/EPRR	31/01/2024	
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Major Incident Plan contains communication action cards.	Partially Compliant	Work programme identifies separate task and finish aligned to communication processes	AEO/EPRR	31/01/2024	
36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	Y	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Established internal processes for communication briefing. Recent Industrial Action provided for testing of systems and processes. ICB co-ordination and cascade through established communication lines. Trust refreshed primary care and PLACE partner contacts to roll out IA communications. Major Incident Plan contains communication action cards. Internet and intranet access to social media. Social media policy.	Partially Compliant	Work programme identifies separate task and finish aligned to communication processes	AEO/EPRR	31/01/2024	
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	Y	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Attendance at meetings	Partially Compliant	Attendance at future meeting	AEO	Continous process	
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	Y	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Attendance at meetings	Partially Compliant	Attendance at future meeting	AEO	Continous process	
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	Y	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	PLACE based working arrangements are in place and where utilised throughout COVID, primarily for PPE arrangements. Regular meetings/calls are held within PLACE across various management portfolio's.	Partially Compliant	PLACE meetings to be established and agreed arrangements will be documented.	EPRR	31/10/2023	PLACE meetings to be arranged and documentation requirement on the agenda
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.		• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all						
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.		• Detailed documentation on the process for managing the national health aspects of an emergency						

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42	Cooperation	LHRP Secretariat	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.		• LHRP terms of reference • Meeting minutes • Meeting agendas						
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	Y	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004		Partially Compliant	Revised policy to be submitted through interna lgovernance process	SO	31/03/2024	
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	Y	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Business Continuity policy. Separate intranet folder holding all business continuity plans.	Partially Compliant	Work programme identifies separate task and finish group aligned to BCMS objectives	AEO/OPS	31/01/2024	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	Y	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Organisational policy in place and EPRR intranet page primary access source. Senior leadership agenda and standing item on directorate meetings. Dynamic business continuity plans considered during IA. Dynamic plans also considered as part of winter planning document.	Partially Compliant	Work programme identifies separate task and finish group aligned to BCMS objectives	AEO/OPS	31/01/2024	
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	Y	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Business Continuity policy. Separate intranet folder holding all business continuity plans. Plans include reference to business critical services.	Partially Compliant	Work programme identifies separate task and finish group aligned to BCMS objectives	AEO/OPS	31/08/2024	

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47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Y	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Organisational policy in place and EPRR intranet page primary access source. Senior leadership agenda and standing item on directorate meetings. Dynamic business continuity plans considered during IA. Dynamic plans also considered as part of winter planning. Plans take into account BCP checklist.	Partially Compliant	Work programme identifies separate task and finish group aligned to BCMS objectives	AEO/OPS	31/08/2024	
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Y	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Recent Industrial action resulted in business continuity plans being invoked across a range of services. Internal and external communication plan. Local Incident Group established. Final report presented to the Board . Separate presentation made to organisation Senior Leadership Team.	Partially Compliant	Work programme identifies separate task and finish group aligned to BCMS objectives	AEO/OPS	31/08/2024	
49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Y	<u>Evidence</u> • Statement of compliance • Action plan to obtain compliance if not achieved	Statement of compliance and report referencing substantial compliance	Fully Compliant				https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.dsptoolkit.nhs.uk%2FOrganisationSearch%2FRY2&data=05%7C01%7Cjohn.morris6%40n
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Y	• Business continuity policy • BCMS • performance reporting • Board papers	Recent Industrial action resulted in business continuity plans being invoked across a range of services. Internal and external communication plan inherent within process. Local Incident Group established. Final report presented to the Board	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	Y	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Inclusion in the 23/24 q4 inernal audit plan. EPRR group reviewing operational plans, updated for winter.	Partially Compliant	Discussions to be held with audit committee chair and audit contractors to include in future business cycle	AEO	31/03/2024	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	Y	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	IA report to Board, winter planning preparation includes a baseline review of services. Internal improvement plans across a range of services. Re-configuration of services to ensure resilence of service offer also improves business contnuity arrangements.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)

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53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	Y	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Utilisation of NHS framework suppliers. Service specific arrangements in place i.e. facilities management. Arrangements in place during Covid. Supply chain BCP. Tender exercises include requirement.	Partially Compliant	Formal review to be established as part of the EPRR business cyle and report to be presented ot the Board. The Trusts internal EPRR group will work with operational managers and procurement to identify business critical suppliers and look to develop the formal process for inclusion in departmental business continuity plans	AEO	30/09/2024	Board business cycle to be updated to include annual reporting of EPRR/BCP arrangements (in addition to current committee updates on a quarterly basis)
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon		• Exercising Schedule • Evidence of post exercise reports and embedding learning						
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Y	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Operational manager for the UTC is responsible for the Hazmat/CBRN processes and procedures. All relevant documentation availible via Team's channel and distributed to operational manager.	Partially Compliant	Work programme identifies separate task and finish group aligned to Hazmat/CBRN objectives	AEO/Ops	31/03/2024	
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Y	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Separate risk assessments in respect of buidling access and waste. Specific risk assessment in respect of Hazmat/CBRN response required.	Partially Compliant	Risk assessments to take place acknowledging building and training shortfall at present. Mitigating actions to be developed.	EPRR	31/03/2024	Engagement and agreement required with CHP and other buiding tenants. Potential reconfiguration of rooms required.
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Y	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Internal processes include access arrangements for specialist signposting. Contact numbers for specialist agencies held on UTC reception. IOR documentation circulated to staff.	Partially Compliant	Work programme identifies separate task and finish group aligned to Hazmat/CBRN objectives	AEO/Ops	31/03/2024	

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58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Y	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes •Plans for the management of hazardous waste •Hazmat/CBRN plans and procedures include sufficient provisions to manage the stand-down and transition from response to recovery and a return to business as usual activities •Description of process for obtaining replacement PPE/PRPS - both during a protracted incident and in the aftermath of an incident	Building plan needs to be agreed with landlord and associated tenants in respect of earmarking decontamination and isolation arrangements. Unit was designated PLACE site for recent management and treatment of Avian flu outbreak (local company managed the incineration of flocks of dead birds). Worked with ICB, UKHSA and partner organisatons to develop and implement local processes and procedures. PPE replacement processes well established. UTC needs to develop its own specific Hazmat/CBRN plan alongside landlord and other tenants within the building.	Partially Compliant	Building user group exists and will include on the agenda plans to specifically review EPRR arrangements and with particular regard to flexing building facilities to accommodate Hazmat requirements	EPRR/Estates	31/03/2024	Engagement and agreement required with CHP and other buiding tenants. Potential reconfiguration of rooms required.
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.		Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource						
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	Y	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Personal Protective Equipment stock is held for staff. EPRR Documentation is available on the Trust's TEAM's channel. Hazmat IOR and guidance held on TEAM's channel.	Partially Compliant	Work programme identifies separate task and finish group aligned to Hazmat/CBRN objectives	AEO/Ops	31/03/2024	

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61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	Y	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	All PPE equipment is stock managed. Staff are fit tested in line with guidelines. No specialist equipment is held but all routine equipment is serviced as per manufacturer guidelines.	Partially Compliant	Work programme identifies separate task and finish group aligned to Hazmat/CBRN objectives	AEO/Ops	31/03/2024	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans		Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53						
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Y	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	TNA established for all on call members. Operational staff witihn the unit do not have identified specific training. No specific risk assessment.	Non Compliant	Training schedule to be delveloped in line with clinical guidelines. Job descriptions to be reviewed	EPRR/UTC Manager	31/12/2023	
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Y	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	TNA established for all on call members. Operational staff witihn the unit do not have identified specific training.	Non Compliant	Training schedule to be delveloped in line with clinical guidelines. Job descriptions to be reviewed	EPRR/UTC Manager	31/12/2023	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Y	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	All applicable staff fit tested and masks held in stock, alongside other PPE equipment.	Partially Compliant	Work programme identifies separate task and finish group aligned to Hazmat/CBRN objectives	AEO/Ops	31/03/2024	

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66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Y	<u>Evidence</u> • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Avian flu outbreak and response alongside partner agencies including ICB, UKHSA and acute hospital. Specific Hazmat/CBRN training required. Review meetings held with partner agencies and processes updated. Initial response communicated via ICB EPRR into Trust's EPRR manager.	Partially Compliant	Work programme identifies separate task and finish group aligned to Hazmat/CBRN objectives	AEO/Ops	31/03/2024	
67	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response. The support provided by NHS Ambulance Services must include, as a minimum, a biennial (once every two years) CBRN/HazMat capability review of the hospitals including decontamination capability and the provision of training support in accordance with the provisions set out in these core standards.		Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).				
68	**CBRN Support to acute Trusts**	**Capability Review**	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.						
69	**CBRN Support to acute Trusts**	**Capability Review Frequency**	NHS Ambulance Trusts must formally review the CBRN/HazMat capability in each designated hospital biennially (at least once every two years).		Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. Evidence of progress/close-out of actions.						
70	**CBRN Support to acute Trusts**	**Capability Review report**	Following each formal review of the capability within a designated hospital, the NHS Ambulance Trust must produce a report detailing the level of compliance against the standards set out in this document. That report must be provided to the designated hospital and the NHS England Regional EPRR Lead. Copies of all such reports must be retained by the NHS Ambulance Trust for at least 10 years and they must be made available to any inspections or audits conducted by the National Ambulance Resilience Unit (NARU) on behalf of NHS England.		Evidence of those reports and that the designated hospital and NHSE EPRR Lead are in receipt of those. Dip sample of last 10 years of reports, e.g., please provide reports from 2015, 2018, and 2022 to show adherence to the retention of reports for 10 years.						
71	**CBRN Support to acute Trusts**	**Train the trainer**	NHS Ambulance Trusts must support each designated hospital in their region with training to support the CBRN/HazMat decontamination and PRPS capability. That training will take the form of 'train the trainer' sessions so trainers based within the designated hospitals can then cascade the training to those hospital staff that require it.		Written statement as to how this is achieved, which can then be further investigated during inspection. Evidence of training records and/or a documented training schedule. Provision of suitable training documentation – syllabus, lesson plans, etc., that shows the detail of training delivered.						
72	**CBRN Support to acute Trusts**	**Aligned training**	Training provided by the NHS Ambulance Trust for this purpose must be aligned to national train the trainer packages approved by the National Ambulance Resilience Unit for CBRN/HazMat decontamination and PRPS capabilities.		NARU can provide the latest version number of associated training packages. This can then be cross-referenced against lesson plans and training packages in acute Trusts to ensure up-to-date national training is being delivered.						

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73	**CBRN Support to acute Trusts**	**Training sessions**	Provision of training sessions will be arranged jointly between the NHS Ambulance Trust and their designated hospitals. Frequency, capacity etc will be subject to local negotiation.		Clear evidence of documentation (e.g., a contract, MoU, or equivalent, that details how training is delivered to acute Trusts, how often, etc.).						

Ref	Domain	Standard	Deep Dive question	Further information	Community Service Providers	Organisational Evidence - Please provide details of arrangements in order to capture areas of good practice or further development. (Use comment column if required)	Self assessment RAG Red (not compliant) Not evidenced in	Action to be taken	Lead	Timescale	Comments
DD1	**EPRR Training**	**EPRR TNA**	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	Y	Organisational TNA incorporates Strategic, Tactical, AEO, EPRR lead and loggists.	Fully Compliant				
DD2	**EPRR Training**	**Minimum Occupational Standards**	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	Y	Organisatonal TNA mirrors the minimum occupational standards portfolio for role specific posts.	Fully Compliant				
DD3	**EPRR Training**	**EPRR staff training**	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	Y	Tactical and Strategic on call members are also responsible for local EPRR/Business Continuity planning.	Fully Compliant				
DD4	**EPRR Training**	**Senior Leadership Training**	Those within the organisation that are accountable for the oversight of EPRR arrangements are included in a TNA.	Training needs analysis roles includes AEO and any of those with delegated authority.	Y	Organisational TNA incorporates Strategic, Tactical, AEO, EPRR lead and loggists.	Fully Compliant				
DD5	**EPRR Training**	**Access to training materials**	Those identified in the organisations EPRR TNA(s) have access to appropriate courses to maintain their own competency and skills.	For example: On-call or nominated command staff have access to Principles of Health Command training. Access to UKHSA e-learning and courses offered	Y	Compendium of availible courses being developed to align to TNA requirements.	Partially Compliant	Compendium of available courses being developed to align to TNA requirements.	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
DD6	**EPRR Training**	**Training Data**	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	Y	EPD will hold training records utilising ESR and OLM functionality.	Fully Compliant				
DD7	**EPRR Training**	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Y	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropiate. EPD will manage, monitor compliance via established processes utilising ESR and OLM.	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
DD8	**EPRR Training**	**JESIP doctrine**	The Organisations delivered / commissioned EPRR training is aligned to JESIP joint doctrine	Download the Joint Doctrine - JESIP Website	Y	Organisatonal TNA mirrors the minimum occupational standards portfolio for role specific posts. Documentation is available to all staff on the on-call Teams channel. Doctrine also referenced in the Major Incident Plan.	Fully Compliant				
DD9	**EPRR Training**	**Continuous Improvement process**	In line with continuous improvement processes, the organisation has a clearly defined process for embedding learning from incidents and exercises in organisationally delivered / commissioned EPRR Training	Organisation has a process in place whereby relevant training material is reviewed following an update to EPRR plans and arrangements.	Y	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropiate	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance
DD10	**EPRR Training**	**Evaluation**	The organisations delivered / commissioned EPRR training is subject to evaluation and lessons identified from participants so as to improve future training delivery.	Evaluation data and evidence of changes based on the feedback. Feedback from peer assessment.	Y	Processes to be updated to present reports as appropiate	Partially Compliant	Processes to be updated to present reports as appropiate	AEO/EPRR/EPD	Continous process	Managed through internal EPRR group and updates via internal governance

Ref	Domain	Standard	Detail	NHS Ambulance Service Providers	Organisational Evidence	Self assessment RAG **Red (non compliant) =** Not compliant with the core standard. The organisation s EPRR work programme shows compliance will not be reached within the next 12 months. **Amber (partially compliant) =** Not compliant with core standard. However, the organisation s EPRR work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months. **Green (fully compliant) =** Fully compliant with core standard.	Action to be taken	Lead	Timescale	Comments
H1	**HART**	**HART tactical capabilities**	Organisations must maintain the following HART tactical capabilities: • Hazardous Materials (HazMat) • Chemical, Biological Radiological, Nuclear, Explosives (CBRN) • High Consequence Infectious Disease (HCID) • Marauding Terrorist Attack • Water Operations • Safe Working at Height • Confined Space • Unstable Terrain • All-Terrain Vehicle Operations • Support to Security Operations These represent both local and national capabilities that mitigate risks within the National Risk Register. They must be maintained even through periods of significant local or regional demand pressure.	Y						
H2	**HART**	**National Capability Matrices for HART**	Organisations must maintain the HART capabilities in compliance with the scope and interoperable specification defined within the National HART Capability Matrices.	Y						
H3	**HART**	**Compliance with National Standard Operating Procedures**	Organisations must ensure that HART units and their personnel remain compliant with the National Standard Operating Procedures (SOPs) during local and national deployments. It is the personal responsibility for each member of HART staff to access and know the content of the National Standard Operating Procedures (SOPs)	Y						
H4	**HART**	**Staff competence**	Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies.	Y						
H5	**HART**	**Protected training hours**	l Training Information Sheets for HART. Organisations must ensure that operational HART personnel maintain the minimum levels of competence defined in the National HART Training Information Sheets, and corresponding sub-competencies. 1 – 4 H5 H5 Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). Organisations must ensure that all operational HART personnel are provided with no less than 37.5 hours of protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven-week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven-week period). If HART staff are given additional local skills and training requirements outside of the scope defined within the National HART Matrices, that local training must be provided in addition to the 37.5 hours protected for core HART training.	Y						
H6	**HART**	**Training records**	Organisations must ensure that comprehensive training records are maintained for each member of HART in their establishment. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets. It must also include any restrictions in practice and corresponding action plans. Individual training records must directly cross reference the National Training Information Sheets.	Y						

H7	**HART**	**Registration as Paramedics**	All operational HART personnel must be professionally registered pre-hospital clinician. This will normally be an NHS paramedic, but this standard does not preclude the use of other NHS clinical professionals providing the Trust ensures the individuals have an appropriate level of pre-hospital experience and training. To ensure the appropriate clinical standard of care is maintained in accordance with the original DHSC mandate, the expectation is that the clinical level will be equivalent to or exceeding that of an NHS Paramedic.	Y						
H8	**HART**	**Six operational HART staff on duty**	Organisations must maintain a minimum of six operational HART staff on duty, per unit, at all times (24/7)	Y						
H9	**HART**	**Completion of Physical Competency Assessment**	All HART applicants must be recruited in accordance with the minimum requirements set out in the national HART recruitment and selection manual. Local recruitment provisions can be added to this mandatory minimum as required by NHS Ambulance Trusts.	Y						
H10	**HART**	**Mandatory six month completion of Physical Competency Assessment**	All operational HART staff must undertake an ongoing Physical Competency Assessment (PCA) to the nationally specified standard every 6 months. Failure to achieve the required standard during these assessments must result in the individual being placed on restricted practice until they achieve the required standard. The Trust must then implement appropriate support for individuals on a restriction of practice.	Y						
H11	**HART**	**Returned to duty Physical Competency Assessment**	Any HART staff returning to work after a period of absence which exceeds 7 weeks must be subject to a formal review to ensure they receive sufficient catch up training and to ensure they are sufficiently fit (evidenced through the successful completion of a Physical Competency Assessment) and competent to continue with HART operational activity. It is the responsibility of the employing Trust to manage this process.	Y						
H12	**HART**	**Effective deployment policy**	Organisations must maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	Y						
H13	**HART**	**Identification appropriate incidents / patients**	Organisations must maintain an effective process to identify incidents or individual patients, at the point of receiving a 999 call, that may benefit from the deployment of HART capabilities. Organisations must also have systems in place to ensure unreasonable delays in HART deployments are avoided.	Y						
H14	**HART**	**Notification of changes to capability delivery**	In any event that the organisation is unable to maintain the HART capabilities safely or if consideration is being given to locally reconfigure HART to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the HART capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y						
H15	**HART**	**Recording resource levels**	Organisations must record HART resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily at shift change over even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where HART staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y						
H16	**HART**	**Record of compliance with response time standards**	Organisations must monitor and maintain accurate local records of their level of compliance with all HART core standards defined in this document. That must include accurate records of compliance with staffing levels and responses time standards for every HART deployment. Organisations must comply and fully engage with any audits or inspections of the HART capabilities that are commissioned by NHS England. Compliance records must be made available for annual audits or inspections conducted by NHS England or NARU and must be made available to NHS commissioners or regulators on their request.	Y						

H17	**HART**	**Local risk assessments**	Organisations must maintain a set of local specific HART risk assessments which supplement the national HART risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation must also ensure there is a local process to determine how HART staff should conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
H18	**HART**	**Lessons identified reporting**	Organisations must have a robust and timely process to report any lessons identified following a HART deployment or training activity that may affect the interoperable service to NARU within 12 weeks using a nationally approved lessons database.	Y						
H19	**HART**	**Safety reporting**	Organisations must have a robust and timely written process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 24 hours of the risk being identified.	Y						
H20	**HART**	**Receipt and confirmation of safety notifications**	Organisations must have a written process to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU or other relevant national body within 2 days of the notification being issued.	Y						
H21	**HART**	**Change Request Process**	Organisations must use the NARU coordinated Change Request Process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.	Y						
H22	**HART**	**Initial deployment requirement**	Four HART personnel must be available or released and mobilised to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. This standard does not apply to pre-planned operations. The standard will not apply if the nearest HART unit is already deployed dealing with a higher priority incident requiring HART capabilities. If the HART team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						
H23	**HART**	**Additional deployment requirement**	Once a HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that six HART personnel are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. Confirmation of this requirement would usually come from; the HART Team Leader based on information from the call, one of the four HART Operatives already mobilised or from other emergency service personnel (including Ambulance personnel) in attendance at the scene. Delays in the deployment of all six HART staff could create a direct risk to the application of a safe system of work at the scene.	Y						
H24	**HART**	**Attendance at strategic sites of interest**	Organisations maintain a HART service capable of placing six HART personnel on scene at strategic sites of interest within 45 minutes. These sites were initially determined through the Model Response Doctrine which led to the strategic placement of HART units. The 45 minute standard is therefore primarily associated with key transport infrastructure and densely populated areas. Where a Trust through their LRF have identified additional strategic sites of interest which may be beyond a 45 minute HART response, the Trust must have local multi-agency plans to act as a contingency for a potentially delayed HART response. A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region. If the HART Team is already deployed on an incident requiring specialist HART capabilities, the Trust must take steps to mobilise another HART team to the new incident (either from within its own geography or via national mutual aid) within 15 minutes of that call being received by the Trust.	Y						

H25	**HART**	**HART Mutual aid**	Organisations must ensure that their 'on duty' HART personnel and HART assets maintain a 30-minute notice to move to anywhere in the United Kingdom following a mutual aid request endorsed by NHS England or NARU. Trusts can also maintain the 30-minute notice to move by way of a recall to duty or on-call process (i.e. where members of the on-duty team are unable to deploy due to child care or personal commitments at the time of the notification). A delayed response will not breach this standard if the nearest live HART team is already deployed at an incident requiring specialist HART capabilities within the same region	Y							
H26	**HART**	**Capital depreciation and revenue replacement schemes**	Organisations must ensure appropriate capital depreciation and revenue replacement schemes are maintained locally to replace nationally specified HART equipment. This must include maintaining capital provisions of at least £1.9 million depreciated over 5 years to maintain the HART fleet and incident ground equipment. Internal HART budgets and expenditure must be in accordance with the reference costs set nationally for HART units. Given that the HART capabilities are national as well as local, HART funding provision must not be reallocated internally away from HART within the express permission of NHS England (the National EPRR team).	Y							
H27	**HART**	**Interoperable equipment**	Organisations must procure and maintain minimum levels of interoperable equipment specified in National Equipment Data Sheets. To maintain minimum levels of interoperability, national interoperable equipment that has not be specified within National Equipment Data Sheets should not be utilised as part of the HART capabilities.	Y							
H28	**HART**	**Equipment procurement via national buying frameworks**	Organisations must procure interoperable equipment using the national buying frameworks (where applicable) coordinated by NARU unless they can provide assurance that the local procurement is interoperable and meets the requirements of the National Equipment Data Sheets. Any locally procured equipment that does not have a National Equipment Data Sheet which has been procured locally to support the delivery of training, sits outside of the national safe system of work. Trusts must ensure that they have local risk assessments and governance provisions in place to manage the use of such equipment. Any such equipment must not be deployed at incidents in support of HART capabilities.	Y							
H29	**HART**	**Fleet compliance with national specification**	Organisations must ensure that the HART fleet and associated incident ground technology remain compliant with the national specification. Nationally specified vehicles must conform to the national loading lists for each vehicle and the vehicles state of readiness must be updated on the national monitor systems. This will include national location tracking.	Y							
H30	**HART**	**Equipment maintenance**	Organisations must ensure that all HART equipment is maintained according to applicable standards and in line with manufacturers recommendations. This will include standards specified in the National Equipment Data Sheets and relevant associated BS or EN related standards (or equivalent).	Y							
H31	**HART**	**Equipment asset register**	Organisations maintain an asset register of all HART equipment. Such assets are defined by their reference or inclusion within the Capability Matrix and National Equipment Data Sheets. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y							
H32	**HART**	**Capital estate provision**	Organisations must maintain suitable estate provision for each HART unit which complies with the national estate specification as a minimum.	Y							
S1	**SORT**	**Maintenance of national specified MTFA capability**	NHS Ambulance Trusts must maintain a combined MTA (Marauding Terrorist Attack) and CBRN (Chemical Biological Radiological Nuclear) capability in accordance with national specifications. These capabilities operate in support of Hazardous Area Response Team deployments when required.	Y							
S2	**SORT**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain compliant with the national safe system of work specified by the National Ambulance Resilience Unit (NARU).	Y							

S3	**SORT**	**Interoperability**	NHS Ambulance Trusts must ensure that the SORT capabilities (MTA and CBRN) remain nationally interoperable and confirm the scope of operational practice defined within national capability matrices published by NARU.	Y						
S4	**SORT**	**Access to specialist scientific advice**	Organisations have robust and effective arrangements in place to access specialist scientific advice relevant to the full range of CBRN incidents. All Commanders and NILOs / Tactical Advisors must be able to access this advice at all times (24/7).	Y						
S5	**SORT**	**SORT establishment**	NHS Ambulance Trusts must maintain a minimum establishment of 290 SORT trained staff. For compliance purposes this must be for at least 90% of the calendar year. Trusts should have 35 SORT staff on duty between the hours of 06:00 and 02:00 daily (365 days per year). Recall to duty programmes must be in addition to this on duty requirement. For compliance monitoring and reporting the following provisions apply: • Trusts will not be penalised or deemed to be non-compliant if the number of SORT staff fluctuates between 30 and 35 during any given shift. • Less than 35 but more than 25 on up to 3 occasions per month = compliant. • Less than 30 and more than 25 on more than 3 occasions in any given month = non-compliant. • Less than 25 at any time = non compliant.	Y						
S6	**SORT**	**Completion of a Physical Competency Assessment**	All active SORT staff within each NHS Ambulance Trust must successfully complete a physical competence assessment every 12 months (annually). The physical competence assessment must be conducted to the nationally specified standard (as specified by the National Ambulance Resilience Unit). 'Active' staff means staff that are undertaking operational shifts where their numbers are being included within SORT staffing level data for the Trust. SORT staff that have not successfully completed a physical competency assessment within a 12 month period must be placed on a restriction of practice. They must not respond to an incident as a SORT operative whilst on such a restriction of practice and the Trust must have robust processes in place to ensure compliance with this provision. Staff on a restriction of practice for SORT must not be counted as part of the SORT on-duty staffing levels.	Y						
S7	**SORT**	**Staff competency**	NHS Ambulance Trusts must ensure that each individual SORT member of staff remains compliant with the competency standards defined within national Training Information Sheets (TIS's) published by NARU for SORT staff and CBRN training is aligned to Skills for Health occupational standard EC25 – Decontaminate individuals affected by chemical, biological, radiological or nuclear incident. This training requirement includes providing a minimum of 7 days training (minimum of 52.5 hours) every 12 months. This training must be split into at least two separate sessions per operative per annum (it cannot be delivered in a single consecutive training session or period).	Y						
S8	**SORT**	**Training records**	NHS Ambulance Trusts must ensure that comprehensive training records are maintained for all SORT personnel in their establishment. These records must include; a record of mandated training completed aligned to the national Training Information Sheets (TISs), when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the SORT skill sets. It must also include any restrictions in practice and corresponding action plans.	Y						
S9	**SORT**	**Provision of clinical training**	NHS Ambulance Trusts are required to provide supportive training to statutory Fire and Rescue Services within their Trust geography that have a declared MTA capability. That supportive training must cover the clinical elements of the response and working jointly with Ambulance HART and SORT deployments for MTA incidents.	Y						

S10	**SORT**	**Staff training requirements**	NHS Ambulance Trusts must ensure that all frontline operational staff have received familiarisation training or briefing on how non-specialist / non-protected Ambulance responders should deal with an MTA incident. This should be included as part of annual mandatory training requirements. It is recognised that Ambulance Trusts have various staff in training or on alternate duties at any point in time. Therefore, for compliance purposes, the Trust will be deemed to be compliant with this requirement providing it can evidence that over 80% of frontline staff have received the required familiarisation training when audited or inspected.	Y						
S11	**SORT**	**Arrangements to manage staff exposure and contamination**	NHS Ambulance Trusts must ensure they have robust procedures in place to document all staff who may have become exposed or contaminated during incidents involving CBRN or hazardous materials. These procedures must include attendance at scene monitoring, exposure monitoring and post exposure management.	Y						
S12	**SORT**	**CBRN Lead trainer**	NHS Ambulance Trusts must have sufficient capacity of dedicated training or instructional staff for SORT to enable the Trusts to deliver and maintain the nationally specified training requirements each year.	Y						
S13	**SORT**	**FFP3 access**	NHS Ambulance Trusts must ensure that frontline staff who may come into contact with confirmed infectious respiratory viruses have access to FFP3 mask protection (or equivalent such as a Powered Respirator Protective Hood PRPH) and that they have been appropriately fit tested (where applicable). The specification and standards for this protection (including the Air Particulate Filtration) must comply with the provisions set out in the relevant national Equipment Data Sheet (EDS).	Y						
S14	**SORT**	**IOR training for operational staff**	NHS Ambulance Trusts must ensure that all frontline operational staff that may make contact with a contaminated patient are sufficiently trained in Initial Operational Response (IOR) principles of Remove Remove Remove. Organisations must maintain records to demonstrate how many staff are trained (and when the training occurred).	Y						
S15	**SORT**	**Effective deployment policy**	NHS Ambulance Trusts must maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the SORT capability. These procedures must be aligned to the MTA Joint Operating Principles (produced by JESIP).	Y						
S16	**SORT**	**Identification appropriate incidents / patients**	NHS Ambulance Trusts must have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of SORT personnel to an incident requiring the MTA or CBRN capability. This must include specific mechanisms to identify on-duty SORT staff and make them available to response to the incident as quickly as possible. These procedures must be aligned to relevant Joint Operating Principles (JOPs, produced by JESIP).	Y						
S17	**SORT**	**Change Management Process**	NHS Ambulance Trusts must use the national Change Management Process coordinated by NARU before reconfiguring (or changing) any SORT procedures, equipment or training that has been specified as nationally interoperable.	Y						
S18	**SORT**	**Record of compliance with response time standards**	NHS Ambulance Trusts must monitor their compliance with the SORT core standards set out in this document. The Accountable Emergency Officer in each Trust is responsible to their Board for the levels of compliance against these standards. Each NHS Ambulance Trust must maintain accurate records of their compliance with the core standards set out in this document and make those records available during annual audits or inspections commissioned by NHS England. These records should also be made available to NHS commissioners and regulators on request.	Y						

S19	**SORT**	**Notification of changes to capability delivery**	SORT is both a national and regional capability. It provides critical mitigation to risks articulated in the risk register for the United Kingdom. NHS Ambulance Trusts must not take the SORT capability offline or reconfigure it locally without first obtaining permission from the National Ambulance Resilience Unit or NHS England's national EPRR team. In the first instance, the discussion needs to be with the NARU On-Call Duty Officer. In any event that the organisation is unable to maintain the SORT capability safely or if consideration is being given to locally reconfigure SORT to support wider Ambulance operations, the organisation must notify the NARU On-Call Duty Officer and obtain national approval prior to any action being taken which may compromise the SORT capability. Written notification of any default of these core standards must also be provided to the Trust's NHS England Regional EPRR Lead and the NARU Director within 14 days of the default or breach occurring.	Y						
S20	**SORT**	**Recording resource levels**	NHS Ambulance Trusts must record SORT resource levels, along with any restrictions of practice, and deployments on the nationally specified system. Resource levels must be updated on the system at least twice daily even if the data is the same. Data recorded on the system must be in accordance with the requirements set by the National Ambulance Resilience Unit. Each Trust must have arrangements in place to ensure the required data is uploaded to the system even where SORT staff may be deployed on an incident because the system is used to continually monitor the national state of readiness against national threats and risks.	Y						
S21	**SORT**	**Local risk assessments**	NHS Ambulance Trusts must maintain a set of local specific SORT risk assessments which supplement the national SORT risk assessments. These must cover specific local training venues or local activity and pre-identified local high-risk sites. The organisation may determine what locations are considered high-risk (often in conjunction with the LRF), but the assessment must be for/or include MTA and CBRN specific risks. The organisation must also ensure there is a local process to regulate how SORT staff conduct a dynamic risk assessment at any live deployment. This should be consistent with the JESIP approach to risk assessment.	Y						
S22	**SORT**	**Lessons identified reporting**	NHS Ambulance Trusts must have a robust and timely process to report any lessons identified following a SORT deployment or training activity that may affect the interoperable service to NARU within 12 weeks using the nationally approved lessons database. Note: the 12 weeks starts from resolution of the incident.	Y						
S23	**SORT**	**Safety reporting**	NHS Ambulance Trusts have a robust and timely process to report to NARU any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the SORT service as soon as is practicable and no later than 24 hours of the risk being identified. Reports must be made using the national safety alert system managed by NARU.	Y						
S24	**SORT**	**Receipt and confirmation of safety notifications**	NHS Ambulance Trusts have a process to acknowledge and respond appropriately to any national safety notifications issued for SORT by NARU within 2 days.	Y						
S25	**CBRN**	**HAZMAT / CBRN plan**	NHS Ambulance Trusts must ensure that their major or complex incident plans include specific provisions to manage a MTA or CBRN incident. These provisions must align to the national SORT matrices and operating procedures published by NARU. All SORT staff must have access to both the Trust plans and the national safe system of work provisions (including procedures, generic risk assessments etc) published by NARU and should be familiar with their contents. These plans must also be aligned to the relevant JESIP / JOP provisions.	Y						
S26	**SORT**	**SORT Audit and inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the SORT capability that are commissioned by NHS England.	Y						
S27	**SORT**	**SORT capability funding**	NHS Ambulance Trusts must ensure that the national funding provided to support the SORT capability within Trusts is used to support the maintenance of that capability. The Trust must not redirect these funds and use them for other internal purposes within the express permission of NHS England or NARU.	Y						

S28	**SORT**	**SORT Readiness to deploy**	NHS Ambulance Trusts must ensure their SORT capability remains at a high state of readiness to deploy to MTA or CBRN related incidents between the hours of 0600 and 0200 daily. On receipt of an emergency call or notification by a partner agency of a potential incident involving CBRN or a marauding terrorist attack, NHS Ambulance Trusts must immediately identify all SORT staff on duty within their system and prepare to deploy those that are not committed or that can be made available from lower priority calls.	Y						
S29	**SORT**	**SORT response time**	Once a SORT capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations must ensure that at least 30 SORT staff are allocated to respond to the incident (or a designated holding area) within 60 minutes. This includes the SORT staff that may have already been deployed and this can include off duty staff who have made themselves available through recall to duty. Any SORT staff available to respond in less than 60 minutes, must be responded as quicky as possible. The 60 minutes is the total envelope in which a minimum of 30 SORT responders must be assigned to the incident. The NHS Ambulance Trust can use less SORT staff to resolve a smaller scale incident without breaching this standard, providing the decision is based on clear information or intelligence indicating that 30 staff would not be required due to the nature or scale of the incident. Any decision to limit the number of SORT responders sent to the incident must be approved by a Tactical or Strategic Commander and must be clearly documented. The decision will be subject to external review post incident.	Y						
S30	**SORT**	**SORT Mutual Aid**	NHS Ambulance Trusts must maintain their SORT capability at a state of readiness which is able to support a national deployment under mutual aid with reference to the national mutual aid policy. As an interoperable capability, it is nationally expected that Trusts provide SORT mutual aid when requested by NHS England, NARU or the National Ambulance Coordination Centre.	Y						
S31	**SORT**	**PPE availability**	NHS Ambulance Trusts must ensure that the nationally specified personal protective equipment is available for all operational SORT personnel and that the equipment remains compliant with the relevant national Equipment Data Sheets (EDSs).	Y						
S32	**SORT**	**Equipment procurement via national buying frameworks**	NHS Ambulance Trusts must procure SORT (MTA and CBRN) equipment specified in the SORT (MTA and CBRN) related Equipment Data Sheets and where applicable through the buying frameworks maintained by NARU. NHS Ambulance Trusts must also ensure sufficient financial provisions are in place to replace SORT equipment as specified by the relevant national Equipment Data Sheets. For MTA equipment, this should include an annual programme of rolling replacement.	Y						
S33	**SORT**	**Equipment maintenance**	All SORT equipment must be maintained in accordance with the manufacturer's recommendations and applicable national industry standards. This must include a programme of regular inspections and preventative maintenance as specified in relevant national Equipment Data Sheets.	Y						
S34	**SORT**	**SORT asset register**	NHS Ambulance Trusts must maintain an asset register of all SORT (MTA and CBRN) assets specified in the relevant national capability matrices and associated national Equipment Data Sheets. The register must include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).	Y						
S35	**SORT**	**PRPS - minimum number of suits**	NHS Ambulance Trusts must maintain the minimum number of PRPS suits specified by NHS England and NARU. These suits must remain live and fully operational. Trusts must also ensure they have a financial / revenue replacement plan in place to ensure the minimum number of suits is maintained and replaced as required by the national Equipment Data Sheets.	Y						
S36	**SORT**	**Individual / role responsible for SORT assets**	NHS Ambulance Trusts must have a named individual or role that is responsible for ensuring SORT assets are managed appropriately.	Y						

S37	**SORT**	**CBRN countermeasures**	NHS Ambulance Trusts must ensure that they make CBRN countermeasures available for use by frontline Ambulance staff. This must include distribution of countermeasures across frontline assets in accordance with the specification and requirements defined within the relevant national matrix and Equipment Data Sheets (EDSs).	Y							
S38	**SORT**	**Water supply for clinical decontamintion**	NHS Ambulance Trusts must ensure they have local or regional agreements and procedures in place to facilitate access to water supplies to carry out clinical decontamination. This may be achieved in conjunction with Fire and Rescue Services.	Y							
S39	**SORT**	**Equipment Vehicles**	Organisations must maintain a minimum of four vehicles to provide the MTA pooled equipment These vehicles should be replaced at a maximum of every 7 years. A minimum of 160 sets of pooled ballistic PPE and associated medical consumables must be available split over the organisations geographical area based on a local Trust assessment of risk.	Y							
S40	**SORT**	**Equipment vehicle readiness**	In conjunction with standards S29 and S30, MTA pooled equipment vehicles must be maintained at a high state of readiness to deploy. At least one asset must be mobilised within 15 minutes of a SORT response being confirmed as being required for an incident. Failure to rapidly mobilise the equipment on these vehicles will delay the deployment of responders at the scene.	Y							
S41	**SORT**	**Vehicle Tracking**	NHS Ambulance Trusts must ensure that vehicles used to deploy interoperable capabilities can be tracked nationally by NARU via nationally approved systems. This includes the vehicles associated with the SORT capability that are used to transport either pooled MTA equipment or CBRN resources to the scene of an incident.	Y							
M1	**MassCas**	**Mass casualty response arrangements**	NHS Ambulance Trusts must ensure they have plans and procedures in place that specifically cater for a mass casualty incident and that those provisions are aligned to the national framework or concept of operations for managing mass casualty incidents published by NHS England.	Y							
M2	**MassCas**	**Arrangements to work with NACC**	NHS Ambulance Trusts must have a procedure in place to work in conjunction with the National Ambulance Coordination Centre (NACC) in the event that national coordination is required or activated.	Y							
M3	**MassCas**	**EOC arrangements**	NHS Ambulance Trusts must have effective and tested arrangements in place to ensure their Emergency Operations Centres (or equivalent) can communicate and effectively coordinate with receiving medical facilities (including designated Acute Trusts) within the first hour of mass casualty or major incident being declared.	Y							
M4	**MassCas**	**Casualty management arrangements**	NHS Ambulance Trusts must have a Casualty Management Plan (CMP) (including patient distribution model) which has been produced in conjunction with Regional Trauma Networks and / or individual receiving facilities. These plans and arrangements must be exercised once a year. This can be by way of a table top or live exercise.	Y							
M5	**MassCas**	**Casualty Clearing Station arrangements**	NHS Ambulance Trusts must maintain a capability to establish and appropriately resource a Casualty Clearing Station or multiple Casualty Collection Points at the location in which patients can receive further assessment, stabilisation and preparation on onward transportation / evacuation.	Y							
M6	**MassCas**	**Management of non-NHS resource**	NHS Ambulance Trust plans must include provisions to access, coordinate and, where necessary, manage the following additional resources, as part of the patient distribution model: • Patient Transportation Services • Private Providers of Patient Transport Services • Voluntary Ambulance Service Providers	Y							
M7	**MassCas**	**Mass Cas Audits and Inspections**	NHS Ambulance Trusts must comply and fully engage with any audits or inspections of the mass casualties capability that are commissioned by NHS England.	Y							
M8	**MassCas**	**MCV accommodation**	NHS Ambulance Trusts must maintain the number of mass casualty vehicles assigned to them by the National Ambulance Resilience Unit. These vehicles must be maintained in compliance with the national specification and any guidance produced by NARU to ensure effective interoperability.	Y							

M9	**MassCas**	**Maintenance and insurance**	NHS Ambulance Trusts must insure, mechanically maintain and regularly run the mass casualty vehicles. Each nationally specified mass casualty vehicle must be securely accommodated undercover (garaged) when not deployed and must be maintained with an appropriate shoreline / electrical feed. The vehicle must be parked in a way that would facilitate rapid mobilisation and a high state of readiness. In the event of a mass casualty vehicle being unavailable, within 2 hours the national electronic dashboard must be updated and the NARU On Call Duty Officer informed.	Y						
M10	**MassCas**	**Mobilisation arrangements**	NHS Ambulance Trusts must maintain appropriate mobilisation arrangements for the vehicles which should include criteria to identify any incidents or events which may benefit from the deployment of the asset(s). Trusts must ensure that their mass casualty vehicle (MCV) assets maintain a 30-minute notice to move anywhere in the United Kingdom following a mutual aid request endorsed by NARU. An exception to this standard may be claimed if the MCV is already deployed at a local incident or is non operational.	Y						
M11	**MassCas**	**Mass oxygen delivery system**	NHS Ambulance Trusts must maintain the mass oxygen delivery system on the vehicles, in accordance with the manufacturers guidance (including regular servicing and maintenance).	Y						
M12	**MassCas**	**Drug and pharmaceutical stock management**	In accordance with agreements and instructions from NHS England and local Pharmacy Leads, the drugs and pharmaceuticals which form part of the minimum nationally specified stock for each MCV must be appropriately and effectively maintained by the NHS Ambulance Trust.	Y						
M13	**MassCas**	**Fleet compliance with national specification**	NHS Ambulance Trusts must ensure that the minimum contents for each MCV (specified through the national load list) are maintained on the vehicle and remain fit for operational deployment / utilisation.	Y						
M14	**MassCas**	**Compliance with safe system of work**	NHS Ambulance Trusts must ensure that each MCV is managed in accordance with national procedures and other associated national safe system of work provisions.	Y						
C1	**C2**	**Consistency with NHS England EPRR Framework**	NHS Ambulance command and control must remain consistent with the NHS England EPRR Framework and wider NHS command and control arrangements. Each NHS Ambulance Trust must comply and fully engage with any audits or inspections of the command and control capability that are commissioned by NHS England.	Y						
C2	**C2**	**Consistency with Standards for NHS Ambulance Service Command and Control.**	NHS Ambulance command and control must be conducted in a manner commensurate to the legal and professional obligations set out in the National Command and Control Guidance published by NARU.	Y						
C3	**C2**	**NARU notification process**	NHS Ambulance Trusts must notify the NARU On-Call Officer of any critical or major incidents active within their area that require the establishment of a full command structure (strategic commander down to functional roles) and utilisation of the Trusts interoperable capability assets to manage an incident. Notification should be made within the first 30 minutes of the incident whether additional resources are needed or not. In the event of a national emergency or where mutual aid is required by the NHS Ambulance Service, the National Ambulance Coordination Centre (NACC) may be established. Once established, NHS ambulance strategic commanders must ensure that their command and control processes have an effective interface with the NACC and that clear lines of communication are maintained.	Y						
C4	**C2**	**AEO governance and responsibility**	The Accountable Emergency Officer in each NHS Ambulance Trust is responsible for ensuring compliance with these core standards and the provisions set out within the National Command and Control Guidance published by NARU. NHS Ambulance Trust Boards are required to provide annual assurance against these standards.	Y						
C5	**C2**	**Command role availability**	NHS Ambulance Trusts must ensure that the command roles defined within the National Command and Control Guidance published by NARU are maintained and available at all times within their service area.	Y						
C6	**C2**	**Support role availability**	NHS Ambulance Trusts must ensure that there is sufficient resource in place to provide each command level (strategic, tactical and operational) with the dedicated support roles set out in the National Command and Control Guidance published by NARU standards at all times.	Y						

C7	**C2**	**Recruitment and selection criteria**	NHS Ambulance Trusts must ensure there is an appropriate recruitment and selection criteria for personnel fulfilling command roles (including command support roles) that promotes and maintains the levels of credibility and competence defined in these standards. No personnel should have command and control roles defined within their job descriptions without a recruitment and selection criteria that specifically assesses the skills required to discharge those command functions. Those skills and the mandatory levels of competence are defined within the National Training Information Sheets for Command and the National Occupational Standards for Command. This standard does not apply to the Functional Command Roles assigned to available personnel at a major incident.	Y						
C8	**C2**	**Contractual responsibilities of command functions**	Staff expected to discharge strategic, tactical, and operational command functions must have those responsibilities explicitly defined within their individual contracts of employment.	Y						
C9	**C2**	**Access to PPE**	The NHS Ambulance Trust must ensure that each commander and each of the support functions have access to personal protective equipment and logistics necessary to discharge their role and function. To ensure interoperability at a national incident, this must include access to tabards that are compliant with the specification defined within the National Command and Control Guidance published by NARU.	Y						
C10	**C2**	**Suitable communication systems**	The NHS Ambulance Trust must have suitable communication systems (and associated technology) to support its command and control functions. As a minimum this must support the secure exchange of voice and data between each layer of command with resilience and redundancy built in.	Y						
C11	**C2**	**Risk management**	NHS ambulance commanders must manage risk in accordance with the method prescribed in the National Command and Control Guidance published by NARU and the JESIP principles.	Y						
C12	**C2**	**Use of JESIP JDM**	NHS ambulance commanders at all levels must use the JESIP Joint Decision Model (JDM) and apply JESIP principles during emergencies where a joint command structure is established.	Y						
C13	**C2**	**Command decisions**	NHS ambulance command decisions at all three levels must be made within the context of the legal and professional obligations set out in the National Command and Control Guidance published by NARU. Tactical and operational commanders must utilise the national Standard Operating Procedures (SOPs) for command and associated safe system of work provisions.	Y						
C14	**C2**	**Retaining records**	All decision logs and records which are directly connected to a major or complex emergency must be securely stored and retained by the Ambulance Service for a minimum of 25 years.	Y						
C15	**C2**	**Decision logging**	Commanders at all three levels (strategic, tactical and operational) must have access to an appropriate system of logging their decisions which conforms to national best practice. Ambulance Trusts are under a legal, professional and contractual obligation to ensure their commanders maintain appropriate decision logs.	Y						
C16	**C2**	**Access to loggist**	Each level of command (strategic, tactical and operational) must be supported by a trained and competent loggist. A minimum of three loggists must be available to provide that support in each NHS Ambulance Service at all times. It is accepted that there may be more than one operational commander for multi-sited incidents. The minimum is three loggists but the Trust should have plans in place for additional logs to be kept by non trained loggists should the need arise.	Y						
C17	**C2**	**Lessons identified**	NHS Ambulance Trusts must ensure they maintain an appropriate system for identifying, recording, learning and sharing lessons from complex or protracted incidents in accordance with the wider EPRR core standards and that such learning is shared on the national systems produced by NARU and/or JESIP.	Y						
C18	**C2**	**Strategic commander competence - National Occupational Standards**	Personnel that discharge the strategic commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Strategic commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Strategic commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions.	Y						

C19	**C2**	**Strategic commander competence - nationally recognised course**	Personnel that discharge the strategic commander function must have successfully completed a nationally recognised strategic commander course (nationally recognised by NHS England / NARU). Individuals must not be placed on an active command rota or fulfil strategic commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C20	**C2**	**Tactical commander competence - National Occupational Standards**	Personnel that discharge the tactical commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Tactical commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Tactical commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service tactical commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to a tactical commander understanding the capabilities under their command.	Y						
C21	**C2**	**Tactical commander competence - nationally recognised course**	Personnel that discharge the tactical commander function must have successfully completed a nationally recognised tactical commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil tactical commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						
C22	**C2**	**Operational commander competence - National Occupational Standards**	Personnel that discharge the operational commander function must maintain the minimum levels of competence defined in the National Training Information Sheets, and corresponding sub-competencies, for Command and Control. Operational commanders must also ensure they maintain the standards of competence defined within the NHS England Minimum Occupational Standards for EPRR. Operational commanders must ensure they are fully aware of the provisions in the National Command and Control Guidance published by NARU including the specific requirements of commanders and command functions. Ambulance service operational commanders must have a good professional understanding of each interoperable capability and the tactical options available from these capabilities. They should not be reliant on tactical advisors or NILOs for this level of knowledge. Advisors provide highly technical or specialist advice but that should not be a substitute to an operational commander understanding the capabilities under their command.	Y						
C23	**C2**	**Operational commander competence - nationally recognised course**	Personnel that discharge the operational commander function must have successfully completed a nationally recognised operational commander course (nationally recognised by NHS England / NARU). Courses may be run nationally or locally but they must be recognised by NARU as being of a sufficient interoperable standard. Local courses should also cover specific regional risks and response arrangements. Individuals must not be placed on an active command rota or fulfil operational commander functions unless or until they can demonstrate the appropriate minimum level of qualification for that specific role as defined within the National Training Information Sheets.	Y						

C24	**C2**	**Commanders - maintenance of CPD**	All strategic, tactical and operational commanders must maintain appropriate Continued Professional Development (CPD). This CPD must be aligned to the relevant National Training Information Sheet for Command and the NHS England Minimum Occupational Standards for EPRR. The core competency requirements defined within the relevant Training Information Sheet must be specifically referenced within the CPD portfolio maintained by the individual commander. Individual CPD portfolios must demonstrate sufficient maintenance of skill and competence against the minimum requirements for the role.	Y						
C25	**C2**	**Commanders - exercise attendance**	All strategic, tactical and operational commanders must refresh their skills and competence by discharging their command role as a 'player' at a training exercise every 18 months. Attendance at these exercises will form part of the mandatory Continued Professional Development requirement and evidence must be included in the form of documented reflective practice for each exercise. Acceptable exercises can include the smaller scale exercises run by HART teams as part of their regular training or they can include larger multiagency exercises, including table top exercises. The requirement to attend an exercise in any 18 month period can be negated by discharging the individuals specific command role at a relevant live incident providing documented reflective practice is completed post incident. Relevant live incidents are those where the commander has discharged duties in their command role as part of the incident response, such as delivering briefings, use of the JDM, making decisions appropriate to their command role, deployed staff, assets or material, etc. Failure to demonstrate and document these command functions at an exercise or live incident within an 18 month period must result in the individual being immediately suspended from their command duties until such time as they are able to fulfil this mandatory competency requirement.	Y						
C26	**C2**	**Training and CDP - suspension of non-compliant commanders**	Any ambulance service strategic, tactical or operational commander that has not maintained the competency requirements specified in the National Training Information Sheet applicable to their role, or that has not maintained the relevant continued professional development (CPD) obligations, must be immediately suspended from their command duties. They must be removed from any active command rota and must not discharge their command functions at an incident until such time as the minimum level of mandated competence can be fully demonstrated.	Y						
C27	**C2**	**Assessment of commander competence and CDP evidence**	Each NHS Ambulance Trust must have a process in place to check and verify that strategic, tactical and operational commanders are maintaining appropriate levels of CPD evidence and that they are maintaining the minimum levels of competence defined within the National Training Information Sheets. As a minimum, this must include obtaining an annual signed declaration from all active commanders that they understand the obligations defined within these core standards and that they have maintained the minimum levels of competence and CPD defined within the relevant National Training Information Sheet. Further to these annual declarations, each Ambulance Trust must undertake 'dip sampling' of multiple CPD portfolios from the strategic, tactical and operational command levels to verify the declarations being made. This assessment of randomly selected CPD portfolios should be undertaken by a suitably competent person, such as an Emergency Preparedness professional. The Accountable Emergency Officer in each Ambulance Trust is responsible for ensuring that any commander at any level who has not been able to maintain the minimum competency requirements is immediately suspended from discharging command functions at an incident.	Y						
C28	**C2**	**NILO / Tactical Advisor - training**	Personnel that discharge a NILO or Tactical Advisor function must have completed a nationally recognised NILO or Tactical Advisor course (nationally recognised by NHS England / NARU).	Y						

C29	**C2**	**NILO / Tactical Advisor - CPD**	Personnel that discharge the NILO or tactical advisor function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to date competence in the NILO or tactical advisor discipline.	Y						
C30	**C2**	**Loggist - training**	Personnel that discharge the loggist function must have completed a loggist training course which covers the elements and requirements defined by the National Ambulance Service Command and Control Guidance published by NARU.	Y						
C31	**C2**	**Loggist - CPD**	Personnel that discharge the loggist function must maintain an appropriate continued professional development portfolio to demonstrate their continued professional creditability and up-to-date competence in the discipline of logging.	Y						
C32	**C2**	**Availability of Strategic Medical Advisor, Medical Advisor and Forward Doctor**	The medical director of each NHS ambulance service is responsible for ensuring that the strategic medical advisor, medical advisor and forward doctor roles are available at all times and that the personnel occupying these roles are credible and competent (guidance provided in the National Ambulance Service Command and Control Guidance published by NARU).	Y						
C33	**C2**	**Medical Advisor of Forward Doctor - exercise attendance**	Personnel that discharge the medical advisor or forward doctor roles must refresh their skills and competence by discharging their support role as a 'player' at a training exercise involving ambulance service interoperable capabilities every 18 months. Attendance at these exercises will form part of mandatory continued professional development and evidence must be included in the form of documented reflective practice for each exercise	Y						
C34	**C2**	**Commanders and NILO / Tactical Advisors - familiarity with the Joint Operating Procedures**	Commanders (strategic, tactical and operational) and the NILO and tactical advisors must ensure they are fully conversant with all Joint Operating Principles published by JESIP and that they remain competent to discharge their responsibilities in compliance with these principles	Y						
C35	**C2**	**Control room familiarisation with capabilities**	Control starts with receipt of the first emergency call, therefore emergency control room supervisors (or equivalent) must be aware of the ambulance service's operational capabilities, including the interoperable capabilities, and the implications of utilising them. Control room supervisors must have a working knowledge of major incident procedures and the National Command and Control Guidance published by NARU to enable the initial steps to be taken (e.g. notifying the Trust command structure, wider alerting mechanisms, following action cards etc.)	Y						
C36	**C2**	**Responders awareness of NARU major incident action cards**	Front line ambulance responders will often be, by default, the interim first commander at scene. So, all frontline operational ambulance staff must be aware of basic major incident principles, including their Trust's major incident plan and the need to follow major incident action cards. They must all have access to such cards. All frontline operational ambulance staff must be sufficiently competent to provide accurate information back to the control room and take the initial steps detailed on relevant major incident action cards safely and effectively.	Y						
J1	**JESIP**	**Incorporation of JESIP doctrine**	The JESIP doctrine must be incorporated into all organisational policies, plans and procedures relevant to a multi-agency emergency response within NHS Ambulance Trusts.	Y						
J2	**JESIP**	**Operations procedures commensurate with Doctrine**	All NHS Ambulance Trust operational procedures must be interpreted and applied in a manner commensurate to the Joint Doctrine.	Y						
J3	**JESIP**	**Review process**	All NHS Ambulance Trusts must have a timed review process for all procedures covering major or complex incidents to ensure they remain current and consistent with the latest version of the JESIP Joint Doctrine	Y						
J4	**JESIP**	**Access to JESIP products, tools and guidance**	All NHS Ambulance Trusts must ensure that commanders and command support staff have access to the latest JESIP products, tools and guidance.	Y						
J5	**JESIP**	**Awareness of JESIP - Responders**	All relevant front-line NHS ambulance responders attain and maintain a basic knowledge and understanding of JESIP to enhance their ability to respond effectively upon arrival as the first personnel on-scene.	Y						
J6	**JESIP**	**Awareness of JESIP - control room staff**	NHS ambulance control room staff (dispatchers and managers) attain and maintain knowledge and understanding of JESIP to enhance their ability to manage calls and coordinate assets.	Y						
J7	**JESIP**	**Training records - staff requiring training**	NHS ambulance service providers must identify and maintain records of staff in the organisation who may require training or awareness of JESIP, what training they require and when they receive it.	Y						

J8	**JESIP**	**Command function - interoperability command course**	All staff required to perform a command role must have attended a one day, JESIP approved, interoperability command course.	Y						
J9	**JESIP**	**Training records - annual refresh**	All those who perform a command role should annually refresh their awareness of JESIP principles, use of the JDM and METHANE models by either the JESIP e learning products or another locally based solution which meets the minimum learning outcomes. Records of compliance with this refresher requirement must be kept by the organisation.	Y						
J10	**JESIP**	**Commanders - interoperability command course**	All active commanders (strategic, tactical and operational) are required to ensure that JESIP forms part of their ongoing continued professional development portfolios and evidence. This must include reflective practice that includes specific JESIP principles from an exercise or live incident every 18 months.	Y						
J11	**JESIP**	**Participation in multiagency exercise**	At least every three years, all NHS ambulance commanders (at strategic, tactical and operational levels) must participate as a player in a joint exercise with at least Police and Fire Service command players where JESIP principles are applied.	Y						
J12	**JESIP**	**Induction training**	All NHS Ambulance Trusts must ensure that JESIP forms part of the initial training or induction of all new operational staff.	Y						
J13	**JESIP**	**Training records - 90% operational and control room staff are familiar with JESIP**	All NHS Ambulance Trusts must maintain records and evidence which demonstrates that at least 90% of operational staff (that respond to emergency calls) and control room staff (that dispatch calls and manage communications with crews) are familiar with the JESIP principles and can construct a M/ETHANE message.	Y						

Action Plan				Overall Assessment	Non-Compliant					
Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RAG	Action to be taken	Lead	Timescale	Comments

Over arching changes:	Domain 10 - CBRN renamed to Domain 10 - HazMat/CBRN Domain 10 standards reordered amd renumbered

Previous standard detail					New standard detail			
Ref	Doma n	Standard	Deta	2023 Changes	Ref	Domain	Standard name	Standard Detail
Domain 1 - Governance								
1	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	No change	**1**	**Governance**	**Senior Leadership**	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.
2	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	No change	**2**	**Governance**	**EPRR Policy**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	No change	**3**	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	No change	**4**	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	No change	**5**	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.
6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	No change	**6**	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.
Domain 2 - Duty to risk assess								
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	No change	**7**	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	No change	**8**	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally
Domain 3 - Duty to maintain plans								
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders to ensure the whole patient pathway is considered.	Standard detail has been updated to emphasise the importance of joint working and collaborative planning with emergency services and health partners following lesson identified through JOL working group.	**9**	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	No change	**10**	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	No change	**11**	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	No change	**13**	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic
12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	No change	**12**	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	No change	**14**	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment
15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	No change	**15**	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	No change	**16**	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	No change	**17**	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	No change	**18**	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	No change	**19**	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.
Domain 4 - Command and control								
20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.	No change	**20**	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanism and structures to enable 24/7 receipt and action of incident notifications, internal or external, and this should provide the facility to respond to or escalate notifications to an executive level.
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	No change	**21**	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions
Domain 5 - Training and exercising								

22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	No change	22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	No change	23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements in line with guidance the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)
24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	No change	24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role
25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	No change	25	Training and exercising	Staff Awareness and Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.
Domain 6 - Response								
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	No change	26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	No change	27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	No change	28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	No change	29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	No change	30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	No change	31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	No change	32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)
Domain 7 - Warning and informing								
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	No change	33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	No change	34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	No change	35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	No change	36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media
Domain 8 - Cooperation								
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.	No change	37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with Delegated Authority to authorise plans and commit resources on behalf of their organisation, attends Local Health Resilience Partnership (LHRP) meetings.
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	No change	38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	No change	39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.
40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	No change	40	Cooperation	Arrangements for multi-area response	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.
41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	No change	41	Cooperation	Health tripartite working	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.
42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	No change	42	Cooperation	LHRP Secretariat	The organisation has arrangements are in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.

43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.	No change	**43**	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information with stakeholders and partners, during incidents.
Domain 9 - Business Continuity								
44	**Business Continuity**	**Business Continuity (BC) policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	No change	**44**	**Business Continuity**	**Business Continuity (BC) policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	No change	**45**	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	No change	**46**	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
47	**Business Continuity**	**Data Protection and Security Toolkit (DPST)**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	No change	**47**	**Business Continuity**	**Data Protection and Security Toolkit (DPST)**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.
48	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	No change	**48**	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure
49	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	No change	**49**	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	No change	**50**	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	No change	**51**	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.
52	**Business Continuity**	**BCMS continuous improvement process**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	No change	**52**	**Business Continuity**	**BCMS continuous improvement process**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.	No change	**53**	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements work with their own.
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	No change	**54**	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon
Domain 10 - HazMat/CBRN								
				New Standard	**56**	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented
55	**CBRN**	**Telephony advice for CBRN exposure**	Key clinical staff have access to telephone advice for managing patients involved in CBRN incidents.	Amended wording of standard so not specific to telephony advice.	**58**	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents
56	**CBRN**	**HAZMAT / CBRN planning arrangement**	There are documented organisation specific HAZMAT/ CBRN response arrangements.	Standard detail amended to include specific elements of Hazmat/CBRN plan	**59**	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders
57	**CBRN**	**HAZMAT / CBRN risk assessments**	HAZMAT/ CBRN decontamination risk assessments are in place appropriate to the organisation. This includes: • Documented systems of work • List of required competencies • Arrangements for the management of hazardous waste.	Standard detail amended and supporting information developed with evidence of risk assessments.	**57**	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type
58	**CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate decontamination capability to manage self presenting patients (minimum four patients per hour), 24 hours a day, 7 days a week.	Standard detail amended to incroporate wet, dry, interim and improvised decontamination where necessary and availbilty of staff.	**60**	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be deployed within 30 mins to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s)
59	**CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/ourwork/eprr/hm/ • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Standard detail amended to reflect need to ensure equipment is in line with organisational Hazmat/CBRN risk assessments	**61**	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf
60	**CBRN**	**PRPS availability**	The organisation has the expected number of PRPS (sealed and in date) available for immediate deployment. There is a plan and finance in place to revalidate (extend) or replace suits that are reaching their expiration date.	Standards merged.	**66**		**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availble for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7
68	**CBRN**	**FFP3 access**	Organisations must ensure staff who may come into contact with confirmed infectious respiratory viruses have access to, and are trained to use, FFP3 mask protection (or equivalent) 24/7.					

61	**CBRN**	**Equipment checks**	There are routine checks carried out on the decontamination equipment including: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other decontamination equipment. There is a named individual responsible for completing these checks	Standards merged.	**62**	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes
62	**CBRN**	**Equipment Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date decontamination equipment for: • PRPS Suits • Decontamination structures • Disrobe and rerobe structures • Shower tray pump • RAM GENE (radiation monitor) • Other equipment					
63	**CBRN**	**PPE disposal arrangements**	There are effective disposal arrangements in place for PPE no longer required, as indicated by manufacturer / supplier guidance.	Standard detail amended to reflect need to ensure the organisation has processes in place to manage waste, including but not limited to PPE.	**63**	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans
64	**CBRN**	**HAZMAT / CBRN training lead**	The current HAZMAT/ CBRN Decontamination training lead is appropriately trained to deliver HAZMAT/ CBRN training	Hazmat/CBRN Training standards have been consolidated from four into two standards	**64**	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments
65	**CBRN**	**Training programme**	Internal training is based upon current good practice and uses material that has been supplied as appropriate. Training programmes should include training for PPE and decontamination.					
66	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		**65**	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles of 'Remove, Remove, Remove' and isolation when necessary. (This includes /but is not limited to\ acute. community.
67	**CBRN**	**Staff training - decontamination**	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.					
				New standard	**67**	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme
					68	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access specialist scientific advice relating to CBRN/HazMat incident response.

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 December 2023**
Agenda Item	**86/23i**		
Report Title	**FINANCE REPORT – MONTH SEVEN (OCTOBER 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 seven:

- The Trust is reporting a breakeven position, in line with the 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 £2.90m against a plan of £3.00m.
- Income is £58.31m for the year-to-date against a plan of £57.39m.
- Expenditure is £58.31m against a plan of £57.39m.
- Pay is £36.93m against a plan of £36.84m.
- Agency spend is £3.40m against a plan of £3.04m.
- Non pay expenditure is £17.92m against a plan of £17.33m.
- Capital charges are £0.13m below plan.
- Capital expenditure is £0.43m at month seven, planned spend is £0.98m.
- Cash is £17.72m

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**	**07 December 2023**
Agenda Item	**86/23i**		
Report Title	**FINANCE REPORT MONTH SEVEN (OCTOBER 2023)**		
Report Author	Rachel Hurst – Deputy Director of Finance		
Purpose	To brief the Board on the financial position as at Month Seven		

1. SCOPE

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

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

2. FINANCIAL POSITION AS AT MONTH SEVEN

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

2.2 The purpose of this paper is to update the Committee on the financial position of the Trust at the end of October 2023 (Month 07).

2.3 The Trust was given the opportunity to revise the 2023/24 Plan during month five, recognising the additional income and expenditure associated with the pay award. Some other minor changes were also made to adjust the plan, reflecting the year to date performance and amending the plan profiles accordingly.

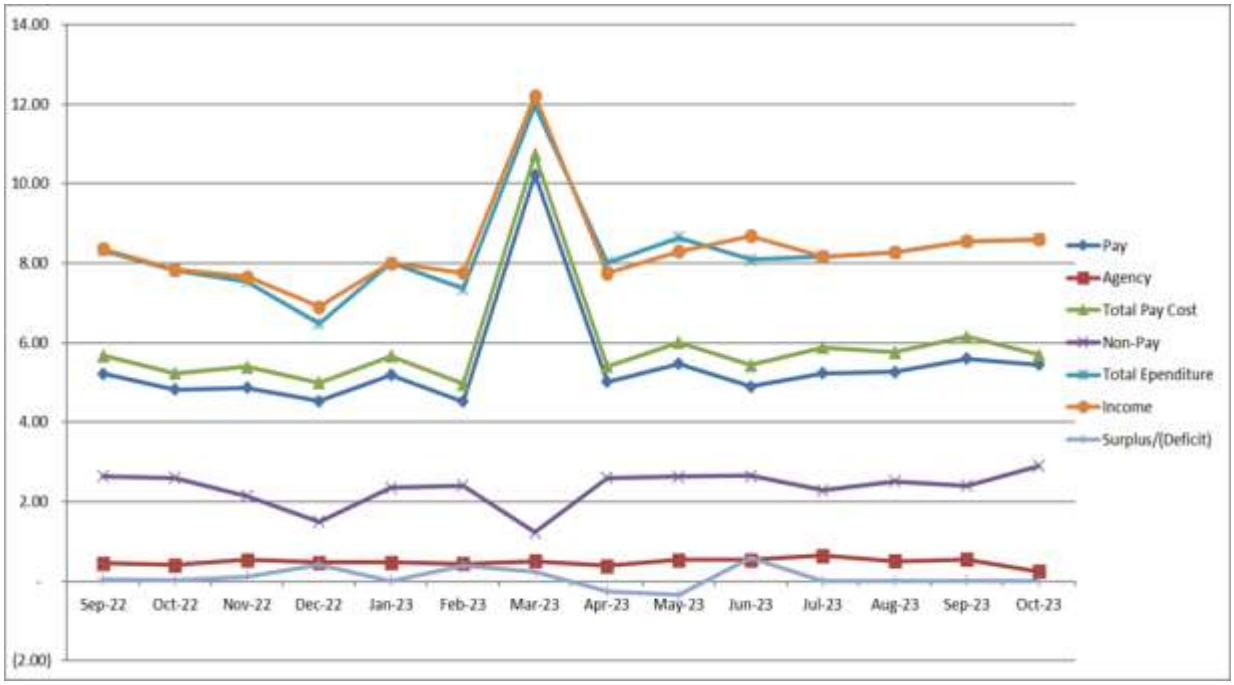
2.4 No change has been made to the overall breakeven planned position. All references in this report will be to the updated plan.

Table 1 – Summary of financial performance

Summary Performance Month 07 2023-24	Month 7 Plan (£M)	Month 7 Actual (£M)	Month 7 Variance (£M)	YTD Plan (£M)	YTD Actual (£M)	YTD Variance (£M)	Full Year Plan (£M)	Forecast Outturn M12 (£M)
Income	(8.11)	(8.59)	0.48	(57.39)	(58.31)	0.92	(97.94)	(99.43)
Expenditure - Pay	5.46	5.45	0.01	36.84	36.93	(0.09)	64.15	64.15
Expenditure - Agency	0.24	0.25	(0.01)	3.04	3.40	(0.37)	4.22	4.22
Expenditure - Non Pay	2.39	2.88	(0.49)	17.33	17.92	(0.59)	29.26	30.82
EBITDA	(0.03)	(0.02)	(0.01)	(0.19)	(0.06)	(0.12)	(0.31)	(0.24)
Financing	0.03	0.02	0.01	0.18	0.05	0.13	0.31	0.24
Normalised (Surplus)/Deficit	(0.00)	(0.00)	(0.00)	(0.01)	(0.01)	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)	(0.00)	(0.00)	(0.01)	(0.01)	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)	(0.00)	(0.00)	(0.01)	(0.01)	0.00	0.00	0.00
CIP	0.43	0.45	0.02	3.00	2.90	(0.10)	5.15	5.15
Capital	0.23	0.08	0.16	0.98	0.43	0.55	2.10	2.10
Cash	24.94	17.72	(7.22)	24.94	17.72	(7.22)	24.66	22.36
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



2.5 The Trust is reporting a break even position at month seven in line with plan.

Income

- Income was above plan by £0.48m in month, primarily due to additional pay award funding received relating to the Dental contracts.

Pay

- Pay costs are below plan by £0.01m in month seven.

Agency

During month seven, the Trust has incurred costs of £0.25m against the plan of £0.24m. The planned reductions in the second half of the year are now starting to take effect.

The month-on-month expenditure has decreased by £0.30m. (See Appendix 1 for details).

The full year plan and forecast remains at £4.22m. Each directorate has a recovery plan to achieve the plan position by year end.

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

- Dermatology – locum consultants. This is activity driven and locum usage was front loaded to reduce waiters – the service now has no over 40 week waiters.
- Halton District Nursing – high cost off framework agency use is now reducing, spend is mainly GRI covering 14 WTE vacancies.
- Warrington Community Paediatrics – locum consultants. This is activity driven to prevent waiting lists from increasing and is partially funded by the ICB as part of the Neuro Developmental pathway.
- Intermediate Care Bed Based (Padgate House) – high cost off framework agency use is vastly reduced.

The Director of Finance has met with all Directorate Leadership Teams (DLT) and corporate service budget managers to discuss individual service agency usage and reduction targets for all areas.

Detailed agency reduction plans from all services currently utilising agency staff have been presented to EMT and will be monitored by them over the remainder of the year.

Initial plans reduce the forecast full year spend by c£1m, with an additional reduction of £0.5m required to meet the planned agency spend.

All vacancies currently covered by agency staff are in the process of being critically reviewed and recruitment treated as a priority.

EMT have instructed that all existing off framework agency usage was to be ceased from 1 October (ensuring clinical safety is maintained) with, in the absence of recruitment to existing vacancies, the utilisation of bank and on framework agency as the only short term solution.

Working with operational staff, work is ongoing increasing the number of staff registered with and available on the Trust bank.

All future off framework agency requests will require formal Executive approval prior to engagement.

- Agency costs incurred in month seven equated to 44.29 whole time equivalent staff.

The table below shows agency spend by Directorate/Borough on a YTD basis, forecast outturn and a revised forecast outturn based on the planned agency cap.

Area	Sum of YTD Actual £k	Sum of Forecast £k	Revised Agency Cap Forecast £k
Childrens	343.84	538.34	485.14
Corporate	162.02	226.02	203.60
Dental	70.43	87.43	78.79
Halton	763.21	1,041.21	937.96
Warrington	2,062.69	2,794.19	2,517.11
Grand Total	**3,402.20**	**4,687.20**	**4,222.61**

Non Pay

During month seven the Trust has spent £2.88m on non pay, £0.49m above plan.

The underlying (adjusted for the cumulative reprofiling impact) 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.

2.6 Adjusting for one off working capital adjustments and the pay award impact, all month seven run rates are consistent with expectations and previous year comparators (see table 2 above).

3. COST IMPROVEMENT PROGRAMME (CIP)

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

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 seven is £3.00m, against which achievement of £2.90m is reported.

3.5 The Director of Finance has met with Directorate Leadership Teams to discuss the current planned CIP schemes and opportunities to support identification and delivery of additional savings in year. CIP recovery plans have been presented to EMT and subject to the internal governance processes, should deliver a significant increase in recurrent CIP.

3.6 Further detail is provided in the table below:

CIP / Savings Analysis

Category	M7 £k	Recurrent £k	Non Recurrent £k
Income	1,157	474	683
Pay	1,348	259	1,089
Non Pay	396	296	100
Total	**2,901**	**1,029**	**1,872**

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. As at month seven, the ICS is reporting an adverse variance from plan of £176m.The ICS has requested recovery plans from all places, and individual providers reporting adverse variances from plan are subject to recovery meetings.

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

5.1 Total capital expenditure as at 31st October was £0.43m against a plan of £0.98m.

5.2 The proposed capital programme includes a contingency of £0.32m which consists of £0.10m general contingency and £0.22m 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.

5.3 Procurement is now progressing orders in conjunction with services.

5.4 In October 2023 there was a net cash outflow of £1.00m with a closing cash balance of £17.72m.

5.5 The outflow has arisen due to (i) increased payments to Community Health Partnerships for property leases following a full account reconciliation which led to aged balances being paid; and (ii) increased tax, national insurance and pension contributions paid following the consultant's pay deal finalised in September 2023.

5.6 Total debt as at 31st October is £10.20m after allowing for the bad debt provisions, of which £7.18m relates to invoiced debt. Overall debt has increased by £1.82m from September and overdue debt has increased by £0.22m.

5.7 The primary reason for the increase is the debtor balance with Warrington Borough Council which comprises seven months invoices for Intermediate Care (totalling £1.52m) which were raised in October (following the agreement of the contract value with the Council) and remained unpaid at month end.

5.8 Total trade and other payables as at 31st October are £9.84m, of which £5.11m relates to creditors.

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

Month	Target to be paid %	No of Invoices %	Value of Invoices %
Apr-23	95.0	99.7	99.9
May-23	95.0	99.3	99.4
Jun-23	95.0	98.9	99.8
Jul-23	95.0	97.7	93.7
Aug-23	95.0	92.9	94.8
Sep-23	95.0	95.9	97.5
Oct-23	95.0	96.6	95.8
Year to date performance	**95.0**	**97.3**	**97.3**

5.10 There has been a dip in the Trust performance against the 95% target in recent months. The finance team are currently reviewing the reasons for this and will be addressing any issues to improve the position.

5.11 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.

6. RECOMMENDATIONS

6.1 The Board is asked to:

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

Committee Chair's Report

Name of Committee/Group:	Finance and Performance Committee		**Report to:**	Board of Directors
Date of Meeting:	23 November 2023		Date of next meeting:	25 January 2024
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 Nick Gallagher, Director of Finance Sarah Brennan, Chief Operating Officer	**In Attendance** Lynne Carter, Chief Nurse Rachel Hurst, Deputy Director of Finance Eugene Lavan, Deputy Chief Operating Officer John Morris, Deputy Director, Estates (from Estates items onwards) Mark Charman, Assistant Director of Transformation Jan McCartney, Trust Secretary **Observers:** Rita Chapman, Public Governor, Rest of England	**Key Members not present**:	**Apologies received from:** Dave Smith, Assistant Director of IT Gareth Pugh, Assistant Director of Finance Anita Buckley, Information Team

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
CIP Chair's Report			The Committee received the chair's report.	The Committee noted that a significant amount of work is underway to identify potential recurrent savings, and these will then need to go through the quality impact assessment process to validate. The Committee recognised that although schemes to deliver the total CIP target had been identified, a proportion of this was non recurrent and some schemes were still subject to QIA.

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

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				The Chief Nurse is now the SRO and Executive Lead for CIP. The rationale for requirement for QIA will be reviewed and formally reported to Quality Committee. The Committee requested feedback from Quality Committee once completed.
Finance	4		Month 7 finance report received and provided assurance. The Committee noted that: • Month 7 23/24 is breakeven and on plan • CIP remains behind plan • BPPC has dipped slightly – internal review underway • Healthy cash position, reduction in month but expected to increase again in coming months as income received back from ICS • Capital programme - procurement now underway.	The Committee noted the financial position is on plan. The Committee noted that CIP identified remains behind plan, although performance to date has improved. The Committee noted agency spend. The top four spend areas remain the same. The Committee noted the actions taken to date and planned. Any impact on quality and service delivery will be monitored via Performance Council. The Committee noted the capital position and an update in terms of procurement will be provided in the next report. The Committee recommended the financial report to the Board.
Performance	4,8		IQPR for month 6 was received by the Committee.	The Committee noted the report with the addition of several new key performance indicators. There is one cancer indicator reporting as red in month – this is the 31 day wait from diagnosis to treatment. This is due to a small number of patients being treated within the timeframe which

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				is being managed by the service and some of which is patient choice. The percentage of patients being referred to A&E is above target and work is underway with the Widnes GP Federation to look how more patients can be managed safely in the community. The two DQMI indicators are red due to the need to collect a larger set of information and clinical templates will be revised to ensure that the required fields are present. There is a focus on managing DNAs/ was not brought to ensure that we manage service capacity within children's services as this impacts the ability to manage waiting list pressures. In Audiology, performance has improved but there is pressure to see the remaining patients from the paediatric audiology incident. Most patients will be seen by the end of October therefore allowing the service to focus on the waiting list pressures. The percentage of patients waiting under 18 weeks has deteriorated due to an increased number of patients waiting to be see in the Halton Community Paediatric Service. There is an increasing number of patients waiting to be seen in all the dental pathways particularly for minor oral surgery in Cheshire and Merseyside.

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Committee Chair's Report

				From a quality perspective there is an increased % of incidents causing haem and medication incidents causing harm which is being monitored by the patient safety meetings. The % of risks identified as 12 or above has decreased. The falls indicators which are red are being monitored as this is there first red data point. From a people perspective, staff turnover has reduced from 12.3% to 12.04% and the rolling sickness has decreased from 5.66%to 5.56% but sickness absence actual has deteriorated, and the indicator is red in month. Compliance with PDRs remains green. From a finance perspective, the Trust is slightly above plan on expenditure, agency, and non-pay. Overall, the position is challenged, trying to balance operational delivery and quality of service with the financial pressures and supporting staff to return to work from sickness absence. The 18-week RTT has deteriorated from 69% to 65% and this is due to an increase in dermatology and community paediatrics in Halton and Warrington. From a quality perspective, all the training indicators are reporting as green. There is one new red indicator in relation to duty of candour but the incident which breached was stepped down and not found to be a duty of candour.

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Committee Chair's Report

				From a people perspective, there are small increases in turnover and actual sickness absence. PDRs are now reporting as green. From a finance perspective, a breakeven position is reported with a gap in CIP delivery and agency spend is above plan at £3.16m versus a plan of £2.80m.
Performance	4,8		The Chair's report from Performance Council for month 06 was received.	The Committee received the report. The Committee supported the request for waiting list trajectories as a priority to help inform how the Trust manages capacity and demand.
Estates	4		Estates Report Green Plan Update	The Committee received the report and noted – Europa Point works due to commence 15/01/24. The Committee received the report which referenced the national fleet strategy which impacts upon salary sacrifice and fleet vehicles for the Trust. This will need to be considered as part of future capital plans e.g., the provision of charging points and any impact on fleet size.
Digital	8		Chair's report from DIGIT	The Committee received the report. The Committee noted the constraints on resources including Business Intelligence.
Audit	4		MIAA and KPMG Audit recommendations	The Committee noted the report. The Committee agreed to recommend to Audit Committee to accept the requested extension to the completion dates to the end of January 2024 for Data Quality.

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Committee Chair's Report

Risks	4		Risk paper	The Committee noted the report and the new risks added to the risk register. The Committee queried the risk rating for risk 2428 and the Chief Nurse confirmed that Risk Council will be reviewing risk descriptors at the next meeting and risk scores then reviewed against any updates.
BAF	4,7,8		BAF 4 BAF 7 BAF 8	The Committee requested that the narrative relating to CIP be reviewed. No changes identified. Risk rating unchanged. No changes identified. Risk rating unchanged.
Governance	4,7,8		Review of meeting	The Governor observer noted that it would be helpful to have a session on the updated IQPR for governors.
Risks Escalated: None from the meeting **Actions delegated to other Committees:** **Recommendation to Audit Committee to approve extension to DQ recommendation to January 2024.** **Quality Council – Quality Committee and Performance Council to review the criteria for QIA requirement and feedback to F&P Committee.** **Nothing delegated**				

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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:	12 October 2023		Date of next meeting:	11 January 2024
Chair:	Linda Chivers, Non-Executive Director		Quorate (Yes/No):	Yes
Members present/attendees:	**Committee Members Present:** Linda Chivers, Committee Chair Gail Briers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director 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 Jan McCartney, Trust Secretary Gary Baines, MIAA Audit Engagement Manager Adrian Poll, Senior Audit Manager, MIAA Phillip Leong, Anti-Fraud Specialist, MIAA **Observers** Andrew Mortimer, Governor	**Key Members not present**:	**Apologies received from:** Abdul Siddique, Non-Executive Director Rachel Hurst, Deputy Director of Finance Louise Thornton, Senior Financial Accountant Debbie Weir, Financial Controller KPMG not in attendance at the agreement of the Chair given they are currently not in contract

Key Agenda Items:	BAF	RAG	Key Points/Assurance Given:	Action/decision:
Urgent items to be taken	1		The Chair confirmed for the minutes that the Board had agreed to recommend to the Council of Governors that KPMG be awarded an extension to their contract for the years 23/24 and 23/24 to allow time for procurement and potential collaboration discussions to take place	Assurance received.

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Committee Chair's Report

Well Led Action Plan monitoring	1		The Committee received a report updating on the actions taken to address accepted recommendations from the Facere Melius review. Good progress has been made with each and success criteria have now been developed for all along with assignment to either a Board Committee or the main Board for oversight.	Assurance received.
New Fit and Proper Person Test (FPPT) Framework	1		The Committee received a report outlining the requirements of the new Framework along with the timetable for implementation. Good progress has already been made on a number of the recommendations. The Committee is mindful that there may be a further strengthening to the framework once the outcome of the Lucy Letby public inquiry is completed. The Executive Lead for this programme was notified as being the Director of Finance. The Committee considered that this should sit with the Chief Executive in his role as Accountable Officer and it was agreed this would be fed back to the Executive Management Team. It was further noted that MIAA recommended an internal review of FPPT be included in the three yearly cycle of Internal Audit, which was agreed.	Assurance received
Clinical Audit Review	1		The Committee should have received a report on Clinical Audit, however this has been deferred to the January meeting.	Assurance recieved
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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			In relation to BAF1 it was agreed to add the Moderate Assurance for the Quality Review – Patient Feedback at Service Level and to update the assurances to reflect the most recent Internal Audit Review finding levels. 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. The Committee were advised that a review of all Corporate Risks had been undertaken in order to map them to the proposed new strategic objectives and risks.	
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 an increase in approaches from staff seeking guidance on declarations had been seen.	Assurance received.
Review of Losses, Special Payments and Waivers	1,4		Proposed bad debt write offs totalling £1,265.59 were noted and assurance received that all possible recovery options had been exhausted. It was noted there had been no Special Payments in the quarter. The Committee were assured that due process had been followed for all 4 waivers, which were documented.	Assurance received.

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Committee Chair's Report

Mersey Internal Audit Agency Progress Report	1, 2		The Committee received assurance that the Internal Audit Programme was progressing to plan. The Committee noted the completion of the Quality Review – Patient Feedback at Service Level and the Moderate Assurance awarded since its last meetings and confirmed that the Quality and Safety Committee will oversee the implementation of the recommendations.	Assurance received. The Assurance level for the Quality Review audit will be added to the BAF.
MIAA Anti-Fraud Progress report	1,4		The Committee received the regular progress report. It was noted that there had been a significant increase in the number of Fraud Prevention Checks which had been issued to the Trust in the year to date, indicating a substantial increase in threat levels. The report documented the work ongoing within the Trust to mitigate against these threats. It was noted that as always this was a comprehensive report on the work undertaken. Two referral queries had been received in the period which had been converted to investigations bringing the total number of live investigations to 4.	Assurance received
Annual Review of Effectiveness of the Anti-Fraud service	1, 4		The Committee received a report detailing the responses to the annual review questionnaire. The overall satisfaction level was 4.59 out of 5 which was a very positive response and MIAA had been grateful for the feedback included in the responses. It was disappointing that 1 member of the Committee did not complete the questionnaire and members were reminded of the importance of participating in these reviews	Assurance received and completion of the effectiveness review to be added to the BAF

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Committee Chair's Report

External Audit progress report	1,4		The regular technical update was received by the Committee.	Technical briefing noted
Annual Review of External Audit Effectiveness	1, 4		The committee received a report detailing the responses to the annual effectiveness questionnaire. All members of the Committee had participated. The overall satisfaction level was 4.37 out of 5. One question which related to the effectiveness of liaison between External and internal Audit had brought the overall score down and it was noted that on feedback from both Internal and External Audit that the reliance placed on Internal Aduit work had reduced significantly in recent years. It was agreed this question was potentially no longer relevant and prior to next year's questionnaire the questions would be reviewed. The report had been shared with KPMG prior to the meeting and they had provided a positive response to the feedback confirming they would take on board potential areas for improvement.	Assurance received and report completion to be added to the BAF.
Review of the meeting	1		There was general agreement the meeting had been effective.	
Risks Escalated: None from the meeting				

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Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**87/23**		
Report Title	**INTEGRATION & COLLABORATION**		
Executive Lead	Colin Scales – Chief Executive Officer		
Report Author	Rob Foster – Programme Director Collaboration and Integration		
Presented by	Rob Foster – Programme Director Collaboration and Integration		
Action Required	☐ **To Approve**	☐ **To Assure**	☒ **To Note**

Executive Summary

The purpose of this report is to provide insight and oversight to the Board about the progress with integration and collaboration developments and progress with delivery of our Communities Matter strategy.

Previously considered by:

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

Strategic Objectives

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

☒ **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living

☒ **People** – to be a highly effective organisation with empowered, highly skilled and competent staff

☒ **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs

☒ **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability

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

☐ **BAF 1**	☐ **BAF 2**	☒ **BAF 3**	☒ **BAF 4**	☒ **BAF 5**	☒ **BAF 6**	☒ **BAF 7**	☒ **BAF 8**
Failure to implement and maintain sound systems of corporate governance	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

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

BOARD OF DIRECTORS

Title of Meeting	BOARD OF DIRECTORS	Date	7 December 2023
Agenda Item	87/23		
Report Title	INTERGRATION & COLLABORATION		
Report Author	Rob Foster – Programme Director Collaboration and Integration		
Purpose	The purpose of this report is to provide insight and oversight to the Board about the progress with integration and collaboration developments and progress with delivery of our Communities Matter strategy.		

1. Introduction

1.1 The purpose of this report is to present an update on progress with, and delivery of the Trust's Community Matters strategy (2023-2026).

1.2 It will also include information on partnership matters, including any relevant updates on place based, system and/or provider collaborative progress.

2. Strategy into action

2.1 NHS Prevention Pledge

2.1.1 As a key component of our Health Equity objective, we were delighted to attend the NHS Prevention Pledge Summit on Tuesday 26th September in Liverpool.

2.1.2 Our Chair, Karen Bliss, collected our Prevention Pledge award from Prof. Ian Ashworth (Director of Population Health, NHS Cheshire & Merseyside), where we committed to adopting the NHS Cheshire & Merseyside Prevention Pledge.

2.1.3 The event celebrated the successes and learning to date in adoption of the NHS Prevention Pledge and was the first time all 17 Trusts adopting the Pledge have met in person since work started on this programme in 2020. Additional delegates were also in attendance from primary care, ICB Place, local authority public health, OHID, NHS England and the voluntary sector.

2.1.4 Adoption of the Pledge provides Trusts with a framework of 14 core commitments to address and measure impact on the following themes: prevention of physical and mental ill health; social value and anchor institutions; health inequalities; staff health & wellbeing; MECC; quality improvement; and, working with partners at place to prevent readmission.

2.1.5 Sam Ollerenshaw, Bridgewater's Community Health and Wellbeing Project Lead

gave a presentation on Community Health Workers, and we've since been approached by Liverpool place to see how the scheme could be expanded into some areas of Liverpool.

2.1.6 This is a critical milestone in our Health Equity work, and we forecast signing up to be an Anchor Institution within the next 4-6 months.

2.2 Widnes Urgent Treatment Centre

2.2.1 We have recommenced our partnership approach with Widnes PCN/General Practice around a potential collaboration in the Widnes Urgent Treatment Centre (UTC), a key focus for the Halton Adult Directorate.

2.2.2 Our aims are to work together to initially collaborate on service delivery and then to explore and move towards a fully integrated primary and community Urgent Treatment Centre. We believe it is possible to develop a service model that will do this by integrating skills and workforce from primary and community care to widen the understanding of Urgent Treatment and increase the range of pathways that can be offered.

2.2.3 It is hoped that the partnership will support our clinical teams to manage more complex patients in the community and to ensure that the 'on the day' urgent care activity is retained as far as possible in Halton as opposed to patients diverting to either of the two local accident and emergency departments.

2.2.4 We hope that this will be the first of several partnership opportunities both in place and across the Trust.

2.3 Dentally – New Patient Access System for the Dental Network

2.3.1 A Project Board and Implementation Group was established which supported delivery of a signed contract for Dentally on 26th September.

2.3.2 Data Migration review (testing) is now in progress following the suppliers process and including the Trusts qualitative and quantitative checks. 29 Super Users within the network received training on the 20th /21st November, enabling further access in a testing environment to be extended further to clinicians.

2.3.3 Clinical Safety Hazard Workshops are in progress to develop Clinical Safety Case Report including mitigation/controls for highlighted risks and work is progressing to align the support model for Dentally users with other trust clinical systems.

2.3.4 Full implementation of the system will be monitored by the Dental Directorate Leadership Team who will be updated by the Project Board. Benefits to patients will include access to a Patient Portal so patients can upload information such as their current medications, Dentally Mail to send patient letters, SMS (text messages) regarding appointments and an Online Booking system for appointments so appointments can be booked at the convenience of the patient as opposed to just being allocated. It is hoped that the system will help to reduce non-attendance and support clinical time to be maximised.

2.4 GP Health Connect strategic partnership

2.4.1 We have commenced a strategic partnership with GP Health Connect, the GP Federation in Runcorn, Halton, to support our ambition to further develop a compelling vision and set of objectives that delivers integrated partnership working with our local Primary Care Networks/General Practices.

2.4.2 Work is underway to scope and develop a project to focus on our Integrated Neighbourhood model, with clearly defined population cohorts, in collaboration and partnership with local general practice.

2.4.3 As part of the project, we are exploring how we maximise the resources and assets already available to us all, to achieve greater efficiency, impact, and outcomes.

2.5 Understanding inequalities and their potential impact

2.5.1 We will shortly commence a piece of work to develop an understanding and methodology of how Bridgewater can use its data to support patients living with health inequalities proactively.

2.5.2 The initial focus will be on community dental services, with learnings being applied across our service portfolio.

2.5.3 The work will be undertaken in four phases:

- Information gathering to understand health inequalities in community dental.
- Assessment of data and analysis required to understand the challenge.
- Mapping and analysis of available data sources to the assessment in step (ii).
- Development of a high-level methodology to be used across all services.

3. Public & community engagement

3.1 The Public & Community Engagement (PACE) group has continued to focus on developing the plans and appropriate governance to drive forward and deliver our engagement ambitions.

3.2 Engagement activities have taken place with a number of groups/organisations, including:

- Warrington Disability Partnerships
- Warrington Deaf Club
- Power in Partnerships (Halton)
- Halton Veterans Legion
- Irish Community Cares

3.3 Information, learning and actions from all engagement activities are captured, with a central action log being created. The PACE group has responsibility to oversee the delivery of the action log.

3.4 A critical component of our approach is sharing the learnings and actions across our services, and asking our services what questions they have for our communities. The PACE group is working with the Directorates to co-produce an approach whereby we embed our engagement loop into the existing Directorate Leadership Team structures.

3.5 We have also been involved in place-based engagement activities, specifically:

- Engagement workshops with the One Halton leadership team, the Health Creation Alliance and Lloyds Bank Foundation to develop a vision and strategy for community engagement across Halton.
- Reviewing the Warrington VCSE Working Together Compact with partners to ensure it is fit for purpose and aligned to the vision and ambitions of the Warrington Together Partnership.

4. Partnerships

4.1 Halton place

4.1.1 As part of the One Halton partnership, a new Long-Term Condition (LTC) management/Integrated Neighbourhood Model workstream is commencing, with a purpose to collaboratively develop and implement Long Term Condition Management models for the population of Halton, adopting the key principles of integrated neighbouring approach.

4.2 Warrington Place

4.2.1 The Ageing Well Board met face to face led by the Director of Adult Social Care and Chief Operating Officer. This meeting was with the purpose of reviewing the programmes that the Board would focus on over the next 12 months as it was recognised that the remit of the Board had expanded over the year. It was decided that a number of programmes would become business as usual and that the Board would focus on 5 main programmes which were agreed as:

- Dying Well with Dignity
- Integrated Community Teams (ICTs)
- Implementing 'One Front Door'
- Falls
- Dementia

4.2.2 The Chief Operating Officer supported by the Programme Manager for ICTs held a visioning event to discuss what the focus of the ICT approach would be moving forward. Views of all key stakeholders were gained and a draft framework in terms of next steps has been developed in advance of the first meeting of the ICT Steering Group on 4th December.

4.3 Provider Collaborative (PC)

4.3.1 After extensive partnership engagement, the initial PC portfolio of work focusses on seven distinct programme workstreams that can benefit from an "at scale" approach:

4.3.1.1 Access to Care

The aim of this workstream is to establish a detailed understanding of waiting lists and waiting times for health care services by • reviewing and standardising community waiting time data, • increasing the visibility of fragile services and • identifying opportunities for sharing best practice and collaboration across Cheshire and Merseyside.

4.3.1.2 Community Urgent Care

There are two areas of focus:

The Urgent Community Response (UCR) project focusses on optimising the use of UCR services which enable people to remain at home as much as possible during times of crisis.

The intermediate care project has been running since December 2022 and is currently focussed on establishing a complete and consistent baseline position across all providers/places.

4.3.1.3 Population Health Management

The aim of this workstream is to define the role of community and mental health providers in population health management and to devise a series of interventions that will help our most vulnerable residents receive the care they need

4.3.1.4 Mental Health Transformation

There is a well-established mental health improvement programme that has been welcomed into the PC. The programme recently published its annual report and set out achievements that will be summarised in a future report.

4.3.1.5 Workforce

The aim of this workstream is to make our services more resilient to the workforce challenges faced across health and social care, by tackling common issues together.

4.3.1.6 Community Services for Children and Young People

This programme is still being defined but is likely build on the work of the Beyond programme and focus on strengthening the resilience of the community and mental health services for children and young people. Project areas are likely to include tackling waiting lists for access to services, including ADHD and Speech and Language therapy services.

4.3.1.7 Virtual Wards

Virtual Wards are now operational in all nine places across C&M. In the next phase we will be considering how the services can scale up, improve utilisation and continue to provide valuable support to our residents and the wider health and care system.

5. Measuring and monitoring our new strategy

5.1 The new draft strategy dashboard will be presented and discussed with the Board in Part 2, to review progress, proposed and captured datasets, alongside RAGs and proposed presentational styles.

5.2 Thereafter, the new dashboard will be routinely presented as part of this paper, providing an overview Trust position, as well as separate Directorate dashboards.

6. RECOMMENDATIONS

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

Committee Chair's Report

NHS
Bridgewater
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Name of Committee/Group:	People Committee	**Report to:**	Board of Directors
Date of Meeting:	15 November 2023	Date of next meeting:	17 January 2023
Chair:	Abdul Siddique, Non-Executive Director	Parent Committee:	Board of Directors
Members present/attendees:	Members Abdul Hafeez Siddique, Non-Executive Director (Chair) Tina Wilkins, Non-Executive Director Linda Chivers, Non-Executive Director Dame Elaine Inglesby, Non-Executive Director Paula Woods, Director of People & Organisational Development Sarah Brennan, Chief Operating Officer In attendance Jo Waldron, Deputy Director of People and Organisational Development Mike Baker, Deputy Director of Communications and Engagement Tania Strong, Interim Head of Human Resources Kathryn Sharkey, Head of Workforce Adie Richards, Education and Professional Development Lead Carl Dixon, 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 Jan McCartney, Trust Secretary Helen Young, Freedom to Speak Up Guardian Nicola Handford, Adult Immunisation and IPC nurse Brittney Chu, Business Manager to Joint Medical Directors on behalf of the Medical Director, attended until 11.30 am Agnes Cunliffe, Project Support Officer, taking minutes **Observers** Sarah Power, Governor Observer Arshad Ashraf, Governor Observer Karen Bliss, Trust Chair	Quorate (Yes/No):	Yes
		Key Members not present:	Dame Elaine Inglesby, Non-Executive Director Observer: Rachel Game, Governor Observer Observer: Christina Stankus, Lead Governor

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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
EQUALITY DELIVERY SYSTEM	BAF 5 and 6		The paper was presented by Ruth Besford, Equality and Diversity Lead for assurance purposes. The report was intended to be presented for approval to Board; however due to some timescale issues with comprehensive data gathering and the opportunity for peer review support on the scoring, this has slightly delayed the finalised report. That said, reporting to Board is planned for February 24 following January 24 People Committee therefore, there will be no delay in the submission to NHS England (NHSE). Consideration as to Dental being considered for next year's review was queried by Committee members due to the complexity of Dental and the Geography. Consideration was noted, taking into account that the Trust may want to consider the GM area in line with the Trust footprint.	The Committee noted the content of the reports and were assured on progress and plans for submission to NHSE.
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, both scored below 12 as at 3rd of July 2023. Risk ID 3191: Staff Health and Wellbeing – Risk Score 9	

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

Key Agenda Items (aligned to the BAF, Well-led Action Plan Recommendations – WLR and the 7 NHS People Promises - PP):	BAF, WLR and PP	RAG	Key Points/Assurance Given	Action/decision
			Risk ID 3059: Ongoing Industrial/Strike Action – Risk Score 6 **Educational and Professional Development (EPD) and Organisational Development (OD) Risk Report** During the reporting period there are 2 risks detailed on the EPD and OD Risk Register, one of which is a new risk in relation to the delivery of the Oliver McGowan Training. Risk ID 3078: Mandatory Training Risk ID 3176: Oliver McGowan Training. Issues around the delivery of the face to face element which must be delivered by someone with lived experience of Autism. This is a national issue and we are engaged in national meetings to look to address this collaboratively, possibly with partner Trusts. **Communications Risk Report** The risk in relation to the Trust intranet site has now closed following the launch of the new Trust Extranet. There were no emerging risks presented.	
IQPR – PEOPLE INDICATORS	BAF 5 and 6 WLR 9 PP 1-7		The 5 IQPR people indicators were presented to the Committee for month 5 by Jo Waldron, Deputy Director of People and Organisational Development (OD). Three of the five indicators were reporting green, which is the most positive position the indicators have been in for some considerable time.	The Committee noted and were assured of the progress with the indicators. Further updates will be provided at future meetings. Report next time to include information in relation to the impact of the

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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
			Induction – 99.68% against a target of 85%. Staff Turnover – 12.3% against a target of 12%. Sickness Rolling - 5.66% and Sickness Actual - 5.45% against a target of 5.5%. Detailed reports in relation to Sickness and Statutory and Mandatory Training and PPDR rates were presented later in the meeting as per the agenda. A discussion took place as to the detail behind these indicators i.e. staff groups etc. The Committee were assured that thorough data was considered at POD Council to inform appropriate actions and focus areas. The Deputy Chief Nurse was asked to bring include some information back next time in relation to the impact of the introduction of the Band 6 Community Nurse post.	implementation of the band 6 Community Nurse role.
DIRECTOR'S UPDATE REPORT	BAF 5 and 6 WLR as highlighted in the report PP as highlighted		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 and avoiding duplication with regard to items delivered earlier or later in the agenda. The report this time, as per the request at the last Committee, included areas where there are challenges and potential risks in delivery. The Director's update report tabled the following:	The Committee noted the report and its comprehensive contents. The Committee confirmed that the ask around a summary of key challenges has been met. The report has a column that identifies risks and mitigation.

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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
	in the report		• Letter from the Secretary of State for Health and Social Care, Steve Barclay with regards to equality, diversity and inclusion • Industrial Action Update – Junior Doctors, Consultants and SAS Doctors • NHS Long Term Workforce Plan (LTWP) Update • National Vacancies and Skills Shortages across health and Social Care – Our Vacancy Management • Updated Health & Wellbeing Guidance • Very Senior Manager (VSM) Framework and Pay Award Update • HSJ Awards 2023 – Shortlisted for Primary and Community Care Provider of the Year • ICB Workforce Update for Chairs – October: Sharing of slides • North West Anti-racist Framework Update • Warrington Together Workforce & OD Enabling Group Update (WEG) • North West Staff Retention: Priority Programmes Agreed • Scaling up People Services in Cheshire & Merseyside • The Cheshire and Warrington Skills Bootcamps – Funds for upskilling staff • People Operational Delivery Council – Invite to observe • Staff Engagement – We each have a voice that counts • Time to Talk – Updated approach reconciled to the NHS Our People Promises (7 elements)	

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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
			• Vacancy Management • Reciprocal Mentoring for Inclusion (RMfI) Update • Health & Wellbeing Fortnight – 9th to 20th of October • Rugby League Cares – Extension of our "Side by Side" Programme for 12 months • Targeted Health and Wellbeing • Partnership Working Arrangements	
PEOPLE OPERATIONAL DELIVERY (POD) COUNCIL CHAIR'S REPORT			The report was presented by Jo Waldron, Deputy Director of People and OD. This was the first paper presented to the Committee since the four PODs were amalgamated into one POD Council. The paper provided oversight on the progress of workstreams brought together to deliver the NHS People Plan and Promises, and the People Strategy. It was highlighted that the workstreams are determined and driven by the data, which is brought to the Council, in relation to our People.	The Committee noted the report and were assured on the progress.
REVIEW OF STAFF SICKNESS AGAINST TRUST TARGET OF 5.5%	BAF 5 and 6 WLR 8 PP 4		The Review of Sickness Absence against Trust Target report was presented by Kathyrn Sharkey, Head of Workforce for information and assurance purposes. Over the 12-month period, rolling sickness absence rates decreased month on month from October 2022 to January 2023 but increased in February 2023. It has then shown a decrease month on month from March 2023 to July 2023 from 6.30% to 5.65%. It increased slightly in August 5.66%	The Committee noted the content of the report and were assured that the appropriate scrutiny was being applied.

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			and has reduced again in October 2023 to 5.56%. Actual sickness absence % rate has fluctuated month on month over the 12-month period. As per the request of the Committee, the report this time detailed short term and long term absence by service line. Support and programmes of work to support improvements were presented to the Committee.	
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. Over the rolling 12 month period there have been 21 employee relations cases opened, and at present there are 9 cases currently open. There is one immediate exclusion in relation to Medical and Dental which is currently subject to preliminary investigation. The Trust is in receipt of one Employment Tribunal which is at the early stages of progression with preliminary responses provided to the Tribunal.	The report was noted by the Committee and were assured on the progress.
FREEDOM TO SPEAK UP REPORT			The Freedom to Speak Up Report was presented by Tania Strong, Interim Head of HR (on behalf of Helen Young) 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

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			Since the last report in September 2023 a further 5 concerns have been raised. For the National Guardians Office (NGO) reporting purposes, 2 have been individual concerns and 3 have been collective concerns and therefore 10 members of staff in total. Broad details in relation to the nature of the concerns, by Borough and staffing group were presented. There has been an overall increase in concerns raised since the start of the year which could be due to the FTSU media campaign or that staff are feeling more confident to speak up. We also have to acknowledge that staff may use other routes to speak up e.g. their manager and this information is not yet captured. The Committee were updated on plans to implement an annual Engagement Plan across the Trust, ensuring that activity is wide spread with a strong focus on utilising the Staff Engagement Champions.	
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. Current progress in relation to implementation was provided. There was a recognition that there is a need to use sustained data over time to rely upon.	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
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 six policies presented to HRPG since the last Committee as follows: • Grievance (Revision) • Apprenticeship (Revision) • Civility & Respect Policy and Toolkit (New) • Adverse Weather (New) • Death in Service (Revision) • Equal opportunities (Revision)	The Committee noted the content of the report.
VACCINATION CAMPAIGN AND NUMBERS - STAFF			The Report was presented by Nicola Handford - Adult immunisation and Infection Prevention and Control (IPC) Nurse for information and assurance purposes. The CQUIN goal for 2023/24 is to achieve a flu vaccination uptake of 75% to 80% of frontline healthcare workers. This reporting period, 631 staff (41.6%) have received a flu vaccination. This is a 9% increase from the same reporting period in 2022/23. This campaign to date, 414 (27.3%) members of staff received their COVID-19 booster vaccination. Within the Northwest region, BCHFT are the second highest performing Trust for frontline healthcare workers flu	The Committee noted the reports and were assured on the progress and plans.

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			vaccinations and are top in the Cheshire and Merseyside region at the time of reporting.	
PAYROLL PROVIDER PERFORMANCE REVIEW			The report was presented by Kathryn Sharkey, Head of Workforce, for information and assurance purposes. The Internal Audit was completed January 2023 and all recommendations have been completed. We received 'substantial' assurance on the audit with 1 recommendation to action. Mersey and West Lancashire Teaching Hospitals NHS Trust also undertook a Payroll Provider 2022/2023 Audit via MIAA and received 'high' assurance. Payroll, Bridgewater Transactional Services & Finance have KPI / contractual meeting on a monthly basis.	The Committee noted the reports and were assured on management of the contract.
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 report was presented by Adie Richards, Education and Professional Development Lead for information and assurance purposes.	The Committee noted the reports and were clear on the application of the non-compliance principles with future updates as to why there was non-compliance after the clearly stated deadlines.

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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		As illustrated in the report, all mandatory training modules were above the Trust target, with the majority in excess of 95% compliance. It was noted however that Halton Children's still remain adrift of the target for PPDR compliance. Following the final compliance deadlines, there were still staff who remained non-compliant with some key modules which posed an associated risk, particularly in clinical areas, namely, Safeguarding, Resuscitation and Moving and Handling. The Committee queried the application of the agreed principles, as endorsed by Staff-side and approved by the Board some time ago. These were for those who remained non-compliant after the deadlines. It was noted that these hadn't been fully implemented as yet, but they were in train by way of a review of the reports by individual, line by line. There was a commitment from Sarah Brennan, Chief of Operations for their implementation. Further training dates were being facilitated to ensure that staff who are restricted to non-clinical duties, are doing so for as little time as possible. Sarah Brennan highlighted all the support that had been provided by Corporate Services. In summary, following discussions, the NEDs present were assured that remedial action was being taken and that the principles would be applied to the letter.	

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Committee Chair's Report

NHS
Bridgewater Community Healthcare
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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
TALENT MANAGEMENT AND SUCCESSION PLANNING	BAF 5 and 6 PP 1, 4 and 5		The report was presented by Carl Dixon, Head of Leadership and Organisational Development, for information and assurance purposes. The Committee acknowledged the various programmes of work offered. They enquired as to our approach to succession planning overall, and it was queried as to whether we have an understanding from Executive to floor as to who our successors are – everything available in one place. Jo Waldron clarified that whilst we have a lot going on across the Trust from a succession planning perspective such as a strong leadership and management training offer, PPDRs, Career Conversations, and Workforce Planning meetings with a focus on growing our own, TNAs etc, we don't have a system to record our successors in one particular place. We have an understanding in services based on local discussions and the Workforce Planning meetings, but the lack of a sophisticated system is a national issue which has been flagged at the OD Network meetings and is being looked at as part of the new National Workforce Solution which will replace our current ESR system. This is a significant transformation programme.	The Committee noted the reports and were assured on the progress and plans. The lack of a national system/software is captured below (BAF 5 and 6).
STAFF ENGAGEMENT AND RECOGNITION			The report was presented by Mike Baker, Deputy Director of Communications and Engagement for information and assurance purposes. There were no questions from the Committee.	

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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
MIAA INTERNAL AUDIT UPDATE - **MANDATORY TRAINING AND APPRAISALS REVIEW**	BAF 5 and 6		Carl Dixon, Head of Leadership and Organisational Development assured the Committee that all recommendations had been actioned and closed. The areas for improvement identified by MIAA are now 'business as usual' and are embedded in the new processes i.e. PPDR Audits. It was agreed to close this item on the basis that a final report on audits would go to Audit Committee.	The Committee noted the report and were assured on the progress.
FACILITIES TIME OFF ANNUAL REPORT			The report was presented by Tania Strong, Head of HR for information purposes. It was noted that there were unactive members in the submission and it was clarified that there are various reasons for this, including a reduction in working hours which has impacted on their ability to engage in union duties. Tania Strong was to contact Representatives to explore their current and future status.	The Committee noted the report, along with plans for the Head of HR to contact the Representatives.
BOARD ASSURANCE FRAMEWORK & RISK REGISTER	BAF 5 and 6		A review of BAF 5 and 6 was undertaken. I was noted that this would be the last time that the old BAF would be presented and Jan McCartney, Trust Secretary confirmed that all issues in the old BAF have been moved over to the new. This Committee will oversee the new BAF 4 and 6.	The Committee were assured on the progress and governance around the monitoring of the BAF.

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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
			It was suggested that risk around capacity to support the System Workstreams that had been identified with support from the ICB, be logged along with the lack of a robust Succession Planning system nationally.	
ANY ITEMS FOR ESCALATION TO BOARD OR SHARING WITH OTHER COMMITTEES	BAF 5 and 6		There were no escalations for Board this time and noting noted for sharing with other Committees.	
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. Karen Bliss felt the meeting was informative and well chaired.	
Risks Escalated			None.	

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Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**88/23 (ii)**		
Report Title	**ANTI-RACIST FRAMEWORK UPDATE**		
Executive Lead	Paula Woods (Director of People & Organisational Development)		
Report Author	Ruth Besford (Equality & Inclusion Manager)		
Presented by	Paula Woods (Director of People & Organisational Development)		
Action Required	☐ **To Approve**	☒ **To Assure**	☐ **To Note**

Executive Summary

This paper provides a brief update on the progress being made with regard to the NW Black, Asian, and Minority Ethnic Assembly (the Assembly) Anti-Racist Framework.

To recap, the Board committed to the original Framework in April 2022 and subsequently reaffirmed this commitment to the refreshed Framework in July 2023.

The updated Framework presents a set of deliverables and supporting actions against five principles for anti-racist organisations, and now has a bronze to gold level of attainment.

As previously reported to the Trust Board, we have completed a basic self-assessment against these deliverables and in doing so, we have identified actions to fulfil the levels of attainment which have been shared with Board.

The Framework supports several legal and contractual equality mandates, but more importantly it should support the Trust in further developing equitable and inclusive employment opportunities and healthcare services for ethnically diverse individuals and communities.

As a brief update as to where we are at:

- The Assembly arranged (and continue to do so) a series of monthly workshops to support all committed organisations with the implementation of the Framework and application through self-assessment for bronze to gold level of achievement. These workshops have so far covered:
    - What support do organisations need? - Delivered in September.
    - What does the application and peer review process look like? - Delivered in October.
    - What does the health inequalities deliverable look like? - Due to be delivered on December 6th.
- Delivery and implementation of the Framework is within the remit of the new Equality, Diversity, and Inclusion (EDI) Working Group, with governance through the People Operational Delivery (POD) Council on to the People Committee.

- Working Group membership currently includes the Trust's People Directorate and Non-Executive Director representation (Dame Elaine Inglesby and Abdul Siddique).
- The Working Group is presently developing its form and function in relation to the Framework through:
    - Expressions of interest invites to all Staff Network members, and more widely to all staff with an interest in equality and inclusion.
    - A team journey to develop aims, objectives, and approaches.
    - A deep dive into lived experience of staff and comparator groups to understand inequality and what actions will have real and lasting impact.
- This admittedly is a slower approach than initially planned, and it therefore may result in local Trusts achieving bronze level recognition ahead of Bridgewater. That said, the Working Group's view is that the lived experience of ethnically diverse colleagues must be heard and understood, and actions then taken beyond the 'tick box' of policy and process to enable us to truly embed equity, inclusion, and anti-racist practices and cultures. This is also in line with the ethos of the Anti-Racist Framework.

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**	**7 December 2022**
Agenda Item	**88/23 (ii)**		
Report Title	**ANTI-RACIST FRAMEWORK UPDATE**		
Report Author	Ruth Besford (Equality & Inclusion Manager)		
Purpose	To provide an update report on the Trust Anti-Racist Framework commitment and actions.		

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 In April 2022 the Board endorsed the implementation of the NHS North West Black, Asian, and Minority Ethnic Assembly (the Assembly) Anti-Racism Framework. There were twenty drivers in total 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.

2.2 Since that time there have been several developments in the NHS. In 2023 we have seen the publication of the NHS Long Term Workforce Plan and accompanying Equality, Diversity, and Inclusion (EDI) Improvement Plan. Furthermore, awareness has been raised

regarding racism in the NHS in the employment tribunal case of Ms A Cox v NHS Commissioning Board (NHS England North West). Ms Cox pursued successful claims of race discrimination, harassment, and whistleblowing detriment.

2.3 The first Anti-Racism Framework was an all or nothing approach, whereby all twenty deliverables had to be met before an application for assessment could be submitted for consideration. With some deliverables likely requiring some time, and in some cases potentially years, to embed and evidence, this left most Trusts unable to demonstrate progress and commitment to the principles of the Framework.

2.4 The Assembly, having listened to feedback sought and received 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. The updated Anti-Racist Framework was published in summer 2023, when the Trust Board re-confirmed its ongoing commitments.

2.5 This paper provides a brief update on progress against the Anti-Racist Framework for the Board's information and assurance.

3. ANTI-RACIST FRAMEWORK UPDATE

3.1 The updated Anti-Racist Framework retains the original five principles for an anti-racist organisation and has embedded against each principle four key drivers with direct deliverables and support actions – the direct deliverables provide the framework for self-assessment against the bronze to gold levels with the supporting actions providing guidance and signposting. An example from bronze level is shown below:

1. Key driver: Anti-racism as mission critical.

2. Direct deliverable: Evidence of how the organisation has acted to make anti-racism work mission critical in the past year.

3. Supporting action: An anti-racism statement to be produced and published detailing organisational commitment to racial equity.

3.2 The Trust has undertaken a self-assessment and has determined that there are areas where we are delivering the supporting actions fully, but also gaps against each level at this stage.

3.3 The Assembly is hosting monthly workshops for all committed and interested Trusts, which Bridgewater representatives are attending.

3.4 In September, the first workshop gave a general overview and opportunity for discussing the support that Trusts would like from the Assembly in implementing the Framework.

3.5 The October workshop looked more closely at what the self-assessment and peer/stakeholder review might look like, and from that the theme for the December workshop was agreed with all Trusts discussing difficulties around one bronze level

deliverable for evidencing reducing a health inequality in the communities they serve. The main challenge identified was the alignment of Equality Leads for the Framework being in People functions with little connection to service and patient delivery.

3.6 As a draft, the assessment and application paperwork is simple to populate, with the deliverables for each level waiting to be completed with evidence. What is important is that the template is peer reviewed by staff/networks and the Board before submission to the Assembly.

3.7 As a Trust the Framework is being implemented by the newly established EDI Working Group, which sits for governance under the People Operational Delivery (POD) Council.

3.8 At its early stages at this time the Working Group members are discussing the form and function of the group, and how it will lead and support on delivery of the Anti-Racist Framework and other equality priorities.

3.9 The membership, which at this time includes People Directorate colleagues and two Non-Executive Directors, is committed to the group taking steps to engage the voices of lived experience and allies so that actions agreed have real, measurable, and lasting impact on equality and inclusion for our staff and our patients and communities. What the group suggests is that the Framework will be used to start a wider conversation about the fundamentals of anti-racism and what this might look like at the Trust, before considering a submission for the bronze level award. This will ensure that staff engagement sits at the heart of this programme – and quite rightly so.

3.10 First steps are:

1. A request for expressions of interest from Staff Network members and allies for inclusion from throughout the workforce, (people who are passionate about making the workplace and services inclusive for all). This may be as part of the Working Group, a project task and finish group, a focus group, or something in a different capacity that evolves as the work develops. The Working Group recognise that key to equality and inclusion, indeed one of the three aims of the General Equality Duty, is removing barriers to involvement. Through different approaches, we want to ensure any staff member who wishes to be involved is able to do so in the capacity that they choose.

2. A face to face half day team journey session with Working Group members and interested staff, led by the Trust's Organisational Development Leadership Team, is planned for January 2024.

3. A deep dive into data and lived experience, including the lived experience of those in comparator groups so that root causes of inequality can be studied, and learning taken to deliver action plans.

4. A desk top research into health inequalities in local communities, in partnership with the Trust's Principal Lead for Public Health.

3.11 It should be noted that this approach will mean that local Trusts are likely to 'achieve' the Anti-Racist Framework levels ahead of Bridgewater, but the Working Group is committed to a robustness of approach, to fully listening to and involving our staff voices, and to taking

steps (sometimes innovative and exploratory) so that the Trust can truly achieve anti-racism.

3.12 The planned approach will also support the fundamentals of the Framework and enable us to prioritise anti-racism, understand lived experience, grow inclusive leaders, and act to tackle inequality.

4. RECOMMENDATION

4.1 Members are asked to note the contents of this report for information and assurance on the progress being made on the Anti-Racist Framework.

Bridgewater Community Healthcare NHS Foundation Trust

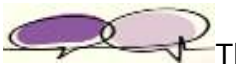
BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 DECEMBER 2023**
Agenda Item	**88/23 (iii)**		
Report Title	**WE EACH HAVE A VOICE THAT COUNTS**		
Executive Lead	Paula Woods - Director of People and Organisational Development		
Report Author	Jo Waldron - Deputy Director of People and Organisational Development Jeanette Hogan - Deputy Chief Nurse Mike Baker - Deputy Director of Communication and Engagement		
Presented by	Lynne Carter – Deputy Chief Executive & Chief Nurse Paula Woods - Director of People and Organisational Development		
Action Required	☐ **To Approve**	☒ **To Assure**	☒ **To Note**

Executive Summary

A paper was presented at the Trust's October Board that outlined our approach to NHSEs recommendations in response to the Lucy Letby case, her trial and her subsequent conviction. The report also gave an overview of the results in relation to 'Freedom to Speak Up' from our Annual Staff Survey and the internal anonymous survey conducted by the Trust in June/July 2023, which outlined that strengthening our existing systems and processes and focusing on creating a sustainable culture of listening will provide safe, high-quality care and protect our patients.

We are actively recruiting Freedom to Speak Up Champions. Our Freedom to Speak up Guardian is visiting services across the Trust to talk about her role and the various ways and means that our staff can raise concerns.

 This report aims to build on the previous report by providing the overview in Table 1, of some of the many mechanisms we have across the Trust which allow us to listen to our staff, ensuring we commit to the NHS Our People Promise - 'We Each have a Voice that Counts.' This is the focus of our December Leader in Me event which will be attended by a representative of the National Guardian's Office.

We are confident that the strengthening and coming together of our systems, with a strong focus on feedback utilising our well established "You Said….We Did….We are Doing" approach, will show ongoing and sustainable improvements in how engaged, valued and psychologically safe staff feel, which would then hopefully translate into our staff survey results which measure the seven elements of the People Promise.

Over time, our Communication Team has further developed to pick up staff engagement as well as communication. A redesign of the function was undertaken to lend itself to both communication and

engagement and the latter was moved from the Trust's Leadership & Organisational Development Team to the Communication Team. The Communication and Engagement Team now has a Senior Manager and a Co-ordinator whose portfolios focus on 'engagement' as well as communication.

The Trust has over 70 Staff Engagement Champions and work is underway to ascertain if they are active or not. The role of the Champions is under consideration, and they will be referred to going forwards as People Promise Champions and People Promise Ambassadors. The Communications and Engagement Team are in the process of devising a piece of work to potentially remodel and repurpose the Champion role, so it becomes a crucial part of how we engage with our Colleagues. In any event, the role will include health and wellbeing as per the national requirement to have Health & Wellbeing Champions.

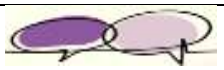
Previously considered by:	
☐ **Flu Group**	☐ **Freedom to Speak Up Guardian Group**
☐ **Medical & Dental Professional Governance**	☐ **PEOPLE HUB**

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**	**7 December 2023**
Agenda Item	**88/23 (iii)**		
Report Title	 **WE EACH HAVE A VOICE THAT COUNTS**		
Report Author	Jo Waldron - Deputy Director of People and Organisational Development Jeanette Hogan - Deputy Chief Nurse Mike Baker - Deputy Director of Communication and Engagement		
Purpose	This report builds on the previous report to Board (Listening to Staff Voices and Freedom to Speak Up) by illustrating some of the many mechanisms we have across the Trust which allow us to listen to our staff, ensuring we commit to the NHS Our People Promise - 'We Each have a Voice that Counts.'		

1. INTRODUCTION

1.1 A paper was received at the October Board meeting, following NHSEs recommendations in response to the Lucy Letby trial. This was titled, "Listening to Staff Voices and Freedom to Speak Up".

1.2 The report gave an overview of the results in relation to 'Freedom to Speak Up' from our Annual Staff Survey and the internal anonymous survey conducted by the Trust in June/July 2023, which outlined that strengthening our existing systems and processes and focusing on creating a sustainable culture of listening, will provide safe, high-quality care and protect our patients.

1.3 This report aims to build on that by providing an overview to the Board of some of the many mechanisms we have across the Trust which allow us to listen to staff, ensuring we commit to one of the seven elements of the NHS People Promise, 'We Each have a Voice that Counts.' Furthermore, those approaches yield feedback from our staff that we can attribute and align to the seven elements of the People Promises as a whole.

1.4 We are confident that the strengthening and coming together of our systems, with a strong focus on feedback utilising our well established 'You Said….We Did….We are Doing' approach, will show ongoing and sustainable improvements in how engaged, valued and psychologically safe staff feel, which would then hopefully translate into our staff survey uptake and results.

1.5 Work is ongoing to develop a Staff Engagement Plan which will include a calendar of engagement events.

1.6 As referred to in the Executive Summary, the Communications and Engagement Team are in the process of devising a piece of work to potentially remodel and repurpose the Staff Engagement Champion role, so it becomes a crucial part of how we engage with our Colleagues. Going forward these will be People Promise Champions and People Promise Ambassadors.

2. HOW WE LISTEN TO OUR STAFF

2.1 The Trust's clear and communicated management structure ensures that staff have an understanding of their support, should they need it. This is further supported by the requirement for all Managers to have regular 121 conversations with their staff, along with Team Meetings, ensuring the dissemination of Trust information such as the monthly Team Brief. 121s now include wellbeing conversations.

2.2 Research suggests that line managers play a fundamental role in ensuring staff feel engaged, valued and psychologically safe. The Messenger Review on NHS Leadership 2022 commented that the reviewers "sensed a lack of psychological safety to speak up and listen". This was echoed in the recent National Guardians Office Annual Report.

2.3 Many of our initiatives have been focussed on encouraging staff to raise concerns, however the ability to listen and then to act is often assumed. Our more formal approach is to ensure that all of our staff are encouraged to speak up and that we will listen and act.

2.4 The role that Managers play in getting the sharing of information, communication, and engagement right, cannot be underestimated and it is important that we provide Managers with the right training and support to execute their duties in ensuring their staff are supported, listened to, and most importantly that their feedback is acted upon.

2.5 The Trust is currently scoping out levels of FTSU training for all staff which will ensure that staff are able to encourage questioning and in particular the professional curiosity which frequently leads to learning and support. There will be a nine month trajectory for training compliance that our FTSU Guardian is working on with support from another Guardian.

2.3 That said, to enhance the fundamental role that Managers play, the Trust has a commitment to listening to its staff and to fulfil one of the seven elements of the NHS Our People Promise - 'We Each have a Voice that Counts'. This is done by ensuring that there are numerous and varying opportunities for staff to talk to us and feel they have a voice. Feedback yielded is also aligned to the other six of the seven elements and everything we do now reconciles back to those seven elements which are measured by the annual NHS Staff Survey and the national Quarterly Pulse Surveys (NQPS).

2.4 In addition to the seven People Promise elements (outlined in Figure 1), the NHS Staff Survey also reports against the two elements of 'staff engagement' and 'morale'. As our 2022 results showed, it is pleasing that both elements matched the NHS Community Trust comparator average:

People Promise Element / Theme	2022 score	Community Trust Average
Staff engagement	7.2	7.2
Morale	6.1	6.1

2.5 Figure 1 shows the full seven elements of the NHS People Promise, of which this report focuses on the element of "**We Each have a Voice that Counts".**

Figure 1

2.6 Table one provides a high-level overview of the mechanisms we have in place and how we measure their success.

Table 1

 **How we listen….. "We Each have a Voice that Counts"**	**Approaches**	**Measures/Reporting**
Time to Talk Sessions	The Trust's Chair and Chief Executive endeavour to go out to meet Teams, twice a month. In addition, a member of the Trust's Executive Team and a Non-Executive Director meet monthly to talk with our teams, get to know them better, share the latest Trust news, work experiences, and consider the current and ongoing support for their health and wellbeing. The Time to Talk process has been reviewed and is now specifically aimed at asking a series of questions linked	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs Populated Time to Talk templates

 **How we listen….. "We Each have a Voice that Counts"**	**Approaches**	**Measures/Reporting**
	to the NHS Our People Promise. There are seven elements to the Promise which enables us to measure against them by way of various means. Feedback will be in the form of the well-established 'You Said…We Did…We are Doing' approach that our staff are familiar with. Structuring the Time to Talk sessions with the seven elements of the NHS People Promise will enable us to further measure how we are fulfilling each of the promises. The process still supports free flowing conversations.	A summary of actions logged at sessions, are now captured on the new Time to Talk template with mechanisms to feedback on progress and ensure these are delivered up Aggregation of feedback against the questions posed will be captured in one overall document
Time to Shine	Time to Shine meetings provide teams within the Trust with the opportunity to share their experiences and raise awareness as to what they do. That may be learning from an incident, a quality improvement that has been implemented in the team, or just an opportunity to celebrate the work that the team do and deliver. These meetings take place regularly and allow time for discussion.	Quality Council Patient and Staff Stories – Trust Board
Staff Engagement Champions	We have approximately 70 Staff Engagement Champions across the Trust who provide an opportunity for us to have two-way communication from staff on the ground. The Champions ensure that information is disseminated, and a key part of their role is to provide valuable feedback from staff as to what they need to make their work life better. A review is currently taking place around the Staff Engagement Champions role so they can be aligned and embedded further into the seven elements of the NHS Our People Promise. The success of the Staff Engagement Champions' remit is about quality of the Champion rather than the quantity of Champions within the Trust. The work being undertaken here, will be absolutely fundamental in the success of this important role to the organisation. It has been agreed that we will rename the Champions, People Promise Champions. Furthermore, we will have	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs Staff Communication & Engagement reports to the POD Council and People Committee

 **How we listen….. "We Each have a Voice that Counts"**	**Approaches**	**Measures/Reporting**
	People Promise Ambassadors. The former will be active, whilst the latter will be Champion advocates.	
Annual Staff Survey, National Quarterly Pulse Survey (NQPS) and Staff Survey Action Plans	The Annual Staff Survey and more recently the National Quarterly Pulse Survey is promoted extensively to ensure we have a strong representative sample to meaningfully assess staff experience. The process is cyclical with the launch, results and action planning process planned throughout the year. Results are analysed and a Trust wide Action Plan is developed. Equally, Directorate results are disseminated and Associate Directors and Corporate Deputies are asked to meet with their Teams to review the results and develop a collaborative local action plan, informed by the staff themselves. Action plan progress is monitored at DLTs and is reported to People Operational Delivery (POD) Council, and then on to People Committee. Reports are also presented to the JNCC, LNC and Trust Board. A national Staff Survey Dashboard has been developed and following this year's Staff Survey results, we hope to have improved feedback mechanisms, along with greater analysis.	Staff Survey Results Staff Survey Action Plans Staff Survey – Staff Engagement Score Increase in uptake of Staff Survey – our best ever response rate for 2023 Improvement in People KPIs National Quarterly Pulse Survey (NQPS) results Reports to the People Council, Performance Council, People Committee, JNCC, LNC and Trust Board
Team Brief	Delivered monthly, the Team Brief provides an opportunity for staff to ask questions online. These are responded to at the time and/or are fed back once the answers are sought.	Team Brief includes a Q&A facility
Live Briefings and Q&A Sessions	Periodically, live briefings and Q&A sessions are run by the Trust to enable staff to hear key messages and engage in discussions that are topical or timely. An example of this is where the Director of People & OD communicated and engaged with staff on the Government's plans to introduce mandatory covid vaccines for NHS Staff to remain in their employment.	Live access to Executive Directors The issuing of Q&As
Quality Summits	Quality Summits provide a framework to bring relevant clinical and corporate services together to collaborate to support a service when there has been a quality or performance issue using quality improvement methodology for service improvement.	Quality Council

 **How we listen….. "We Each have a Voice that Counts"**	**Approaches**	**Measures/Reporting**
Workforce Planning Sessions	Workforce Planning sessions take place each year with services to seek their views on how we can better shape our workforce to deliver care for our patients based on their feedback. The focus is on 'grow your own' models with the utilisation of Apprenticeships, career pathways and succession planning for our current staff who have an aspiration to progress in the organisation. These sessions are led by our Head of Workforce and our Deputy Chief Nurse and are attended by our EPD Team to inform our Training Needs Analysis (TNAs). Our Apprenticeships Lead, our OD Team and HR Business Partners are also engaged in the process.	Improvement in People KPIs Contribution to CIPs Improvement in Quality Indicators Improvement in Patient Experience Reports to POD Council and People Committee
JNCC – Joint Negotiation & Consultation Committee	Our Joint Negotiation & Consultation Committee is a Trust wide meeting with Executives, Deputies (by way of membership) and our Staff-side representatives. The meeting is a means of the Trust imparting information to our Staff-Side Colleagues e.g. Trust news, finance updates, policies and future plans. This ensures that we can effectively inform, consult and negotiate on behalf of our staff with input from their respective Trade Union Bodies. From time to time, the Trust will run developmental sessions with Staff-side to allow for a review of partnership principles and the JNCC's constitution etc.	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs Employee Relations Climate – reduction in disciplinaries and grievances ER reports to the People Committee
LNC – Local Negotiation Committee	Our Local Negotiating Committee is the Medical and Dental equivalent to our JNCC. Please see above.	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs. Employee Relations Climate – reduction in disciplinaries and grievances ER reports to the People Committee
Our Just Culture Journey – 4 Step Process,	Our Just Culture Journey was a significant transformation programme whereby we established a '4 Step' process for dealing with employee issues and incidents. We look	Employee Relations case loads

 **How we listen….. "We Each have a Voice that Counts"**	**Approaches**	**Measures/Reporting**
developed and implemented with our Staff-side Collagues	at these through a learning lense. In doing so, we now pick up our formal policies and procedures as a last resort. The application of the process enables us to listen to the voices of the staff affected and most importantly for us to act on the feedback we receive and consider any lessons learned. As reported to the People Committee, we are seeing a positive trend in the number of employee relation issues such as suspensions, formal disciplinaries and grievances.	Employee Relations Climate – reduction in disciplinaries and grievances Positive Staff-side partnership working arrangements ER reports to the People Committee
HR and Staff-side Meetings	Our Director and Deputy Director of People and Organisational Development meet with our Staff-Side Colleagues bi-monthly on an informal basis by way of our partnership working approach. Any emerging issues are discussed and addressed quickly to avoid escalation. This meeting enables detailed discussions to take place on employee relations cases, their progress or lack of progress. Our Staff-Side Colleagues attend the POD Council and the Trust's People Committee. Furthermore, they are actively engaged and integrated into projects that affect our staff such as us being a pilot for the North West Wellbeing Policy, the Civility and Respect Framework, Sexual Safety at Work, our pledge for the prevention of Gambling Harm and much more.	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs Employee Relations Climate – reduction in disciplinaries and grievances ER reports to the People Committee
Freedom to Speak Up – Guardian Visits	Our Freedom to Speak up Guardian is visiting services across the Trust to talk about her role and the various ways and means that our staff can raise concerns.	FTSU policy and procedure Reports to People Committee and Trust Board
Senior Leadership Team Meetings	SLT takes place bi monthly and also accommodates a meeting of both the SLT and EMT (Executive Management Team).	Minutes of meetings and action logs
On-boarding and Exit Interviews	New starters and Staff who are leaving the Trust are asked to comment on their experience to ensure that any lessons can be learned. Surveys are carried out that enable us to consider the feedback received and act on it accordingly.	On-boarding and Exit Questionnaires

 **How we listen….. "We Each have a Voice that Counts"**	**Approaches**	**Measures/Reporting**
	Reports are presented to the Trust's POD Council to ensure that Trust wide actions can be taken forward and Directorate breakdowns are provided to DLTs to support any local action planning. Corporate Induction attendance is at a constant 99%, against a target of 100%.	Staff Survey Results – Staff Engagement Score People KPIs – recruitment, retention and turnover Report to the POD Council and People Committee
Training and Trust meetings (including evaluations) - Leader in Me, Staff Thank You Awards, etc	Leader in Me – quarterly events open to all staff to attend. Annual Staff Awards - provide staff with an opportunity to nominate their Colleagues and Teams and celebrate success. All Trust training and Trust wide engagement sessions are evaluated to ensure that feedback is taken into consideration for future sessions and action planning.	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs Feedback Questionnaires The number of nominations for Staff Awards
Targeted Health and Wellbeing sessions	The Health and Wellbeing Team are offering targeted support into services where there are high levels of absence in relation to stress. These sessions involve engaging with staff directly to understand any potential issues and work with them to support solutions. Our Health and Wellbeing Lead is now attending monthly DLTs, providing Leadership and Organisational Development updates, engaging and taking away any actions that can be supported. The DLTs have been informed of the work taking place, using absence data from the Trust's ESR System and explaining that targeted outreach health and wellbeing sessions will take place with Teams across the Trust that have displayed both a medium (30% to 49%) and high (above 50%) percentage of absence related to S10 (stress, anxiety, depression). Meetings have taken place with Team Managers and Health and Wellbeing Outreach sessions have taken place with the following Teams:	Staff Survey results Staff Survey - Staff Engagement Score Improvement in People KPIs – absence rates and turnover rates Feedback Questionnaires Evaluation of Wellbeing Sessions Action planning informed by the feedback received Absence Trends Reports as presented

How we listen….. "We Each have a Voice that Counts"	**Approaches**	**Measures/Reporting**
	• 0-19 Immunisation Teams – Children's Services • Corporate Estates Admin – Corporate • Urgent Care Centre – Halton • Paediatric Bladder and Bowel Service – Halton Sessions are booked with the Learning Disability Nursing Team in Halton. Awaiting meeting dates to be confirmed are: • Adult Falls & Rehabilitation Team – Warrington • Adult District Nursing West Bath Street Team – Warrington • Health Care Support Workers – Warrington • Adult Single Point of Access Team – Warrington The above is in addition to the long standing alignment of HR Business Partners and HR Managers to each of the Boroughs and Corporate Services to support attendance management and wellbeing.	to the POD Council and People Committee
Annual Staff Health & Wellbeing Events – Wellbeing Fortnight	The Trust held a Health and Wellbeing Fortnight from the 8th to the 20th of October. Programmes of both face to face and virtual health and wellbeing sessions were attended by 88 staff. Evaluation survey requests have been sent out to those staff who attended. These will be shared once summarised.	Evaluation survey to be analysed with overall reporting to the People Council and People Committee Features to be included in the Bridgewater Bulletin
Rugby League Cares – "Side by Side" Programme	We have a wellbeing partnership arrangement with Rugby League Cares who have been supporting the Trust with mental wellbeing programmes for over a year. Whilst the delivery of their programmes is a psychologically safe space for our staff, they are able to evaluate key themes for the Trust to focus on, based on the feedback that they receive from the staff groups they work with. Meetings are taking place this month to scope out the forthcoming programmes of work. The feedback from our staff on this programme that is supporting their mental wellbeing has been extremely positive. RL Cares delivered up sessions during our Health and Wellbeing	POD Council (People Operational Delivery Plans) People Committee Staff Survey results as per the focus on staff health and wellbeing Programme evaluation Health & Wellbeing Fortnight survey evaluation

How we listen….. "We Each have a Voice that Counts"	Approaches	Measures/Reporting
	Fortnight with regards to sleep, positive mindset and building resilience.	
Clinical Staff Meetings	The Chief Nurse and her Team meet with groups of Nurses and AHPs to listen to concerns, ideas and issues relating to their roles. This work has also led to the development of the Clinical Leadership Plan.	Clinical Leadership Framework Staff survey results- staff engagement score and raising concerns Sharing good practice across teams
Professional Nurse Advocates	These staff provide restorative supervision to our staff and can raise issues anonymously with the senior clinical Teams. They are crucial in providing support to staff who are concerned about practice and/or behaviours.	Staff Survey results Staff Survey - Staff Engagement Score Health and Wellbeing data/reporting
Education & Professional Development Team (EPD)	Supporting staff training and development, listening to staff issues, and clinical concerns which can be fed back to Clinical Leads and Managers are just some great areas of work that the Team contributes to.	Raising concerns through our processes
Audits in Practice	Our processes for audits in practice (for example IPC audits) provide the opportunity for staff to raise issues and for these to be fed back via audit results for action.	Audit action plans via Quality Council
Preceptorship and Corporate Induction **National Preceptorship Interim Quality Mark – Award**	New starters are informed of processes and how to raise concerns and this is a feature of our preceptorship work to encourage staff to speak up. Our Freedom to Speak Up Guardian has a slot at Corporate Induction as does the Trust's Risk Manager. We were notified on the 23rd of November that we had been awarded the national Preceptorship Interim Quality Mark. This is valued for two years.	Corporate Induction and preceptorship feedback Student Satisfaction Surveys NPIQM accreditation and use of logo

3. NEXT STEPS

3.1 Since the Board meeting in October and in addition to the Time to Talk sessions there have been a number of Quality Visits by the senior nursing team and some ad hoc meetings with teams by the Chief Nurse. There is a schedule of Chief Nurse Clinical visits planned to commence in January 2024 specifically aimed at listening to clinical concerns which will be regularly in place in addition to the Time to Talks.

3.2 The patient safety meetings and serious incident review panels have also added increased focus on whether raising concerns has been a feature in any root cause analysis or could have prevented any issue.

3.3 In recognition of the key role that Managers play, the Trust has reviewed its current Leadership and Management Development offers to strengthen the training for Managers, around instilling psychological safety in their teams and encouraging staff to have a voice, and ensuring that Managers are supported to act on that feedback.

3.4 The Leader in Me event on the 15th of December is solely dedicated to demonstrating to our staff that we have a commitment to listening and acting on their feedback. The session will focus on psychological safety and overcoming any real or perceived barriers to speaking up.

There will be external speakers present on the morning of the event with an interactive and facilitated staff session in the afternoon that focuses on the various means the Trust has to raise concerns.

3.5 There is a recognition that we need to strengthen our approach to Trust wide feedback on all of the mechanisms we have in place to listen to our staff and we are striving to continuously develop and improve.

3.6 Over the coming weeks and months, we intend to enhance our approach to "You Said…..We did….We are Doing" as a means of ensuring that all feedback received is acted upon and communicated out to staff in a timely manner.

4. SUMMARY AND CONCLUSION

4.1 Whilst we have a really positive approach to listening to our staff, it is recognised that based on the results of the 2022 Staff Survey and the recent anonymous survey, that we need to do more. There will always be room for improvement.

4.2 Staff who feel they are listened to, with their feedback acted upon, will be more likely to provide the invaluable feedback that we need to improve our experience for staff and ultimately our patients and service users.

5. RECOMMENDATION

5.1 The Trust Board is asked to note the various mechanisms that we have across the Trust to listen to our staff and be assured on the future plans to enhance our approach to acting upon it and feeding back to staff in a timely manner.

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**89/23**		
Report Title	**REFRESHED 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**

Executive Summary

The purpose of this report is to ask the Board to approve the refreshed Board Assurance Framework (BAF) which reflects the updated strategic objectives. It outlines the journey of the development of the BAF and presents the document to be used going forward within the Board, Committees of the Board, and other key Trust meetings in the management of risks against the Trust objectives.

Previously considered by:

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

Strategic Objectives

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

☒ **Innovation and collaboration** – to deliver innovative and integrated care closer to home which supports and improves health, wellbeing and independent living

☒ **People** – to be a highly effective organisation with empowered, highly skilled and competent staff

☒ **Quality** – to deliver high quality, safe and effective care which meets both individual and community needs

☒ **Sustainability** – to deliver value for money, ensure that the Trust is financially sustainable and contributes to system sustainability

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

☒ **BAF 1**	☐ **BAF 2**	☐ **BAF 3**	☐ **BAF 4**	☐ **BAF 5**	☒ **BAF 6**	☒ **BAF 7**	☒ **BAF 8**
Failure to implement and maintain sound systems of corporate governance	Failure to deliver safe & effective patient care	Managing demand & capacity	Financial sustainability	Staff engagement and morale	Staffing levels	Strategy & organisational sustainability	Digital services

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

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**7 December 2023**
Agenda Item	**89/23**		
Report Title	**REFRESHED BOARD ASSURANCE FRAMEWORK**		
Report Author	Jan McCartney – Trust Secretary		
Purpose	The purpose of this report to ask the Board to approve the refreshed Board Assurance Framework (BAF) which reflects the updated strategic objectives.		

1. Introduction and Background

1.1 The purpose of this report is to present an updated refreshed Board Assurance Framework (BAF) to the Board of Directors. A BAF is a document that tells a Board how it is managing the major strategic risks that could prevent it from achieving its objectives.

1.2 The BAF is used at all Board and Committee meetings, it is also considered at Council meetings that report to Board Committees. The Head of Internal Audit opinion 2022/23 provides an opinion of substantial assurance, 'that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently'. The BAF is an integral part of enabling the Trust to achieve this.

1.3 In April 2023 the Board approved a new strategy, 'Communities Matter', which included a refreshed set of strategic objectives. These are:

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

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

2. Development of refreshed Board Assurance Framework

2.1 The Board recognised that the BAF would need a substantial refresh to reflect these updated objectives, recognising that some objectives were new to the Trust.

2.2. Initially all the information from the current BAF was transferred to a new document describing the updated objectives. The Trust Secretary then met with all the Executive leads individually, and their senior team, to start to populate the new document. This included drafting the narrative for the risks, identifying controls and any gaps in those controls. A new section was added that could capture emerging risks.

2.3 The individual BAF risks were then assigned a principal Committee who would take oversight of that particular risk, whilst recognising that the style of this particular BAF would require multiple Committees to contribute and shape each risk. An additional risk was added as BAF1 to reflect the risk of failing to implement and maintain sound systems of corporate governance and failure to deliver on the Trust's strategy.

2.4 Each of the Committees then had sight of the developing document to enable members and attendees to contribute to the BAF.

2.5 In October 2023 the Board had an opportunity to review the refreshed BAF in the closed section of the Board meeting. The Board asked for the Executive team to review the document in detail and then for each Executive lead to meet with the relevant Committee Chair to review updates.

2.6 At the Board Time Out in November 2023 the Board had another opportunity to review and update the BAF. All the updates have been incorporated and the final version is being presented to the Board for approval today.

2.7 This version of the BAF is likely to undergo many updates in the coming months as the Board and its Committees start to use and embed it.

3. Recommendation

3.1 The Board is asked to note the development of the refreshed BAF and approve this version for use going forward. Approval of this version of the BAF will result in the current BAF being closed and archived.

BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST – BOARD ASSURANCE FRAMEWORK

LAST UPDATED 29 NOVEMBER 2023

STRATEGIC OBJECTIVES

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

BAF 1 **Governance** **Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy**	BAF 2 **Quality** **Failure to deliver quality services and continually improve**	BAF 3 **Health Equity** **Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients**	BAF 4 **Staff** **Failure to create an environment for staff to grow and thrive**	BAF 5 **Resources** **Failure to use our resources in a sustainable and effective way**	BAF 6 **Equality, Diversity & Inclusion** **Failure to build a culture that champions equality, diversity and inclusion for patients and staff**	BAF 7 **Partnerships** **Failure to work in close collaboration with partners and staff in place and across the system**
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 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 Rating** Inherent risk rating 2 (C) x 5 (L) = 10 **high** Current risk rating 2 (C) x 4 (L) = 8 **medium** Target risk rating 2 (C) x 2 (L) = 4 **low**	**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 **low**	**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 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 **low**	**Risk Rating** Inherent risk rating 3 (C) x 4 (L) = 12 **high** Current risk rating 3 (C) x 4 (L) = 12 **high** Target risk rating 3 (C) x 2 (L) = 6 **low**
Risk Appetite: Cautious	**Risk Appetite:** Open	**Risk Appetite:** Open	**Risk Appetite:** Open & Seek	**Risk Appetite:** Open	**Risk Appetite:** Seek	**Risk Appetite:** Seek

Board Assurance Framework (BAF) December 2023 – V1

BAF 1:
Governance

Failure to implement and maintain sound systems of Corporate Governance and failure to deliver on the Trust's Strategy

RELATED OBJECTIVES:
- Quality
- Health Equity
- Staff
- Resources
- Equality, Diversity and Inclusion
- Partnership

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

Preference for safe delivery options that have a low degree of residual risk and only a limited reward potential

Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		
Chief Executive Officer last review: November 2023 **Audit Committee** last review: Month 2023 Risk Ratings review: Month 2023	If the Trust is unable to put in place and maintain effective corporate governance structures and implement and maintain sound systems of Corporate Governance, then there may be poor oversight of Board level risks and challenges, resulting in damage to reputation, integrity and accountability, resulting in failure to deliver on the strategy. 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 ICB, 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 **Rationale for current score** • Governance structure approved by Board and audited by internal and external auditors. • Substantial Assurance – Heads of Internal Audit opinion 2022/23 • Triangulation with Risk Register, Incidents, items on Committee agendas. • Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. Increased assurance from system relationships and partnerships • Trust Strategy 2023 'Communities Matters', now approved by Board with enabling strategies • Trust System Oversight Framework (SOF) is segment 2 • Well Led 2023 report and recommendations accepted and action plan being developed	**Prevent Controls** • Accountability Framework in place • Board Assurance Framework & Risk Register • Board development • Standing Financial Instructions • Scheme of Reservation and Delegation • Operational management structure and policies and procedures are in place • Trust Board scrutiny	**Detect Controls** • Board development • Chair working within wider system • Committees receive by exception reports from operations leads, these are reported to the Board • Contributing to work across the system in relation to developing Children's Services • Council structure, reporting to Committees • Engagement internally / externally with partners • Execs carrying out SRO roles within system, e.g. aging well, starting well, workforce and integrated community teams • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • Implementing dental strategy with partners • Joint working on a number of projects with commissioners and local authority • Performance framework – enabling strategies - operation delivery plans • Regular Exec meetings with commissioners and other key stakeholders • Senior Leadership Team meeting monthly • Senior staff involvement with borough based integrated care partnerships visions; 'Warrington Together' and 'One Halton' • Staff engagement • Targeted action planning on Staff Survey results • Compliance with ICB requirements	**Assurances** • Annual Review of Effectiveness of Audit Committee • Annual Review of Effectiveness of External Audit Service • Annual Review of Effectiveness of Internal Audit & Anti-Fraud • Annual Reports received from Committees of the Board • Board, Committees (Audit, Quality & Safety, Finance & Performance, and People) • Clean Unmodified Audit Opinion & clean VFM opinion 2022/23 • Daily automated data reporting • Declarations of Interests Register • Emerging integrated governance structures with partners • External independent Well Led review 2023 • Internal Audit Plan agreed for 2023/24 • 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 • MIAA governance checklists • MOU in place where services are delivered in conjunction with other partners • Programme Director – Collaboration and Integration • Trust continuous improvement plan in place **Audits** • Board Assurance Framework Review - (2022/23) • Risk Management Core Controls – high assurance (2022/23) • DSPT Audit – substantial assurance (2022/23) • Conflicts of Interest 2022/23 – high assurance

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.
- Implementation of revised system governance arrangements, to be finalised – ongoing maturity
- the immaturity of the work on measuring the delivery and impact of the Trust's strategy

Emerging risks:
Financial system risk may have implications for the Trust going forward

Board Assurance Framework (BAF) December 2023 – V1

BAF 2:
Quality

Failure to deliver quality services and continually improve.

RELATED OBJECTIVES:
- Health Equity
- Resources
- Staff

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:

OPEN

Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.

Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		

Deputy CEO / Chief Nurse
last review: November 2023
 	
Q&S Committee
last review: Month 2023
 	
Risk Ratings review: Month 2023
 	
In collaboration with People
	If we fail to deliver quality services and continually improve, in a safe, inclusive environment then there may be potential harm to patients, an increase in complaints and claims and as a result, poor patient experience.
	
	Risks on register 15 plus
	2829: Safeguarding – IHA Pathway
	3177: IPC concerns in Warrington Wolves
	3178: ADHD medication shortages (nationally)
	
	Rationale for current score
	
	• Winter plan
	• Enabling strategies:
	  • Medicines Management
	  • Safeguarding
	  • Engagement
	  • Risk
	  • People strategy
	  • EDI strategy
	• Industrial action (BMA)
	• Number of quality risks
	• Quality & Safety governance structure in place.
	• Robust QIA process for service changes
	• Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports.
	• Waiting list pressures
		Prevent Controls
		• Clinical policies, procedures & pathways
		• Weekly Senior Safety Huddle
		• Directorate Team Meetings
		• Freedom to Speak Up Guardian in place
		• Quality Impact Assessment Process
		• Risk Management, Quality, Performance & Transformation Councils in place
		• Trust Strategy – Communities Matter
		• Winter Plan
		• Statutory & Mandatory Training
			Detect Controls
			• Clinical & Internal Audit Programme
			• Clinical Quality and Performance Groups (CQPGs) in place with all NHS commissioners.
			• E-roster monitoring
			• End of Life group
			• Equality Impact Assessments
			• Health and Safety group
			• Increased reporting of incidents, including medication incidents
			• IQPR & quality dashboards
			• Learning from Deaths report
			• Quality Council
			• Performance Council
			• Quality & Safety Committee bi-monthly meetings
			• Quality Impact Assessments
			• Quality Visits
			• Trust Transformation Programme (BOOST)
			• Patient experience scores
			• Listening to staff voices
			• Revalidation & registration
				Assurances
				• Regular engagement with CQC
				• External Well Led review
				• IQPR & quality dashboards
				• Consistency of reporting patient safety incidents (measured nationally)
				• Deep dives at Committee
				
				Audits
				• Risk Management Core Controls- High assurance (2022/23)
				• Waiting List Management – substantial assurance (2022/23)
				• Safeguarding – substantial assurance (2022/23)
				• Quality Spot Check – significant assurance (2021/22)

Gaps in controls and assurance and mitigating actions:
- Staff compliance with mandatory and service and role specific training
- Paediatric Audiology
- Clinical leadership strategy – in development
- Recruitment & Retention
- CIP 2023/24

Emerging risks:
Community Paediatrics –
1. ADHD/ASD national medication shortage, and
2. ADHD increasing levels of demand

BAF 3:
Health Equity

Failure to collaborate with partners and communities to improve health equity and build a culture that champions ED&I for patients.

RELATED OBJECTIVES:
- Equality, Diversity, and Inclusion
- Partnerships
- Quality

RISK RATING:
Inherent risk rating: 3 (C) x 5 (L) = 15 **significant**
Current risk rating: 3 (C) x 4 (L) = 12 **high**
Target risk rating: 3 (C) x 2 (L) = 6 **medium**

RISK APPETITE:

OPEN

Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.

Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		

Medical Director
last review: November 2023
 	
Q&S Committee
last review: Month 2023
 	
Risk Ratings review: Month 2023
 	
In collaboration with F&P and People
	If we fail to understand health inequity with our communities, we may fail to deliver services in an equitable way, which could contribute to health inequity and our patient's ability to improve their health.
	
	Risks on register 15 plus
	No risks at this level
	
	Rationale for current score
	
	• Enabling strategies:
	  • Prevention Pledge
	  • JSNA
	• Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports.
	• Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. Increased assurance from system relationships and partnerships
	• Trust Strategy 2023 'Communities Matter', now approved by Board with enabling strategies
	• Trust System Oversight Framework (SOF) is segment 2
	• Health equity will be influenced by national, regional and local policies. The Trust will influence some elements of health equity but cannot be singularly responsible for improving health equity where we work.
		Prevent Controls
		• Board development
		• Chair working within wider system
		• 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
		• Health Inequalities and Prevention Pledge Trust Board Oversight – engagement and delivery of Health & Care Act & strategic milestones
		• Performance framework – enabling strategies - operation delivery plans
		• Embedding an expectation of improving health equity in board, committees and Trust groups.
			Detect Controls
			• Execs carrying out SRO roles within system, e.g. starting well, living well and aging well.
			• Joint working on a number of projects with commissioners and local authority
			• Patient Satisfaction Surveys
			• Regular Exec meetings with commissioners and other key stakeholders
			• Senior staff involvement with borough based integrated care partnerships visions including: 'Warrington Together', 'One Halton' and Dental Networks
			• Understanding activity and referral data in relation to access to services
			• Health & Wellbeing Boards
			• CIPHA
			• Childrens and Adults safeguarding Boards
				Assurances
				• Emerging integrated governance structures with partners
				• Engagement internally / externally
				• Executive Directors hold regular meetings with all key partners and stakeholders
				• Implementing Dental Strategy with partners
				• 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
				• MOU in place where services are delivered in conjunction with other partners
				• Programme Director – Collaboration and Integration
				• Achieving Anchor status
				• Developing health equity indicators in IQPR
				
				Audits
				• Waiting List Management – substantial assurance (2022/23)

Gaps in controls and assurance and mitigating actions:	Emerging risks:
• Implementation of revised system governance arrangements, to be finalised – ongoing maturity • Health equity improvement is a system responsibility • Mature health equity indicators • Quality Impact Assessment Panels	

BAF 4:
Staff

Failure to sustain an environment for staff to develop, grow and thrive.

RELATED OBJECTIVES:
- Equality, Diversity and Inclusion
- Health Equity
- Partnerships
- Resources
- 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 **low**

RISK APPETITE:

OPEN - Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.

& SEEK - Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)

Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		

Director of People & OD
last review: November 2023
 	
People Committee
last review: Month 2023
 	
Risk Ratings review: Month 2023
	If we fail to sustain an environment for staff to develop, grow and thrive, in a safe, inclusive environment then it may result in low staff morale, 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
	
	Rationale for current score
	
	• Enabling strategies:
	  • People
	  • Staff engagement framework
	  • EDI Strategy
	
	• Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports.
	
	• Vacancy management rates
		Prevent Controls
		• Apprenticeship Programme
		• Bi-monthly meetings with Staff Side
		• Freedom to Speak Up
		• In-house Resilience Training Programme
		• Local Negotiating Committee, Joint Negotiation & Consultative Committee
		• North West Person-Centred approach to absence management
		• Occupational Health Service & Staff Health & Wellbeing Officer/Board Health & Wellbeing Guardian
		• Onboarding surveys
		• People Committee Organisational and local Staff engagement plan
		• People Plan, Promises & NHS Long Term Workforce Plan
		• POD Council
		  • Culture and Leadership
		  • Recruitment & Retention
		  • Health & Wellbeing programme
		  • Education & Professional development
		• PPDR and Statutory & Mandatory Training compliance report
		• Talent Management process and Succession Planning Tool (Scope For Growth)
		• Reward package
		• Vacancy Management (standing agenda item DLTs)
		• Workforce planning and plans
		• Staff governors
			Detect Controls
			• Feedback from Quality and Safety Committee on workforce issues
			• Safer staffing
			• Monthly Time to Talk including CEO Q&A sessions
			• National Staff Survey
			• North West Person-Centred approach to absence management (early adopter Trust)
			• Onboarding surveys
			• People Indicators / KPIs
			• POD Council (operational plans)
			  • Culture and Leadership
			  • Recruitment & Retention
			  • Health & Wellbeing programme
			  • Education & Professional development
			• PPDR and Statutory & Mandatory Training compliance report
			• Exit interview questionnaire
			• Staff Friends and Family Test (SFFT) and Staff Engagement Surveys
			• Staff Networks Staff Stress Audit Survey
				Assurances
				• Employee Relations Activity Report
				• Outcome of Staff Survey – sustained score for staff engagement
				• Responsible Officer's Board report
				• Staff Survey and 'temperature check' surveys
				• Triangulation of People Indicators
				
				Audits
				• Conflicts of Interest – high assurance (2022/23)
				• Mandatory Training & Appraisals – moderate assurance (2022/23)
				• Freedom to Speak Up substantial assurance (2020/21)
				• Induction - substantial assurance (2020/21)

Gaps in controls and assurance and mitigating actions: • Staff morale and resilience (inc. cost of living crisis) – ongoing monitoring, communication, engagement and health and wellbeing services and programmes • Pay negotiated nationally, strikes ongoing			**Emerging risks:** System wide commitment to level playing field on incentives National shortage of key staff groups	

Board Assurance Framework (BAF) December 2023 – V1

BAF 5:
Resources

Failure to use our resources in a sustainable and effective way

RELATED OBJECTIVES:
- Equality, Diversity and Inclusion
- Health Equity
- Quality
- Staff

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

Willing to consider all potential delivery options and choice while also providing and acceptable level of reward.

Lead Director/ Lead Committee	Principal risk	Prevent Controls & Assurances		

Director of Finance
last review: Month 2023
 	
F&P Committee
last review: Month 2023
 	
Risk Ratings review: Month 2023
 	
In collaboration with People
	Failure to utilise our resources in an efficient effective and sustainable way could impact on the quality and safety of services provided.
	
	(Recourses include workforce, finance, estates and digital)
	
	Risks on register 15 plus
	
	3155: Failure to meet CIP target (Dental)
	
	Rationale for current score
	
	• Triangulation with the various areas of resource including; financial, physical, digital and staff.
	• Triangulation with Risk Register, Incidents, items on Committee agendas, Council Chair's Reports.
	• Governance arrangements in place
	• Committees of the Board
	• Break even budget 2022/23 achieved
	• Enabling strategies:
	  • Digital
	  • Finance
	  • Estates & Development
	  • Green Plan
	  • People
	  • EDI
		Prevent Controls
		Careful utilisation of our resources will enable us to invest and transform our services to ensure continued sustainability of the services we provide.
		This will be achieved through:
		
		Finance - National and regional financial planning and management arrangements, Trust Financial Plan and planning process, Accountability Framework and Standing Financial Instructions with limits approved by the Board, Agreed medical and nursing revalidation protocols, preparation and remedial processes.
		
		People - Agreed recruitment and selection policies and processes (safer recruitment / FPPT). Bi-monthly meetings with staff side between JNCC, HR Policies and working groups, People Strategy & NHS Long Term Workforce Plan, POD Council, DLT discussions including HR Business Partners, Business continuity plans in place, Robust temporary staffing expenditure control and monitoring – MIAA follow up in progress
		
		Digital - Trust Digital Strategy, project governance and assurance, DSP Toolkit, GDPR Cyber Security standards, Service Management standards (ITIL, ISO etc)
		
		Estates - Capital Plan, Estates Strategy Trust hybrid working Green Plan, Process around Capital and Revenue Business Cases
		
		Operations - Transformation Council etc
			Detect Controls
			• Agency staff reporting / Staff sickness reporting
			• Audit Committee receives reports from internal audit and external audit
			• Capital Group monthly review
			• CIP plus QIA process
			• Exec team and Committees receive Audit Recommendations tracker
			• F&P Committee review bi-monthly financial performance
			• People Committee review KPIs
			• ICB control and reporting (finance, workforce and activity)
			• NHSE monthly returns
			• Premium Pay and Spend reporting
			• Scrutiny of Agency spend
			• Staff survey / Pulse Survey results
			• Turnover rate reporting
				Assurances
				• Board review of internal audit plan
				• Board review of external audit plan and annual accounts
				• Escalation from Quality & Safety Committee
				• Health Rostering / Safer Staffing Report
				• Integrated Quality Performance Report includes workforce metrics including training levels and 'heat map'
				• Monthly Finance Report including
				  • Financial position / Forecast Position
				  • Cash & Capital
				  • Working Capital
				  • CIP
				• Performance report indicating number of lapsed registrations each month
				• Review of Winter Plans
				• Vacancy approval process reviews use of agency staff – regular review of staffing levels
				• Workforce plans developed by service to support recruitment
				
				Audits
				
				Internal audit
				Payroll audit - substantial assurance (2022/23)
				• Data Quality & Performance Targets - substantial assurance (2022/23)
				• Waiting List Management - substantial assurance (2022/23)
				• Induction audit - substantial assurance (2020/21)
				• Key Financial Systems - high assurance (2020/21) and substantial assurance (2022/23)
				
				External audit
				• Clean Unmodified Audit Opinion & clean VFM opinion 2022/23

Gaps in controls and assurance and mitigating actions:	Emerging risks:
• The 2023/24 Trust plan reflects challenging CIP • 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. • Safe Staffing reporting	ICB management of system deficit Review of Trust estate

Board Assurance Framework (BAF) December 2023 – V1

BAF 6: **Equality, Diversity & Inclusion** **Failure to build a culture that champions ED&I for staff**	**RELATED OBJECTIVES:** • Health Equity • Resources • Staff	**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) = 1 **low**	**RISK APPETITE:** **SEEK** **Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)**

Lead Director/ Lead Committee	**Principal risk**	**Prevent Controls & Assurances**		

Director of People & OD
last review: November 2023
 	
People Committee
last review: Month 2023
 	
Risk Ratings review: Month 2023
 	
In collaboration with F&P and Q&S
	If we fail to continue to build a culture that champions EDI for staff, (the baseline) then:
	
	- we will not meet the diverse needs of our workforce, adversely impacting on the provision of compassionate care to our diverse population, representative of the communities we serve.
	
	- staff with protected characteristics may have a poor experience
	
	Risks on register 15 plus
	No risks at this level
	
	Rationale for current score
	
	• Current risk rating reflects that the Board acknowledges that, despite the controls and assurances in place, this will be ongoing:
	  • Organisational restructures, service redesigns and reorganisations
	  • Patient experience may be adversely affected (links to Q&S Committee)
	  • Restoration and recovery programmes / post covid effects
	  • Recovery from Industrial Action
	  • Uncertainty / Impact of national change programmes – Health & Care Act integration and collaboration
	• Enabling strategies:
	  • Equality, Diversity & Inclusion
	• People Committee ensure governance and holds to account.
	• Triangulation with Risk Registers, incidents, employee relations activity, items on Committee agendas, Council Chair's Reports, IQPR People Indicators and KPIs
		Prevent Controls
		• Anti-Racist Framework
		• Bi-monthly meetings with Staff Side with regard to the NHS EDI Improvement Plan
		• EDS2
		• Education & Professional development
		• Health & Wellbeing programme
		• Local Negotiating Committee and Joint Negotiation & Consultative Committee
		• North West Person-Centred approach to absence management (one of 4 Trusts piloting this)
		• People Committee
		• Organisational and local Staff engagement plan
		• POD Council
		• Public Sector Equality Duty
		• Recruitment & Retention processed (EDI focused)
		• Talent Management process and Succession Planning Tool (Scope For Growth)
		• Just Culture
		• WDES
		• WRES
			Detect Controls
			• Feedback from Quality and Safety Committee on workforce issues
			• Freedom to Speak Up process
			• Employee relations activity/case loads
			• Gender Pay Gap Report
			• HR Policies & Procedures
			• In-house Resilience Training Programme
			• Key Operational Delivery Controls
			• National Staff Survey
			• NW EDI Group
			• NW Assembly Support
			• POD Council
			• Revised exit interview questionnaire and processes
			• Staff Friends and Family Test (SFFT) and Staff Engagement Surveys
			• Staff Stress Audit Survey
			• Staff survey feedback
				Assurances
				• Outcome of Staff Survey – sustained score for staff engagement
				• People Operational Delivery Actions Plans
				• Public Sector Equality Duty
				• Staff Networks
				• Staff Survey and 'temperature check' surveys
				• People Indicators and KPIs
				
				Audits
				Internal Audit
				• Freedom to Speak Up – substantial assurance (2020/21)
				• Induction – substantial assurance (2020/21)

Gaps in controls and assurance and mitigating actions:	**Emerging risks:**
• Engagement with staff groups including BAME and LGBT+ staff (remain until all established Networks are considered to be embedded)	

Board Assurance Framework (BAF) December 2023 – V1

BAF 7: Partnerships **Failure to work in close collaboration with partners and staff in place and across the system**	**RELATED OBJECTIVES:** • Quality • Health Equity • Staff • Resources • Equality, Diversity and Inclusion • Partnership	**RISK RATING:** Inherent risk rating: 3 (C) x 4 (L) = 12 **high** Current risk rating: 3 (C) x 4 (L) = 12 **high** Target risk rating: 3 (C) x 2 (L) = 6 **low**	**RISK APPETITE:** **SEEK** **Eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)**

Lead Director/ Lead Committee	**Principal risk**	**Prevent Controls & Assurances**		
Chief Executive last review: November 2023 **EMT** last review: Month 2023 Risk Ratings review: Month 2023	If we fail to 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, then: - we will fail to work with partners to champion patient care, resulting in failure to optimise outcomes and failure to effectively use resources - we will fail to deliver on our Strategic Objectives and the Strategic Objectives of the Integrated Care Board **Risks on register 15 plus** No risks at this level **Rationale for current score** • Enabling strategies: • Dental • Increased assurance from system relationships and partnerships • Triangulation with Risk Register, Staff Survey, reports from Partner organisation, items on all Committee agendas, Council Chair's Reports and EDI Improvement Plan. • Trust involved in the continuing development of the Integrated Care Boards and Provider Collaborative. • Current level of investment in Place based set up • Contribution to Warrington based adaptive reserve fund	**Prevent Controls** • 'Communities Matter' Trust Strategy • Contributing to work across the system in relation to developing services • Emerging integrated governance structures with partners • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • 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 • Health Education England, teach and develop students from partner learning organisations • Voluntary Link Workers • Community Health Workers • SLA with GP Health Connect • MOU with University of Central Lancashire	**Detect Controls** • Board development and NHS Providers • Chair working within wider system • Contributing to work across the system in relation to developing services • Execs carrying out SRO roles within system, e.g. aging well, starting well, workforce and integrated community teams • Exec involvement in ICS and Provider Collaborative development across the Cheshire & Mersey and GM footprint • Joint working on a number of projects with commissioners and local authorities • National involvement in strategy for intermediate care • Performance framework – enabling strategies - operation delivery plans • Senior staff involvement with borough based integrated care partnerships visions; 'Warrington Together', 'One Halton' and dental managed clinical networks • Trust Board Oversight – engagement and delivery of Health & Care Act & strategic milestones • Cross organisational incident reporting and investigation • Intermediate Care Board • Dental Clinical Networks • Place-based maturity assessments (Warrington Together and One Halton)	**Assurances** • Implementing dental strategy with partners • MOU in place where services are delivered in conjunction with other partners • Programme activity of the Mental Health, Community and Learning Disability Provider Collaborative • Public and community engagement • Place-based leadership and influence • ICB Virtual Ward programme • PCN developments and relationships **Audits** •

Gaps in controls and assurance and mitigating actions:	**Emerging risks:**
• Maturity of place-based relationships • Impact of pressures (inc. finance)	

Appendix 1: BAF Tracker – to be added in February 2024

Board Assurance Framework (BAF) December 2023 – V1

Appendix 2: Risk grading criteria

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.

	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.	Multple 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

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	

Bridgewater Community Healthcare NHS Foundation Trust

BOARD OF DIRECTORS

Title of Meeting	**BOARD OF DIRECTORS**	**Date**	**07 December 2023**
Agenda Item	**89/23ii**		
Report Title	**2024/25 CORPORATE CALENDAR**		
Executive Lead	Colin Scales, Chief Executive		
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 proposed calendar for Board, Committees and Board Time out sessions for 2024/25 is attached as Appendix 1.

This has been developed by the Executive team after taking into consideration the cycles of information being available and reports required from Council meetings. This calendar largely reflects the calendar of 2023/24 with minor changes.

Additional meetings to approve specific items such as the financial plan, annual accounts and annual report have been scheduled which may be subject to change.

Recommendation: to approve the corporate calendar for 2024/25.

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

Appendix 1: 2024/25 Corporate Calendar

Key:

- Closed Board
- Open Board
- Board Time Out (BTO)
- Council of Governors
- CoG Development
- CoG Nominations
- Audit Committee
- F&P
- EMT Dev / Bus
- Q&S
- People
- Nom & Rem

	Apr-24			May-24			Jun-24			Jul-24			Aug-24			Sep-24			Oct-24			Nov-24			Dec-24			Jan-25			Feb-25			Mar-25		
		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM		AM	PM	
Sun							2									1									1				2			2					Sun
Mon	1	Bank Holiday					3			1						2									2				3			3					Mon
Tue	2						4			2						3			1						3				4			4					Tue
Wed	3			1			5			3						4			2						4			1		Bank Holiday		5					Wed
Thu	4	Open Board	Closed Board	2	BTO		6	Open Board	Closed Board	4	Audit		1			5	BTO		3	Open Board	Closed Board				5	Open Board	Closed Board	2			6	Open Board	Closed Board	6	BTO		Thu
Fri	5			3			7			5			2			6			4			1			6			3			7			7			Fri
Sat	6			4			8			6			3			7			5			2			7			4			8			8			Sat
Sun	7			5			9			7			4			8			6			3			8			5			9			9			Sun
Mon	8			6	Bank Holiday		10			8			5			9			7			4			9			6			10			10			Mon
Tue	9			7			11			9			6			10			8			5			10			7			11			11			Tue
Wed	10			8	People		12			10	People		7			11	People		9			6			11			8			12	CoG Noms		12	People		Wed
Thu	11			9			13			11	BTO		8	Open Board	Closed Board	12			10	Audit		7	BTO		12			9	Audit		13			13			Thu
Fri	12			10			14			12			9			13			11			8			13			10			14			14			Fri
Sat	13			11			15			13			10			14			12			9			14			11			15			15			Sat
Sun	14			12			16			14			11			15			13			10			15			12			16			16			Sun
Mon	15			13			17			15			12			16			14			11			16			13			17			17			Mon
Tue	16			14			18			16			13			17			15			12			17			14			18			18			Tue
Wed	17	CoG		15	CoG Dev		19	CoG		17	CoG Dev		14	CoG		18	CoG Dev		16	CoG		13	People	CoG Dev	18	CoG		15	CoG Dev		19	CoG		19	CoG Dev		Wed
Thu	18	Q&S		16			20			18	Nom & Rem		15			19	F&P		17			14			19	Q&S		16	BTO		20			20	F&P		Thu
Fri	19			17			21			19			16			20			18			15			20			17			21			21			Fri
Sat	20			18			22			20			17			21			19			16			21			18			22			22			Sat
Sun	21			19			23			21			18			22			20			17			22			19			23			23			Sun
Mon	22			20			24			22			19			23			21			18			23			20			24			24			Mon
Tue	23	Audit		21			25			23			20			24			22			19			24			21			25			25			Tue
Wed	24	x F&P		22			26	x Audit	x BoD	24			21			25			23			20			25	Bank Holiday		22	People		26			26			Wed
Thu	25			23	x Audit	F&P	27	Q&S		25	F&P		22			26			24	Q&S		21	F&P		26	Bank Holiday		23	F&P		27	Q&S		27			Thu
Fri	26			24			28			26			23			27			25			22			27			24			28			28			Fri
Sat	27			25			29			27			24			28			26			23			28			25						29			Sat
Sun	28			26			30			28			25			29			27			24			29			26						30			Sun
Mon	29			27	Bank Holiday					29			26	Bank Holiday		30			28			25			30			27						31			Mon
Tue	30			28						30			27						29			26			31			28									Tue
Wed				29						31	CoG Noms		28						30			27						29	Nom & Rem								Wed
Thu				30									29	Q&S					31			28						30									Thu
Fri				31									30									29						31									Fri
Sat													31									30															Sat

Audit: Anti-Fraud Service Effectiveness Survey

Audit: External Audit Effectiveness Survey

Audit: Internal Audit Effectiveness Survey

Audit Effectiveness Survey

F&P Effectiveness Survey

Q&S Effectiveness Survey

People Effectiveness Survey

Board Effectiveness Survey